



**2012 THE GLOBAL STATE
OF HARM REDUCTION**
TOWARDS AN INTEGRATED RESPONSE



**HARM REDUCTION
INTERNATIONAL**



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The Global State of Harm Reduction 2012

Towards an integrated response

Edited by Claudia Stoicescu

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Abbreviations and acronyms

AHRN	Asian Harm Reduction Network	MENA	Middle East and North Africa
AIVL	Australian Injecting and Illicit Drug Users' League	MENAHRA	Middle East and North African Harm Reduction Network
AIDS	Acquired immunodeficiency syndrome	MDT	Mandatory drug testing
ANPUD	Asian Network of People who use Drugs	MMT	Methadone maintenance treatment
ART	Antiretroviral therapy	MSM	Men who have sex with men
ATS	Amphetamine-type stimulants	NASA	National AIDS Spending assessment
BMT	Buprenorphine maintenance treatment	NGO	Non-governmental organisation
CARICOM	Caribbean Community	NIDU	Non-injecting drug use
CHRC	Caribbean Harm Reduction Coalition	NSP	Needle and syringe exchange programme
CND	Commission on Narcotic Drugs	OST	Opioid substitution therapy
CPR	Cardiopulmonary resuscitation	PAHO	Pan American Health Organization (WHO)
CPT	Co-trimoxazole preventive treatment	PEPFAR	President's Emergency Plan for AIDS Relief
CSO	Civil society organisation	PICTs	Pacific Island Countries and Territories
DCR	Drug consumption room	PNEP	Prison needle and syringe exchange programme
DFID	Department for International Development (UK)	SAHRN	Sub-Saharan African Harm Reduction Network
DOTS	Directly Observed Treatment Short-Course	SAMHSA	US Substance Abuse and Mental Health Services Administration
ECOSOC	Economic and Social Council (UN)	SIF	Supervised or safer injecting facility
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction	STI	Sexually transmitted infection
EMRO WHO	Eastern Mediterranean Regional Office	SPC	Secretariat of the Pacific Community
EC	European Commission	TB	Tuberculosis
EU	European Union	UAE	United Arab Emirates
EuroHRN	European Harm Reduction Network	UK	United Kingdom of Great Britain and Northern Ireland
GDP	Gross Domestic Product	UN	United Nations
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	UNAIDS	Joint United Nations Programme on HIV/AIDS
GP	General practitioner	UNDP	United Nations Development Programme
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit	UNESCO	United Nations Economic, Social and Cultural Organization
HAT	Heroin assisted treatment	UNFPA	United Nations Population Fund
HBV	Hepatitis B virus	UNGASS	United Nations General Assembly Special Session
HBsAG	Marker in the blood indicating active HBV infection	UNICEF	United Nations Children's Fund
HCV	Hepatitis C virus	UNODC	United Nations Office on Drugs and Crime
HIV	Human immunodeficiency virus	MENARO UNODC	Middle East and North Africa Regional Office
HLS	High Level Segment	US	United States of America
IDU	Injecting drug use	VCT	Voluntary HIV counselling and testing
IHRA	International Harm Reduction Association	WFP	World Food Programme (UN)
INCB	International Narcotics Control Board	WHO	World Health Organization
INPUD	International Network of People who Use Drugs		

Introductory comments from Michel Sidibé

Executive Director, UNAIDS

The third edition of the Global State of Harm Reduction report comes at a pivotal time in the HIV epidemic.

Thirty per cent of HIV infections outside sub-Saharan Africa, representing approximately 3 million people, are attributed to injecting drug use. New infections among people who use drugs account for an increasing share of global HIV incidence. In Eastern Europe and Central Asia, injecting drug use accounts for up to 80% of HIV infections, with the annual rate of new HIV infections in the region having increased by more than 250% between 2001 and 2010.^a In several countries in sub-Saharan Africa including Kenya, Tanzania and South Africa a new wave of infections due to drug injecting has emerged in recent years.

This reality serves as an urgent reminder of the commitment made by all United Nations Member States in the 2011 Political Declaration on HIV/AIDS to reduce transmission of HIV among people who inject drugs by 50% by 2015. Achieving this target demands a cohesive response to HIV from UN agencies, states, civil society and affected communities alike based on the strongest available public health evidence and human rights principles.

UNAIDS is unequivocal in its message to Member States about what works to reduce HIV transmission among people who inject drugs. The evidence is clear and decisive: sufficient provision and coverage of needle and syringe programmes, opioid substitution therapy and antiretroviral therapy as part of the nine key interventions outlined in the WHO, UNODC, UNAIDS technical guide work to effectively reduce HIV transmission among people who inject drugs, as well as providing other measurable benefits to individuals' health and their communities.

Despite the existence of these evidence-based and cost-effective harm reduction interventions, their coverage remains shockingly low. As this report highlights, fewer than two clean needles per month are distributed globally per person who injects drugs, under 13% of people who use drugs are enrolled in opioid substitution therapy, and only 4% of people who inject drugs living with HIV are on antiretroviral treatment.^b

Most alarming is that a significant number of countries with reported injecting drug use continue to restrict access to these services. Punitive laws and policies, whether via prohibiting the provision of sterile injecting equipment and opioid substitution therapy, criminalising drug use,

possession of injecting paraphernalia, or denying HIV treatment to people who use drugs, violate people's right to health and harm the community. Such punitive policies not only fail to reduce HIV transmission but create unintended harms – for instance, by driving people who inject drugs away from prevention and care and resulting in prison overcrowding. Responses to HIV should transcend ideology and be based on scientific evidence and sound human rights principles; they should support, not punish, those affected.

UN Secretary-General Ban Ki-Moon stated that “No one should be stigmatised or discriminated against because of their dependence on drugs” and called on UN Member States to ensure that people who use drugs have equal access to health and social services. An important function of UNAIDS is to highlight the adverse human rights and public health impacts of restrictive laws and policies, and “to create protective social and legal environment that enable access to HIV programmes.”^c Further, in its 2011–2015 Strategy, *Getting to Zero*, UNAIDS is explicit about reducing by half the number of “countries with punitive laws and practices around HIV transmission, drug use or homosexuality that block effective responses”.

The need for legal reform aligned with HIV prevention and treatment, complemented by the meaningful involvement of people who use drugs in service and policy formulation and implementation, has never been more imperative than it is now for achieving the goal of universal access.

On behalf of the UNAIDS Secretariat and our co-sponsors, I am proud to say that UNAIDS is committed to playing the leading role in a coordinated, unambiguous and bold UN response to HIV among people who inject drugs. In an increasingly hostile policy climate, we must replace dangerous complacency with decisive action when it comes to HIV-related harm reduction. Without firm global leadership, evidence and human rights-based national policies, bold resource replenishment for harm reduction and urgent scale-up of harm reduction interventions, there will be no “getting to zero”.

The original Global State of Harm Reduction report, published in 2008, provided the first global snapshot of harm reduction service availability and coverage, reflecting the contributions of civil society organisations, multilateral agencies and researchers in the drug-related HIV response. Since then, the biennial reports have become an indispensable reference tool and authoritative resource for a wide range of agencies and individuals engaging in advocacy for harm reduction worldwide. The latest edition

a UNAIDS (2010) *Global Report. UNAIDS Report on the Global AIDS Epidemic*. Geneva: UNAIDS.

b Mathers BM et al. for the UN Reference Group on IDU (2010) The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review, *Lancet*, 372 (9651): 1733–1745.

c UNAIDS (2010) *Strategy 2011–2015: Getting to Zero*. Geneva: UNAIDS

of the report includes important data on viral hepatitis, and a timely focus on intersections between drug use, HIV and harm reduction services among other key affected populations, including women, children and men who have sex with men. These sub-populations of people who inject drugs are often the most marginalised in the global AIDS response, requiring immediate services and a proportionate allocation of HIV prevention resources. The promotion of harm reduction as part of a bolder, more united and more

comprehensive global effort will be essential to halving HIV infections among people who inject drugs by 2015.



Michel Sidibé
Executive Director, UNAIDS

Introductory comments from Michel Kazatchkine

Member of the Global Commission on Drug Policy

People who inject drugs remain a key population in global health, accounting for around 3 million HIV infections and 10 million hepatitis C infections. This is in addition to the numerous financial, social and public health burdens associated with overdose and drug dependence. But if you are reading this report, you probably know this all too well.

However, these issues – and the proven harm reduction interventions that can address them – are more important now than ever before. In a global economic downturn the burden of drug use is likely to increase, while the finances to deal with these problems become ever more limited. In 2011, United Nations Member States committed to reducing HIV transmission among people who inject drugs by 50% in the next four years, and yet we now face a major crossroads in the response. It is essential that people who use drugs are not forgotten or overlooked.

The Global State of Harm Reduction reports have fast become an integral tool in the ongoing advocacy for people who inject drugs. These biennial documents are helping us to track the progress that has been made. Grassroots projects to protect people who inject drugs in the 1980s have been developed, scaled up and integrated into mainstream healthcare in many diverse countries around the world. The evidence base has also grown, allowing harm reduction to become standard jargon for the key international bodies: including the United Nations General Assembly, the Office of the United Nations High Commissioner for Human Rights, the World Health Organization, the Joint United Nations Programme on HIV/AIDS, and the United Nations Office on Drugs and Crime.

I will always be proud to say that the Global Fund to Fight AIDS, Tuberculosis and Malaria explicitly supports harm reduction and is the leading international donor for this approach.^d The Global Fund faces its own challenges in the current financial climate but remains committed to funding essential services including those for people who inject drugs. This report is a

timely reminder of the urgent need for continued and reliable financing for harm reduction.

This report also highlights huge anomalies in the international response. In 2009, at the International Harm Reduction Conference in Bangkok, I stated that some countries “seem determined to swim against the tide with their wilful blindness to the evidence”. This remains the case. For example, there are 120 countries that report HIV transmission among people who inject drugs, yet only 86 countries implement official needle and syringe programmes to some degree in order to prevent this transmission. In a majority of settings, coverage of such programmes is far below the level needed to have an impact. Too often we have seen inexpensive and cost-effective harm reduction approaches being overlooked, overshadowed or undermined by expensive and often ineffectual approaches with a ‘war on drugs’ rhetoric. The compulsory detention, forced treatment, execution, torture and corporal punishment of people who use drugs simply have to stop. They are violations of human rights and international law.

This is the third edition of this flagship publication, which provides the latest data on harm reduction, expanded regional updates and key thematic chapters. I would like to thank Harm Reduction International for giving me the opportunity to provide these introductory comments, and I wish you all the best in using this valuable resource to promote harm reduction in your own settings.



Professor Michel Kazatchkine
Former Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Member of the Global Commission on Drug Policy

^d Bridge J et al. (2012) Global Fund Investments in Harm Reduction from 2002 to 2009, *International Journal of Drug Policy* (23): 279–285.

Introductory comments by Eliot Ross Albers

Executive Director, International Network of People who Use Drugs (INPUD)

On behalf of the International Network of People Who Use Drugs (INPUD), I welcome this third edition of the Global State of Harm Reduction, and thank Harm Reduction International for giving me the chance to add these opening remarks to what has become an essential tool used by INPUD and our members in their advocacy for the provision of essential harm reduction services for our community.

The evidence base for the efficacy of harm reduction programmes is irrefutable and widely supported by international agencies including UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Human Rights.

Despite the overwhelming evidence in favour of harm reduction programmes, this report shows that there remains a significant discrepancy between what we know should be provided^e and what actually is.

The publication of this report is especially timely, as not only are we in the grip of a global recession, but we are also seeing a political retreat from harm reduction on the domestic front by several states that have historically been strong supporters (e.g. the Netherlands and the United Kingdom); on the other hand, their international support for harm reduction remains strong. In many countries in Eastern Europe where the HIV and viral hepatitis epidemics are especially acute among people who inject drugs and largely driven by the sharing of syringes, harm reduction is scorned. For example, Russia, which has a population of 2 million injecting opiate users, of whom 37.2% are estimated to be living with HIV (in some regions prevalence reaches up to 75%),^f refuses to provide needle and syringe exchange and prohibits the provision of methadone. The USA has also reinstated its ban on spending federal funds on needle and syringe programmes. This is a highly retrogressive step, as it applies not just to the USA but to all programmes, no matter where they are based, that receive federal funds.

Far from being provided with the services that we need, people who inject drugs remain criminalised, marginalised, repressed and discriminated against. We face human rights abuses including torture and corporal punishment, execution, arbitrary violence and abuse, compulsory detention and forced treatment in facilities that provide no medical services but that do subject their inmates to forced labour and often cruel and inhuman treatment.^{g,h} In spite of a recent call for their immediate closure sponsored by 12 UN bodies,ⁱ these facilities remain open and are often applauded, or simply ignored, by the guardians of the international system of punitive prohibition.

The Global State of Harm Reduction 2012 shows that where progress has taken place, it has often been at an insufficiently low level to have an impact on viral hepatitis and HIV epidemics among people who inject drugs, and the new programmes that have been implemented are generally small-scale pilots. The universal provision of harm reduction services is just the first step in righting the systematic human rights abuses to which people who use drugs are subjected. INPUD will continue to advocate and organise to make the voices of the illegal-drug-using community heard.

The Global State of Harm Reduction is an invaluable tool in INPUD's advocacy work and a strident wake-up call to anyone who believes that the work of harm reduction is done. We have known for more than 20 years what measures need to be taken to prevent HIV transmission among people who inject drugs, but we are facing a barrier of intransigent ignorance, prejudice and a refusal on the part of many governments around the world to accept the science. This is unacceptable and should be called what it is – wilful neglect and a breach of basic human rights, not least of all, the inalienable right to the highest standard of health to which all people, whether they use illegal drugs or not, are entitled.



Eliot Ross Albers
Executive Director, INPUD

e WHO, UNODC, UNAIDS (2009) *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. Geneva: World Health Organization.

f Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation (2010) *Country Progress Report on the progress of implementing the Declaration of Commitment on HIV/AIDS adopted at the 26th United Nations General Assembly Special Session on HIV/AIDS. Reporting period: January 2008 – December 2009*. Moscow: Federal Service on Customers' Rights and Human Well-being Surveillance of the Russian Federation.

g Stevens A (2012) The ethics and effectiveness of coerced treatment of people who use drugs, *Human Rights and Drugs*, 2(1) 7–16.

h Hall W et al. (2012) Compulsory detention, forced detoxification and enforced labour are not ethically acceptable or effective ways to treat addiction, *Addiction*, pp. 1–3. doi:10.1111/j.1360-0443.2012.03888.x, <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2012.03888.x/pdf> Accessed 9 July 2012.

i United Nations (2012) Joint Statement: Compulsory drug detention and rehabilitation centres. New York: UN, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf Accessed 20 May 2012.

Introduction

About the Global State of Harm Reduction 2012

In 2008 Harm Reduction International (HRI) released the *Global State of Harm Reduction*, a report that mapped responses to drug-related HIV and hepatitis C epidemics around the world for the first time.^j The information gathered for the report provided a critical baseline against which progress could be measured in terms of the international, regional and national recognition of harm reduction in policy and practice. The second edition, *Global State of Harm Reduction 2010: Key Issues for Broadening the Response*, documented major developments in harm reduction policy adoption and programme implementation that had occurred since 2008, enabling some assessment of global progress. It also explored several key issues for harm reduction, such as the response to amphetamine-related harms; harm reduction in prisons; the reduction of various drug-related health harms including bacterial infections, tuberculosis, viral hepatitis and overdose; and the extent to which financial resources for harm reduction are available.^k

The *Global State of Harm Reduction 2012* presents the major developments in harm reduction policy adoption and programme implementation that have occurred since 2010. It also explores several major topics for developing an integrated harm reduction response, such as effective harm reduction services for women who inject drugs; access to harm reduction services by young people; drug use among men who have sex with men and implications for harm reduction; global progress toward building an enabling policy environment for harm reduction implementation through drug decriminalisation and regulation; case studies on sustainability and scale-up of services; and promotion of harm reduction approaches in challenging environments.

This report, and other *Global State of Harm Reduction* resources^l are designed to provide advocacy and reference tools for a wide range of audiences, such as international donor organisations, multilateral and bilateral agencies, civil society and non-governmental organisations (NGOs), including organisations of people who use drugs, as well as researchers and the media.

Methodology

The information in Sections 1 and 2 of this report was gathered using existing data sources, including research papers and reports from multilateral agencies, international NGOs, civil society and harm reduction networks, as well as expert opinion from organisations of people who use drugs and those working in the harm reduction field. Within each region, HRI enlisted support from regional harm reduction networks and researchers to gather qualitative information on key developments^m and to review population size estimates, data on the epidemiology of HIV and viral hepatitis among people who inject drugs, and the extent of provision of needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST).

Quantitative data for the tables at the beginning of each regional update in Section 2 were obtained from a variety of sources. These data seek to reflect the most recent available estimates within each country at the time of the data collection exercise (January–April 2012). Sources used include global systematic reviews conducted by the Reference Group to the United Nations on HIV/ AIDS and Injecting Drug Use (UN Reference Group) on the epidemiology of injecting drug use and HIV and the coverage of key harm reduction interventions in 2008ⁿ and 2010,^o updated reports since then by the UN Reference Group (including forthcoming articles),^p national Global AIDS Progress reports submitted to UNAIDS in March 2012 and national surveillance studies conducted since 2010.^q Where none of these sources were available, the data were unpublished or their reliability was questioned by civil society, researchers or other experts, expert opinion was sought to identify additional sources of information and verify their reliability. Unless HRI was able to identify newer data, prevalence estimates for viral hepatitis were sourced from the review of reviews published by Nelson and colleagues in the *Lancet* in 2011. Data for Western Europe and several countries in Eastern Europe were sourced from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2012 statistical bulletin, unless otherwise stated in the text.^r Sources are provided for all of the estimates reported, and any discrepancies in data are noted in footnotes within the tables or in the text.

^m A copy of the information collection questionnaire for the *Global State of Harm Reduction 2012* can be obtained by contacting info@ihra.net.

ⁿ Mathers B et al. (2008). The global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review, *Lancet*, 372 (9651): 1733–1745.

^o Mathers B et al. (2010). HIV prevention, treatment, and care services for people who inject drugs: A systematic review of global, regional, and national coverage, *Lancet*, 375, DOI:10.1016/S0140-6736(10)60232-2.

^p Petersen Z, Pluddemann A, van Hout MC, Dada S, Parry C & Myers B on behalf of the Secretariat to the United Nations Reference Group on Injecting Drug Use and HIV (2012) *The prevalence of HIV among people who inject drugs and availability of prevention and treatment services: findings from 21 countries. A brief report*. Parow: South African Medical Research Council.

^q Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

^r See <http://www.emcdda.europa.eu/stats12> for more details.

^j Cook C and Kanaef N (2008) *Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*. London: Harm Reduction International.

^k Cook C (2010) *The Global State of Harm Reduction: Key Issues for Broadening the Response*. London: International Harm Reduction Association.

^l See www.ihra.net for more details.

Figures published through international reporting systems, such as those undertaken by the World Health Organization and UNAIDS, may differ from those collated here due to the different scope of monitoring surveys, varying reliability criteria and focus on regions that may include different country classifications.

Regions were largely identified using the coverage of the regional harm reduction networks. Therefore, this report examines the regions of Oceania, Asia, Eurasia (Central and Eastern Europe and Central Asia), Western Europe, Sub-Saharan Africa, Middle East and North Africa, Latin America, the Caribbean and North America.

Where possible, the regional updates were peer reviewed by the regional harm reduction networks and other experts in the field (see Acknowledgements).

This report also contains chapters on major topics for the harm reduction response, which were identified through feedback on the second report and consultation with HRI's Scientific Review Committee and key partners of the organisation. These chapters have been prepared by representatives from civil society, research and multilateral agencies with specific expertise in the area, and reviewed by peers in the field. Although some of the issues covered are fairly new areas with relatively little research to report on, these chapters aim to present what is currently known and raise issues for the international harm reduction community to consider.

Data quality

For global population size estimates of people who inject drugs and HIV epidemiology, this report draws heavily on global systematic reviews conducted by the UN Reference Group. These reviews present only data that fits with reliability criteria established by the UN Reference Group, resulting in data gaps for many countries with HIV epidemics among people who inject drugs.

Given that this remains the most reliable assessment of the state of the epidemic, HRI has presented the UN Reference Group data where these data were the most recent available estimates, and provided data from other sources for those countries and territories for which other reliable sources were available. These included bio-behavioural surveillance reports, academic studies and, for information on the most recent number of NSP and OST sites, expert opinion was also consulted. The data collection process involved regional harm reduction networks and other regional experts reviewing the regional data gathered, including the figures reported in the tables. The data tables were additionally shared for review with researchers and members of the UN Reference Group from around the world. Where the accuracy of data was questioned but no alternate, reliable figures were provided, this is noted in footnotes or within the text.

Although population size estimates for people who inject drugs have become available at the national level for several countries since 2008 (for instance, through UNAIDS Global AIDS Progress reports), a systematic calculation of global population size estimates was not conducted in the context of this report.

The significant data gaps are an important reminder of the need for improved monitoring systems and data reporting on HIV and drug use around the world.

In reporting on the existence and coverage of harm reduction, this report sought input from harm reduction networks, researchers and other experts in the field. Where no updates were available, 2010 data was reported.

The data presented here on epidemiology and coverage represent the most recent, verifiable estimates currently available; however, lack of uniformity in measures, data collection methodologies and definitions for the estimates provided renders cross-national and regional comparisons challenging.

Limitations

This report attempts to provide a global snapshot of harm reduction policies and programmes and, as such, has several limitations. It does not provide an extensive evaluation of the services or policies in place. It must be recognised that the existence of a service does not necessarily denote adequate quality and coverage to have an impact on drug-related harms.

While this report aims to cover some important areas for harm reduction, it focuses largely on the public health aspects of the response and does not document the full spectrum of social and legal harms faced by people who use drugs. Neither does it cover the full spectrum of health harms related to substance use, including, for example, those related to alcohol and tobacco use.

A significant gap in the current edition of the report is the omission of a thematic focus on the intersection between sex work and drug use. HRI is presently in the process of developing a separate publication and web resources addressing drug use among sex workers and broader implications for harm reduction.

Report structure

Section 1 provides a global overview of harm reduction policy and programming.

Section 2 contains nine brief regional updates – Asia, Eurasia, Western Europe, the Caribbean, Latin America, North America, Oceania, Middle East and North Africa, and Sub-Saharan Africa – that examine the developments for harm reduction since 2010.

Section 3 comprises six chapters that explore themes relevant to developing an integrated harm reduction response, including specific barriers to service access faced by women and young people who inject drugs, drug use among men who have sex with men and implications for harm reduction, a global overview of drug decriminalisation policies around the world, and an exploration of sustaining and scaling up services in challenging social and political environments.

1.1 | Harm Reduction **A Global Update**



Harm Reduction: A Global Update

Harm reduction is increasing in recognition around the world. This is demonstrated by several significant developments in policy, implementation and research in the last two years. Among these are increases in the number of countries addressing harm reduction in national policies and strategic plans, as well as those gathering epidemiology and coverage monitoring data among people who inject drugs (PWID) and implementing harm reduction programmes. However, the availability and coverage of harm reduction programmes remains uneven among and within regions, and is particularly limited in low- and middle- income countries. In many parts of the world, harm reduction programmes face widespread challenges in the context of economic and donor uncertainty (see below for more details).

Injecting drug use (IDU) has been documented in at least 158 countries and territories globally.¹ The latest available global population size estimates indicate that 15.9 million (range 11–21 million) people inject drugs around the world.² The most significant numbers of PWID reside in China, the USA and Russia. Reports of HIV among PWID are documented in 120 countries.³ In 2010, nearly half (47%) of people who inject drugs living with HIV in low- and middle-income countries came from five nations – China, Vietnam, Malaysia, Russia and Ukraine.³² Specific sub-populations of PWID, including young people and women who inject drugs, experience elevated barriers to service access (see Sections 2 and 3 for more details).

PWID also face elevated rates of viral hepatitis and tuberculosis. Recent estimates indicate that approximately 10 million PWID worldwide may have hepatitis C, a figure that surpasses HIV infection among this population.³ China is home to more than half (1.6 million, range 1.1–2.2 million) of PWID living with hepatitis C worldwide, followed by the USA (1.5 million) and Russia (1.3 million).³ Asia has the largest populations of PWID with active hepatitis B (HbsAg)^a (300,000, range 100,000–700,000). People living with HIV who also inject drugs have a two- to six-fold increased risk of developing TB compared to non-injectors, and commonly have co-infection with hepatitis B (HBV) and C (HCV) viral infection.⁴ This risk is on average twenty-three times higher in prisons than in the general population⁵ (see Section 2 for more details).

^a HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBc and hepatitis B surface antibodies (anti-HBs). People who inject drugs may have lower clearance rates for HBV than the general population because more PWID may become chronically infected. For more information, see Nelson PK et al (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

The global harm reduction response

International policy developments for harm reduction

In the past two years since 2010, several developments in international policy have occurred, with important implications for harm reduction:

- » On 16 December 2011 the US Congress reinstated the ban on federal funding for needle and syringe exchange programmes (NSPs).⁶ The decision comes just two years after the 21-year-old ban was repealed and signed into law by President Barack Obama in December 2009, thereby allowing states and local public health officials to use federal funds for sterile syringe access. The decision includes reinstatements of bans on both domestic and international use of US federal funds for NSPs as part of the 2012 omnibus spending bill.
- » At the UN High Level Meeting on AIDS in June 2011, states adopted a new declaration with revised targets for measuring progress in the global response, the *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*.⁷ The text of the final outcome document reflects ongoing tensions between evidence and human rights-based approaches, and relativist stances by some states, which emphasise 'local circumstances, ethics and cultural values' at the expense of public health-based strategies.⁸ However, the document also reflected negotiation successes, including the explicit mention of the WHO/UNAIDS/UNODC comprehensive harm reduction package, a pledge to reduce HIV among PWID by 50% by 2015 and concrete, time-bound coverage and funding targets.
- » Countries submitted their first reports to monitor progress against commitments in the 2011 Political Declaration on HIV/AIDS to UNAIDS in March 2012, which will form the basis of an end-of-year report on the state of the global HIV epidemic. The core indicators for country progress reporting have been revised to reflect the new targets set out in the 2011 Political Declaration, and represent one of the most comprehensive tools to date for monitoring the epidemiology of HIV and service coverage among PWID by multilateral agencies.⁹
- » In March 2012, twelve UN agencies called on states to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community.¹⁰ This is a particularly relevant development for countries in Asia, where the continued commitment to compulsory detention by some countries remains a serious human rights concern.¹¹⁻¹² During a meeting with civil society at the 55th Session of the Commission on Narcotic Drugs (CND), however, the International Narcotics Control Board (INCB) refused to denounce such

- centres, or 'any atrocity' committed in the name of drug control.¹³ The INCB President also refused to refrain from referring to people who use drugs (PWUD) as 'abusers' and 'drug abusing offenders' when asked to do so by the International Network of People who Use Drugs (INPUD), who explained the terms were seen as stigmatising and offensive.
- » The role of naloxone in addressing opioid overdose was recognised for the first time in a high-level international resolution in March 2012. Members at the 55th CND unanimously endorsed a resolution promoting evidence-based strategies to address opioid overdose.¹⁴ Introduced by the Czech Republic and co-sponsored by Israel and Denmark (the latter on behalf of the European Union), the resolution calls on UNODC, WHO and other international organisations to work with member states to address the global overdose epidemic.
 - » Also at the 54th session of the CND in March 2011, a resolution was adopted, co-sponsored by the USA, entitled 'Achieving zero new infections of HIV among injecting and other drug users.'¹⁵ Following tense debates, with Russia in particular being resistant to the resolution, member states finally endorsed the WHO, UNAIDS, UNODC comprehensive package on HIV and IDU – a first at the CND.
 - » The emerging issue of new psychoactive substances, commonly known as 'legal highs', and the need to explore considered, evidence-informed approaches other than criminal justice, was recognised in a progressive resolution adopted at the 55th CND.¹⁶ Originally proposed by Australia, the resolution did not call for 'legal highs' to be banned or criminalised, but rather urged countries 'to consider a wide variety of evidence-based control measures to tackle the emergence of new psychoactive substances, including the use of consumer protection, legislation regarding medicine and legislation regarding hazardous substances.' Advocates welcomed the resolution, noting that an acknowledgement of alternative means of regulating illicit substances is an important step forward for member states at the CND.¹⁷
 - » The World Health Organization (WHO) has developed new guidance^b on prevention strategies for viral hepatitis B and C in PWID planned for release at the 19th International AIDS Conference Washington, DC, in July 2012. Recommendations will comprise three distinct but interlinked areas: surveillance, screening and antiretroviral therapy (ART) management in people with HIV and viral Hepatitis B and C co-infections. Recommendations include strengthening hepatitis monitoring systems through standardising case definitions of viral hepatitis, integrating hepatitis with HIV, TB and STI surveillance, and considering sentinel surveillance for acute hepatitis among key populations at higher risk, including PWID.
- » Since 2010 the leadership of the UN Office on Drugs and Crime (UNODC) on HIV-related harm reduction has deteriorated. As UNODC is the lead UNAIDS co-sponsor with responsibility for HIV and IDU, this is a considerable concern. Since taking the office of Executive Director, Mr Yury Fedotov has failed to endorse basic HIV prevention measures related to IDU and has questioned whether his agency has a harm reduction mandate¹⁸ or an official position on OST.¹⁹ HIV/AIDS organisations took the occasion of World AIDS Day in 2011 to write to Mr Fedotov to seek clarification on these issues. They received no reply from Mr Fedotov, rather an ambiguous reply from another senior member of staff.
 - » During the 55th session of the CND, the UNODC Executive Director's report to member states on HIV and IDU reworded the agreed WHO, UNAIDS, UNODC comprehensive package to give prominence to abstinence-based drug treatment and to downplay opioid substitution therapy (OST).²⁰ Throughout the report, HIV prevention was seen as a subset of drug treatment, while the phrases 'opioid substitution therapy' and 'needle and syringe programmes' were avoided. Following an intervention by the European Union, UNODC had to correct the actual wording of the comprehensive package at the plenary of the Commission. To date the document remains unchanged.
 - » Within the European Union, Sweden and Italy continued to play negative roles on harm reduction. As a group, the European Union has weakened in its harm reduction position. This was evident at the High Level Meeting on HIV at the UN, and despite some important progress, also at the 55th CND. This is due in part to harm reduction being seen as a less important diplomatic issue for countries that previously adopted leadership roles internationally, including the United Kingdom and the Netherlands. This is despite strong, ongoing harm reduction programming nationally and funding for harm reduction internationally from those same countries.

An enabling environment for harm reduction

In 2012 there are 97 countries and territories that support a harm reduction approach, four more^c than reported in 2010 (see Table 1.1.1).^{21d} This support is explicit either in national policy documents (eighty-three countries – four more than in 2010), and/or through the implementation or tolerance of harm reduction interventions such as NSPs (eighty-six countries – four more than in 2010)^e or OST (seventy-seven countries – seven more than in 2010).^f

c Macau, Jordan, Syria, Tunisia.

d Inclusion in this list refers both to countries or territories that have newly supported a harm reduction approach in policy and/or practice since 2010, and to countries or territories for which 'not known' was reported in 2010 (i.e. Macau).

e South Africa, Tanzania, Macau and Laos PDR.

f Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

b The new guidance can be downloaded from <http://www.who.int/hiv/pub/guidelines/hepatitis/en/>.

There is a trend towards less punitive responses toward PWID in some countries and regions, with between 25 and 30 countries adopting some form of decriminalisation of possession of drugs for personal use.⁹ Although significant variations in such reforms and how they are implemented and evaluated makes generalisations difficult, emerging evidence indicates that decriminalisation provides an enabling environment supporting implementation and take-up of harm reduction programmes proven to reduce HIV and viral hepatitis transmission.

Table 1.1.1: Countries or territories employing a harm reduction approach in policy or practice^h

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
ASIA				
Afghanistan	✓	✓	✓	x
Bangladesh	✓	✓	✓	x
Cambodia	✓	✓	x	x
China	✓	✓	✓	x
Hong Kong	✓	x	✓	x
India	✓	✓	✓	x
Indonesia	✓	✓	✓	x
Macau	✓	✓	✓	x
Malaysia	✓	✓	✓	x
Maldives	x	x	✓	x
Mongolia	x	✓	x	x
Myanmar	✓	✓	✓	x
Nepal	✓	✓	✓	x
Pakistan	✓	✓	x	x
PDR Laos	✓	x	x	x
Philippines	✓	✓	x	x
Taiwan	✓	✓	✓	x
Thailand	✓	✓	✓	x
Vietnam	✓	✓	✓	x
CARIBBEAN				
Puerto Rico	x	✓	✓	x
Trinidad and Tobago	✓	x	x	x
EURASIA				
Albania	✓	✓	✓	x
Armenia	✓	✓	✓	x
Azerbaijan	x	✓	✓	x
Belarus	✓	✓	✓	x
Bosnia & Herzegovina	✓	✓	✓	x
Bulgaria	✓	✓	✓	x
Croatia	✓	✓	✓	x
Czech Republic	✓	✓	✓	x
Estonia	✓	✓	✓	x

^g See Chapter 3.4 of this publication for a global summary of drug decriminalisation policies.

^h This includes countries that have harm reduction in their national policies or strategy documents on HIV, viral hepatitis and/or drug use. In many countries, harm reduction may appear in one or more of such policies, but not all. Inclusion in this table of NSP, OST and DCRs indicates only the availability of these interventions, rather than their scope or coverage.

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
Georgia	✓	✓	✓	x
Hungary	✓	✓	✓	x
Kazakhstan	✓	✓	✓	x
Kosovo	✓	✓	✓	x
Kyrgyzstan	✓	✓	✓	x
Latvia	✓	✓	✓	x
Lithuania	✓	✓	✓	x
Macedonia	✓	✓	✓	x
Moldova	✓	✓	✓	x
Montenegro	✓	✓	✓	x
Poland	✓	✓	✓	x
Romania	✓	✓	✓	x
Russia	x	✓	x	x
Serbia	✓	✓	✓	x
Slovakia	✓	✓	✓	x
Slovenia	✓	✓	✓	x
Tajikistan	✓	✓	✓	x
Turkmenistan	x	✓	x	x
Ukraine	✓	✓	✓	x
Uzbekistan	✓	✓	x	x
LATIN AMERICA				
Argentina	✓	✓	x	x
Brazil	✓	✓	x	x
Colombia	✓	x	✓	x
Mexico	✓	✓	✓	x
Paraguay	✓	✓	x	x
Uruguay	✓	✓	x	x
MIDDLE EAST and NORTH AFRICA				
Egypt	x	✓	x	x
Iran	✓	✓	✓	x
Israel	✓	✓	✓	x
Jordan	✓	x	x	x
Lebanon	✓	✓	✓	x
Morocco	✓	✓	x	x
Oman	x	✓	x	x
Palestine	x	✓	x	x
Syria	✓	x	x	x
Tunisia	✓	✓	x	x
NORTH AMERICA				
Canada	✓	✓	✓	✓
United States	✓	✓	✓	x
OCEANIA				
Australia	✓	✓	✓	✓
New Zealand	✓	✓	✓	x
SUB-SAHARAN AFRICA				
Kenya	✓	x	✓	x
Mauritius	✓	✓	✓	x
Senegal	x	x	✓	x
Seychelles	x	x	x	x
South Africa	x	✓	✓	x

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle exchange programmes operational	Opioid substitution programmes operational	Drug consumption room(s)
Tanzania	✓	✓	✓	x
Zanzibar	✓	x	x	x
WESTERN EUROPE				
Austria	✓	✓	✓	x
Belgium	✓	✓	✓	x
Cyprus	✓	✓	✓	x
Denmark	✓	✓	✓	x
Finland	✓	✓	✓	x
France	✓	✓	✓	x
Germany	✓	✓	✓	✓
Greece	✓	✓	✓	x
Iceland	nk	x	✓	x
Ireland	✓	✓	✓	x
Italy	✓	✓	✓	x
Luxembourg	✓	✓	✓	✓
Malta	✓	✓	✓	x
Netherlands	✓	✓	✓	✓
Norway	✓	✓	✓	✓
Portugal	✓	✓	✓	x
Spain	✓	✓	✓	✓
Sweden	✓	✓	✓	x
Switzerland	✓	✓	✓	✓
United Kingdom	✓	✓	✓	x

Civil society and networks

Harm reduction networks continue to operate in every region of the world, and are making important contributions at national, regional and international levels. Regional networks include the AHRN Federation, Caribbean Harm Reduction Coalition (CHRC), Eurasian Harm Reduction Network (EHRN), European Harm Reduction Network (EuroHRN), Middle East and North Africa Harm Reduction Association (MENAHRN), Intercambios Asociación Civil (Latin America) and a nascent Sub-Saharan Africa Network. There are also numerous national and local level networks that continue to advocate for harm reduction at these levels.

In recent years, there have been a number of notable developments among regional harm reduction networks. These include the expansion of EuroHRN, which was formed in 2009. The major outputs of the network have been the publication of the first civil society audit in Europe and a report detailing a mapping of drug user organisations throughout the region.²² The research into drug user organisations was particularly significant as it led to the formation of the first pan-European network of PWUD. EuroHRN held its first European Harm Reduction Meeting in Marseille in 2011.

The Asian Harm Reduction Network has gone through significant modifications including a name change to the AHRN Federation. It has undergone organisational restructuring to develop a federation model, which aims to allow national harm reduction organisations and networks to have a key role in determining the future and priorities of the network. The federation consists of national and sub-national harm reduction networks, as well as key focal organisations, and focuses its efforts in India, Indonesia, Thailand, Cambodia, Myanmar, China, Malaysia and Nepal.

MENAHRN has been a significant catalyst for increasing attention to harm reduction in the MENA region since its founding in 2007.²³ In January 2012, MENAHRN began implementation of its round 10 Global Fund grant to expand harm reduction in twelve countries¹ across the region through capacity building, training, advocacy and networking activities. The overall aim of this project is to create a conducive environment for the scale-up and implementation of HIV and harm reduction programmes across the region.

Global networks that include harm reduction as a key component of their work continue to operate at the international level. These include YouthRISE, International Network of People Who Use Drugs (INPUD), International Nursing Harm Reduction Network (INHRN), International Doctors for Healthy Drug Policies (IDHDP), International Centre for Science in Drug Policy (ICSDP), Law Enforcement and HIV Network (LEAHN), Women's Harm Reduction Network (WHRIN) and the International Drug Policy Consortium (IDPC).

IDPC has developed a strong membership base and produced several publications since 2010, including the Second Edition of the IDPC Drug Policy Guide and over twenty drug policy briefings. IDPC facilitates strong civil society involvement and engagement with policy makers at regional and international forums, particularly at the CND, and works at national and international levels to promote open dialogue around a human rights and public health approach to drug policy.

There has been some progress in the engagement of civil society in international policy-making. During the 54th CND session, a resolution was adopted on improving civil society engagement at the Commission. During informal negotiations it was one of the most contested resolutions, reflecting many member states' ongoing discomfort with civil society engagement. The following year, however, the first official civil society hearing was held at the CND: an important and positive development. Despite this improvement, the 2012 session of the CND was marred by the secretariat's censorship of civil society statements. Two oral statements – one criticising the UNODC's Executive Director for a lack of leadership on HIV, and the other on human rights concerns about the International Narcotics Control Board's annual report – were not permitted and had to be amended.

¹ Iran, Pakistan, Libya, Lebanon, Syria, Jordan, Bahrain, Morocco, Egypt, Afghanistan, Oman and Palestine.

Civil society launched a number of significant declarations that sought to mobilise international support for key international forums in 2010 and 2011. The Vienna Declaration,²⁴ a global initiative supported by the Open Society Foundations, was launched at the 18th International AIDS conference in July 2010. Calling for drug policy to be based on scientific evidence, the Declaration received over 17,000 endorsements in less than three months. Notable signatories include three former Latin American presidents, as well as cities, Nobel laureates, scientists, lawyers, academics, researchers, and activists from around the world.

In advance of the UN High Level Meeting (HLM) on AIDS held in June 2011, Harm Reduction International (HRI) launched the Beirut Declaration on HIV and Injecting Drug Use: A Global Call for Action, an initiative aimed at increasing support for harm reduction and related drug policy reform within the proceedings and outputs of the HLM, and raising awareness of the limited international support for harm reduction and the drug policy reforms necessary for its optimal implementation. The Declaration was endorsed by over 200 organisations in the broader HIV/AIDS and development fields^l and was featured in prominent forums. For example, the 9 April 2011 edition of the scientific journal the *Lancet* featured the Beirut Declaration in its editorial, calling for increased attention to harm reduction, IDU and drug policy reform within the proceedings of the HLM.²⁵

The visibility of regional networks of PWUD has also increased in recent years; new networks have been established in Eurasia, Europe and the MENA regions. The Eurasian^k and MENA networks were established in 2010, and the European^l network in 2011.

INPUD has undergone significant changes since 2010 with the selection of a new executive director, a full-time staff team and a newly elected board. INPUD's increased capacity has allowed its staff and members to engage actively in international forums such as the CND and the UNAIDS Programme Coordinating Board (PCB), and at the community level in Afghanistan, Kenya, Tanzania, Eastern Europe, and Central Asia through the delivery of capacity-building workshops and technical assistance. Since 2010, INPUD has become an increasingly important partner representing the perspective of drug using and injecting populations to civil society and multilateral agencies.

The harm reduction 'network of networks' continues to work collectively and share information. It is made up of regional and global networks as well as national harm reduction networks, which include the Canadian Harm Reduction Network (CHRN), Colectivo por Una Política Integral Hacia las

Drogues (CUPIHD, based in Mexico) and the Harm Reduction Coalition (HRC, based in the USA).

Community Action on Harm Reduction

Community Action on Harm Reduction (CAHR) is a new and ambitious five-year project led by the International HIV/AIDS Alliance and made possible by a grant from the Dutch Ministry of Internal Affairs (BUZA). It aims to significantly improve HIV and harm reduction services for people who inject drugs, their partners and children, in China, India, Indonesia, Kenya and Malaysia. The project works to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China, increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within PWID populations in Indonesia. Overall, it aims to reach more than 180,000 people who inject drugs, their partners and children. There is a strong focus on building the capacity of community-based organisations as well as the meaningful engagement of people who use drugs in the development, implementation and evaluation of services within each country.

Global coverage of harm reduction services

The lack of reliable population size estimates for PWID in several countries, and inconsistencies in the quality of available data, make accurate assessments of progress since 2010 challenging. Generally, where data is available, harm reduction service provision has increased in countries where it was already being implemented. Several countries in sub-Saharan Africa, Asia and parts of Eastern Europe and Central Asia have NSPs and/or OST. Despite these improvements, expansion of programmes has been slow and many new programmes are small-scale pilots. The last two years have also witnessed significant scale-down of services in countries with some of the highest HIV burdens among PWID. In most low- and middle-income countries, coverage remains insufficient to stabilise and reverse HIV and viral hepatitis epidemics among PWID.

Needle and syringe exchange programmes

In 2012 there are eighty-six countries and territories that implement NSPs to varying degrees. Models of provision include fixed and specialist NSP sites, community-based outreach, pharmacy provision and vending machines. Three countries have newly implemented NSPs since 2010 -- South Africa, Tanzania and Laos PDR.^m

^j For a complete list of endorsements visit www.ihra.net/endorsements.

^k Refer to Chapter 2.2 of this publication for further information on the development of this network.

^l Refer to Chapter 2.3 of this publication for further information of the development of this network.

^m Macau is not included, although it is newly reported to provide NSP and OST in this report. Provision of harm reduction services in Macau started prior to 2010. However, in past reports, information on Macau was not known/not reported.

Map 1.1: Global availability of needle and syringe programmes in the community and in prisons



The number of operational NSP sites, and the coverage provided through existing services, varies widely among countries and regions. According to internationally recommended targets,ⁿ coverage is high in only a few countries such as Australia, several Western European countries, as well as in Bangladesh, where over 200 needle/syringes per PWID are reached per year.

Generally coverage is lower in low- and middle-income countries, with few changes in provision since 2010 in Latin America and the Caribbean, which distribute less than one needle per person per year.²⁶ An increasing number of sites provide sterile injecting equipment around the world, including in countries that have high HIV and viral hepatitis prevalence among PWID such as the Ukraine and several countries in Asia. Despite increases in provision, existing services in most low and middle-income countries do not reach coverage levels sufficient to stabilise and reverse HIV epidemics among this population. For instance, just an estimated 10% of PWID in Eastern Europe, and 36% in Central Asia, access NSPs.²⁷

Since 2010, NSP provision was scaled back in several countries in Asia^o and Eurasia.^p Seventy-two countries and territories with reported IDU (thirty-eight of them with HIV reported among this population) remain without any NSP provision.

Drug consumption rooms

In 2012 there are fifty-eight cities around the world that operate at least one drug consumption room (DCR). DCRs form a vital part of harm reduction services in some parts of Western Europe, allowing PWUD to inject in a safe space and under medical supervision. They are eighty-six operational DCRs implemented across seven European countries (Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland), as well as one in Sydney, Australia and one in Vancouver, Canada. Denmark is the latest country to implement the intervention. In 2011, an NGO in Copenhagen began operating a mobile DCR without explicit permission or interference from authorities. Ten months later, in June 2012, the Danish parliament officially gave municipalities the legal mandate to operate DCRs, making Denmark the first country globally to implement legally regulated DCRs.²⁸

Opioid substitution therapy

OST is provided in seventy-seven countries worldwide – seven more than reported in 2010.^q Methadone and buprenorphine are the substances of choice for substitution, but in some countries other formulations are also provided, including slow-release morphine and codeine, and heroin-assisted treatment (HAT).

The number of sites providing OST and the proportion of people that receive substitution therapy, is substantially higher in high-income countries. For example, an estimated 61% of PWID are receiving OST in Western Europe.²⁶ Among low and middle-income countries, high coverage has also been reported in Iran, where 42.6% of PWID are receiving OST,²⁷ and in the Czech Republic, with 40% OST coverage.³⁰ Provision of OST has been scaled up in several countries in Asia, Eurasia and the Middle East and North Africa. Since 2010, OST provision has been newly introduced in Tajikistan, Kosovo, Kenya, Tanzania, Cambodia, and Bangladesh. However, the coverage of existing programmes remains substantially below minimum levels recommended by international guidance, and improvements in scale and quality are urgently needed to ensure that interventions achieve the greatest impact.^r

The latest global estimates of OST coverage, from 2010, indicate that 6–12% of PWID are receiving OST, with wide variations among regions.²⁶ OST coverage remains very limited in parts of sub-Saharan Africa, Latin America and Asia. Available data suggest that less than 3% of PWID receive OST in countries such as Cambodia, Indonesia, Myanmar and Vietnam, where IDU has contributed significantly to HIV epidemics.³¹

OST remains unavailable in eighty-one countries with reported IDU (fifty of them with reports of HIV among PWID).

Integrated HIV, viral hepatitis and TB services for people who inject drugs

Data on the extent to which interventions other than NSP and OST, such as treatment for HIV, viral hepatitis and tuberculosis, reach PWID around the world is less available on a global basis. Comprehensive estimates of HIV, viral hepatitis and tuberculosis needs and access among PWID are not available. Existing research suggests that access to ART by people who inject drugs and live with HIV remains disproportionately low compared with other key populations at higher risk of HIV, particularly in low- and middle-income countries.^{32–33} For example, PWID comprise 67% of cumulative HIV cases in China, Vietnam, Russia, Ukraine, Malaysia, but only 25% of ART recipients.³²

Critical barriers affecting the delivery of and access to TB and HIV services for PWID include separate management of TB, HIV, viral hepatitis and drug use, high levels of stigma and discrimination and the criminalisation of drug use in many countries around the world.^{4, 34} Increased research and surveillance efforts are also critical to better understand the true burden of HIV, viral hepatitis and TB among PWID in communities and prisons and the scale of services required.

ⁿ The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

^o For example, Pakistan, Nepal and Cambodia.

^p For example, Belarus, Hungary, Kazakhstan, Lithuania and Russia.

^q Cambodia, Bangladesh, Tajikistan, Kenya, Tanzania, Macau and Kosovo.

^r The 2009 WHO, UNAIDS, UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users categorises OST coverage levels as follows: low: <20% of opioid dependent PWID on OST; medium: 20–40% of opioid dependent PWID on OST; and high: >40% of opioid dependent PWID on OST.

There is an urgent need for greater integration of ART provision with harm reduction services, including OST, as well as with TB and viral hepatitis treatment.^{32, 35} The provision of coordinated and tailored service delivery models, along with peer involvement in treatment delivery, are key to achieving sufficient coverage of these interventions among PWID.³³

Overdose

Overdose remains a leading cause of death globally among PWUD, particularly those who inject. Research from an increasing number of countries has examined overdose-related mortality among people who use opioids, including among PWID.³⁶ However, estimates on the occurrence of overdose mortality and non-fatal overdose outside of high-income countries remains very limited, and usually requires consultation of qualitative data sources and expert opinion.³⁷⁻³⁸ A recent global meta-analysis of prospective studies on mortality associated with heroin and other opioid use found that Asia had the highest crude mortality rate (CMR) at 5.23 deaths per 100 person-years, and Australasia had the lowest (1.08), with overdose most commonly cited as the cause of death.³⁸ Research since 2010 has also shown that PWUD have a 74% greater risk of overdose if they are HIV-positive compared to their HIV-negative counterparts.³⁹ There is a clear need to conduct more research and to improve standardised reporting to obtain an accurate picture of overdose among this population in low and middle-income countries.

The urgent need to address overdose among PWUD was recognised in 2011 by the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has encouraged grant applicants to include overdose services in national proposals since 2010.⁴⁰ The US President's Emergency Plan for AIDS Relief (PEPFAR) has also recently included naloxone provision as part of their revised guidance on PWID.⁴¹

Naloxone, an effective opioid antagonist used to reverse the effects of opiate overdose, remains limited for distribution by peers and family members of PWUD, especially in low- and middle-income countries. As of 2012, community-based naloxone distribution programmes are present to varying degrees in at least sixteen countries, including Afghanistan, Australia, Canada, China, Germany, Georgia, India, Kazakhstan, Kyrgyzstan, Tajikistan, Thailand, the UK, USA, Ukraine, Russia and Vietnam.

Harm reduction in prisons

The provision of harm reduction interventions including NSPs and OST in prisons and other closed settings, remains extremely limited compared with responses in the community. As of 2012, ten countries^s around the world implement NSPs in prison, including Iran and countries in Eastern Europe, Central

Asia and Western Europe. Forty-one countries^t provide OST in prisons. Among these, sixteen are countries in Western Europe, twelve in Eurasia and four in Asia, in addition to Canada, the USA, Puerto Rico, Australia, New Zealand, Iran and Mauritius.

Considering the high rates of IDU and the complex interaction of HIV, viral hepatitis and tuberculosis in prison settings worldwide,⁴²⁻⁴³ there is an urgent need to implement and expand the provision of harm reduction services in these settings. This is especially urgent for Eastern Europe and Central Asia where this interaction in prison settings is most marked.⁴

Resourcing the harm reduction response

The funding landscape has changed drastically since the first comprehensive analysis of harm reduction funding and resourcing gaps was published by HRI in 2010.⁴⁴ The international financial crisis, combined with a shift in aid priorities toward low-income countries and resource constraints at the Global Fund to Fight AIDS, Tuberculosis and Malaria, pose a major threat to the future and sustainability of harm reduction.

HRI previously estimated that approximately US\$160 million (or US\$0.03 per PWID per day) was invested in HIV-related harm reduction in low and middle-income countries in 2007, of which US\$136 million (90%) was from international donors.⁴⁵ This amounted to 7% of the US\$2.13 billion in 2009 and 5% of the US\$3.29 billion in 2010 estimated by UNAIDS to meet the basic HIV prevention needs of PWID.⁴⁶

In June 2011 a group of international experts, including from UNAIDS, the Global Fund, PEPFAR, WHO, the Bill and Melinda Gates Foundation, and the World Bank, launched a new framework for investment in the global HIV response, which has since been endorsed widely by multilateral agencies and researchers.⁴⁷ The investment framework argues for setting priorities based on country-specific epidemiology and calls for the scale-up of investments in evidence-based, high-impact interventions, including NSP and OST for PWID. Modelling of the framework's potential impact indicates that, to avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020, annual resource needs must increase from US\$16.6 billion in 2011 to US\$22–24 billion in 2015.⁴⁸ To achieve the proposed reduction in transmission and AIDS-related deaths among PWID, US\$2.3 billion is required by 2015 (falling to US\$1.5 billion by 2020 through savings in treatment and economies of scale) compared to the US\$0.5 billion estimated to be available in 2011.⁴⁷

During the past decade, and particularly in recent years, the

^s Armenia, Belarus, Kyrgyzstan, Moldova, Romania, Iran, Germany, Luxembourg, Spain and Switzerland.

^t India, Indonesia, Malaysia, Thailand, Albania, Croatia, Czech Republic, Georgia, Hungary, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia, Iran, Canada, USA, Puerto Rico, Australia, New Zealand, Mauritius, Austria, Belgium, Denmark, Finland, Germany, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, UK and Latvia.

Global Fund has emerged as the largest funder for harm reduction programmes targeting PWID. Between Round 1 in 2002 and Round 9 in 2009, an estimated US\$430 million was approved for this population.⁴⁹ Two-thirds of the budgeted funds were allocated to the core package of harm reduction interventions as defined by WHO, UNODC and UNAIDS,⁵⁰ including needle and syringe distribution and OST. More than half of the funds (US\$236 million) were granted to countries in Eastern Europe and Central Asia. Global Fund support for harm reduction has grown steadily since 2009, and has particularly risen in Round 10, when it introduced a funding reserve for grants targeting most-at-risk populations⁵¹ and released the first harm reduction guidance note for applicants.⁴⁰ Subsequent analysis indicates that an additional estimated investment of US\$152 million for PWID was committed in Round 10, taking the ten-year total to nearly US\$580 million (see Table 1.1.2). Although the need for harm reduction services still far outweighs current provision, and hostile policy environments in some countries continue to prevent effective programmes from scaling up,²⁶ commitment to harm reduction improved significantly during this period, both in national level HIV and drug strategies and internationally.

Table 1.1.2: Approved Global Fund investments targeting people who inject drugs, Round 1 (2002) to Round 10 (2010)⁵²

COUNTRY / TERRITORY	TOTAL (US\$)
ASIA	166,700,000
Afghanistan	1,300,000
Bangladesh	10,800,000 *
Bhutan	<100,000
Cambodia	5,800,000 *
China	23,400,000
India	20,800,000 *
Indonesia	14,000,000 *
Malaysia	6,100,000 *
Mongolia	100,000
Maldives	500,000
Myanmar	7,700,000 *
Nepal	7,600,000 *
Pakistan	13,800,000 *
Philippines	1,500,000
Sri Lanka	200,000 *
Thailand	28,000,000 *
Timor Leste	<100,000 *
Viet Nam	25,100,000 *
EASTERN EUROPE AND CENTRAL ASIA	366,100,000
Albania	1,400,000
Armenia	3,100,000 *
Azerbaijan	6,000,000 *
Belarus	17,500,000 *
Bosnia & Herzegovina	9,800,000 *
Bulgaria	9,500,000
Croatia	600,000
Estonia	2,700,000
Georgia	12,700,000 *

COUNTRY / TERRITORY	TOTAL (US\$)
Kazakhstan	29,800,000 *
Kosovo	2,000,000
Kyrgyzstan	25,800,000 *
Macedonia	15,600,000 *
Moldova	7,200,000 *
Montenegro	1,600,000 *
Romania	4,200,000
Russian Federation	38,400,000
Serbia	6,500,000 *
Tajikistan	15,600,000
Ukraine	143,900,000 *
Uzbekistan	12,200,000 *
LATIN AMERICA	10,200,000
Argentina	1,600,000
Mexico	7,000,000 *
Paraguay	1,600,000 *
MIDDLE EAST AND NORTH AFRICA	24,000,000
Algeria	500,000
Egypt	800,000
Iran	8,200,000 *
Jordan	300,000
MENAHRA	6,200,000 * †
Morocco	4,600,000 *
Syrian Arab Republic	1,200,000 *
Tunisia	1,400,000
West Bank and Gaza	800,000
SUB-SAHARAN AFRICA	7,800,000
Burundi	600,000 *
Cape Verde	700,000 *
Kenya	1,900,000 *
Madagascar	1,300,000 *
Mauritius	1,500,000 *
Nigeria	1,300,000 *
Zanzibar	500,000 ‡
Western Europe	900,000
Turkey	900,000
Total (all regions)	575,900,000

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

† The Middle East and North Africa Harm Reduction Association (MENAHRA) received a multi-country grant that covers Afghanistan, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Syrian Arab Republic, Tunisia, and the West Bank and Gaza.

‡ Zanzibar, a semi-autonomous part of Tanzania, receives separate grants from the Global Fund.

In November 2011, however, the Global Fund announced the cancellation of its next funding round (Round 11) along with

the imposition of additional cost-cutting measures. These structural changes at the Global Fund have severe short and long-term implications for harm reduction programme start-up, sustainability and expansion.^u The Transitional Funding Mechanism (TFM) was established by the Global Fund to support the continuation of existing, essential^v programmes, but does not allow for further scale-up or start-up of services. This affected several countries in Asia, Eastern Europe and Central Asia with significant HIV and IDU burdens or emerging epidemics among PWID.²⁷ In addition, several countries that may have planned to submit grant proposals in 2012 and 2013 cannot now do so until 2014.

In November 2011, the Global Fund board also passed the '55% rule', requiring that total funding approved for grant renewals for low-income countries be no less than 55% of any annual funding window.⁵³ As an interim measure, it placed a 75% ceiling on grant renewals funding for lower-middle income countries, further limiting available funds. The new rules, based solely on income status, affected many states with prominent injecting-driven epidemics such as Indonesia, Thailand and Malaysia. In response to concerns voiced by several delegations, the Global Fund Board passed a decision at its 26th Board meeting in May 2012 to freeze the implementation of the '55% rule'.⁵³ A critical component informing this decision was the mobilisation of civil society organisations to document evidence of the short-term effects brought on by the '55% rule' at country level, and to bring this evidence into high-level discussions.^{27, 54} At the time of writing, it is unclear how financing for harm reduction will be prioritised as part of the new Global Fund funding model that is being developed.

The limited donor landscape for harm reduction approaches is further undermined by a shift in bilateral aid priorities and a narrowing of international aid budgets in some countries. Between them, the main bilateral donors for harm reduction – the UK, Australia and the Netherlands – accounted for US\$67.4 million in 2007.⁴⁵ Recently however, these donors too have shifted their priorities away from middle-income countries, and in some cases have noticeably reduced spending on HIV/AIDS. For example, the UK Department for International Development's (DFID) bilateral HIV programmes will be cut by 30% over the next three years, and remaining funds will largely focus on low-income countries.⁵⁵ The President's Emergency Plan for AIDS Relief (PEPFAR) increased its investment in HIV programmes targeting PWID from US\$18.1 million in 2009⁵⁶ to US\$27.7 million in 2011.⁵⁷ However, PEPFAR's funding for harm reduction represents only 0.65% of this budget.⁵⁴ The recent re-instatement of a federal funding ban on needle exchange

programmes, both domestically and abroad, places further constraints on global harm reduction resources.⁶

Few national governments have been willing or able to finance the implementation and scale-up of HIV and harm reduction interventions within their own borders, with a few notable exceptions (such as Malaysia and Taiwan).⁴⁴ For example, when Romania became ineligible for Global Fund resources in 2010, the government failed to support existing NGO-run harm reduction programmes. As a result, the percentage of PWID reached by harm reduction programmes decreased from 76% in 2009 to 49% in 2010. In 2011, the number of newly reported HIV infections among PWID was higher than in previous years, and cases attributed to IDU increased as a proportion of new infections.²⁷ Numerous countries with IDU-driven epidemics are likely to experience a lack of government support following the exodus of international donor funds. Some private donors including the Gates Foundation and Open Society Foundations (OSF) have stepped in to support harm reduction approaches in the absence of national, bilateral and Global Fund support in certain settings. However, this support remains insufficient to maintain and allow sufficient scale-up to halt and reverse existing and emerging epidemics among PWID in the long-term.

Although there is no accurate estimation of the total spend on harm reduction globally, nor the shortfall in 2012, it is clear that recent developments significantly limit potential progress toward international commitments, such as halving HIV transmission among PWID by 2015⁵⁸ and achieving universal access to HIV prevention, treatment, care and support for PWID.⁵⁹ There is an urgent need for civil society (including international and local NGOs, organisations of PWUD) as well as donors and national governments to mobilise as a matter of urgency in order to ensure the continuation and sustainability of programmes and avoid reversing gains^w already made in preventing HIV and other blood-borne viruses among PWID.

The regional updates in **Section 2** of this report provide a more detailed documentation of the state of harm reduction in different parts of the world, particularly highlighting developments since 2010. **Section 3** explores key thematic areas for building an integrated harm reduction response, including specific barriers to access faced by women and young people who inject drugs, and drug use among men who have sex with men, and implications for harm reduction service provision. Additional chapters provide a global overview of drug decriminalisation policies around the world, and an exploration of sustaining and scaling up services in challenging social and political environments.

u For a more in-depth discussion of repercussions internationally see McLean S, Wong F & Konopka S (2012) *HIV, Drug Use and The Global Fund: Don't Stop Now*. Brighton: International HIV/AIDS Alliance. For a detailed discussion in relation to Eastern Europe and Central Asia, see Raminta S, Votyagov S and Pinkham S (2012) *Quitting While Not Ahead: The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe & Central Asia*. Vilnius: EHRN.

v According to official Global Fund guidance, the term 'essential' for the purposes of the Transitional Funding Mechanism includes programmes for PWID.

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w Please see Section 2.2 of this report for a discussion of the situation in Greece as an example of a setting where HIV can re-emerge in the absence of well-resourced responses.



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2.1 | Regional Update **Asia**



Table 2.1.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Asia

Country/territory with reported injecting drug use	People who inject drugs ^a	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ¹	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ¹	Harm reduction response ^b	
					NSP ^c	OST ^d
Afghanistan	20,000 (18,000–23,000) ²	7 ²	36	5.8	✓ (19) ³ (NP)	✓ (1)(M) ³
Bangladesh	21,800–23,800 ²	5.3 ²	>50 ^e	9.4	✓ (120) ⁴ (P)	✓ (1)
Bhutan	nk	nk	nk	nk	✗	✗
Brunei Darussalam	nk	nk	nk	nk	✗	✗
Cambodia	1900 ¹²	24.1 ²	nk	nk	✓ (2)	✓ (1) ⁵
China	2,350,000 ²	6.4 ⁹ 2	67 (60.9–73.1)	9.6 (3.8–15.4)	✓ (>900) ²	✓ (738) ² (B,M)
Hong Kong	30,000 ⁶	nk	--	--	✗ ⁷	✓ ¹
India	177,000–180,000 ⁴	9.2 ⁴	41	10.2 (2.7–17.8)	✓ (261) ⁴	✓ (72) ^h 8 (M,B,O)
Indonesia	105,784 (73,663–201,131) ⁹	36 ²	77.3	2.9	✓ (194) ²	✓ (74) ² (B,M)
Japan	400,000	nk	64.8 (55–74.5)	3.2 (2–4.3)	✗	✗
Korea (Republic of)	nk	nk	57	4	✗	✗
Laos PDR	1700 ²	nk	nk	nk	✓ ²	✗
Macau	238 ¹⁰	1.32 ¹¹	80.4 ¹¹	10.7 ¹¹	✓ (4) ¹¹ (P)	✓ (4) ¹¹ (B,M)
Malaysia	170,000 ²	8.7 ²	67.1	nk	✓ (297) ² (P)	✓ (674) ² (B,M)
Maldives	793 (690–896) ²	0 ¹²	0.7 ¹²	0.8 ¹²	✗	✓ (1) (M)
Mongolia	nk	nk	nk	nk	✓ (1)	✗
Myanmar	75,000 ²	21.9 ²	79.2	9.1	✓ (40) ² (P)	✓ (10)(M) ²
Nepal	(30,155–33,742) ¹³	6.3 ²	87.3 (80.5–94)	5.8 (5.5–6)	✓ (43)	✓ (3) ² (B,M)
Pakistan	91,000 ² c	27.2 ²	84 (75–92.9)	6.8 (6–7.5)	✓ (81)	✗
Philippines	15,506	13.6 ²	70	nk	✓ (3)	✗
Singapore	nk	nk	42.5	8.5	✗	✗
Sri Lanka	nk	nk	nk	nk	✗	✗ ⁿ
Taiwan	nk	13.8 (2–25.6)	41	16.7	✓ (1103)	✓ (90)(B,M)
Thailand	40,300 ¹⁴	21.9 ² o	89.8	nk	✓ (10)(P)	✓ (147) ^p (M)
Vietnam	158,414 ²	13.4 ² f	74.1	19.5	✓ (297) ² (P)	✓ (41) ² (M)

nk= not known

a Unless otherwise stated, data are sourced from Mathers B. et al for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372(9651):1733–1745.

b Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, *Lancet*, 375(9719):1014–28.

c The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.

d The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

e HIV Serological Surveillance conducted in six cities, with the highest prevalence reported among PWID in Kanshat at 95.7% (Bangladesh, Ministry of Health and Family Welfare, 2011).

f Year of estimate: 2007.

g Figure represents national average only and may significant regional variations.

h Figure represents the number of sites managed by the National AIDS Control Organisation (NACO). Researchers in the region estimate that at least 80 additional sites are implemented by external development partners.

i Figure has been queried by civil society sources, with some estimating that it is closer to 60,000. A World Bank survey was underway at the time of writing.

j The total number of NSP sites includes 221 NGO sites and 76 government-run sites.

k Total number of OST sites includes 218 in government hospitals and clinics and 406 private health care practitioners.

l Based on 2009 surveillance in two cities, Addu and Male.

m At least two additional sites were not included as part of this figure since anecdotal reports from civil society indicate that these sites provide buprenorphine for detoxification only rather than for maintenance therapy.






n Although there are no official programmes operating in Sri Lanka, anecdotal reports indicate that some psychiatrists and general practitioners prescribe methadone as OST.

o Estimate based on men who inject drugs only.

p Civil society and experts in the region have suggested that this estimate is too high and may not be representative of the actual level of OST provision in Thailand. It has been suggested that numbers may include clinics which require periodic detoxification and re-enrolment.

Map 2.1.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



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

Harm Reduction in Asia

At least one quarter (4.5 million) of the total estimated number of people who inject drugs (PWID) live in the Asia region, with over half of these residing in China.⁴⁷ At the regional level approximately 16% of PWID are living with HIV,⁴⁷ but significantly higher rates have been detected at local level within several countries. In five countries with updated figures as of 2012 – Cambodia, Indonesia, Myanmar, Pakistan and Thailand – over one fifth to one half of PWID may be living with HIV.²

Regionally, most countries in Asia now offer essential harm reduction services for PWID, although current data do not assess their quality (see Table 2.1.1). Seventeen countries implement needle and syringe exchange programmes (NSPs) to varying degrees, including new programmes in border regions within Laos PDR.¹⁵ Provision of opioid substitution therapy (OST) has expanded in several countries including Myanmar, Malaysia, Indonesia, China, Vietnam and the Maldives, and two countries – Cambodia and Bangladesh – have newly established programmes since last reported in 2010. However, coverage of both interventions remain substantially below minimum levels recommended by international guidance.³⁸ Despite progress made in recent years in improving HIV surveillance, the continued lack of or controversy over reliable data on the size of PWID populations in some parts of the region limit the accuracy of available coverage estimates, knowledge of the true burden of tuberculosis (TB), HIV and viral hepatitis among PWID, evaluation of impacts and planning for scale-up and resourcing needs.

Co-infection with HIV, viral hepatitis (B and C) and/or TB among PWID pose significant challenges across Asia. Greater integration of antiretroviral therapy (ART) with OST services, TB and viral hepatitis treatment, and peer involvement in treatment delivery, are key to achieving sufficient intervention coverage among this population.^{16, 48} Increased prevalence of injection as the route of drug administration for amphetamine-type stimulants (ATS), the most commonly used drugs in Thailand, Laos, South Korea, Cambodia and Japan, has been documented in some countries.¹⁷ Cross-border mobility of PWID may contribute to epidemics among PWID, requiring increasingly collaborative prevention efforts in border areas within Bangladesh, Myanmar, China and Laos. The increasing overlap between injecting drug use (IDU) and sex work may pose an emerging challenge in several local and national contexts, including Sri Lanka, Pakistan and Malaysia.²

There is increased awareness of harm reduction as an evidence-based public health approach to reduce HIV and other co-infections and address the health needs of PWID in the region. Nineteen countries or territories^q identify PWID as

a target population for the HIV response and explicitly include harm reduction in their national plans and/or drug policies, pointing to clear progress since 2009¹⁸ when this was the case for only 14 countries. However, despite these significant improvements, 61% of countries in Asia Pacific still have laws and policies that pose major impediments to the provision of effective HIV prevention, care, treatment and support services for PWID.¹⁹

The funding environment in Asia has become increasingly precarious in the last two years due to the withdrawal of support for harm reduction services by key bilateral donors and a reduction in Global Fund funds. There is an urgent need for strategic investment of available funds in the coverage and quality of high-impact, cost-effective interventions such as NSPs and OST.²⁰⁻²¹

Developments in harm reduction implementation

Needle and syringe exchange programmes

Of the 25 countries and territories in Asia where IDU has been reported, 17 – two more than reported in 2010^r – implement NSPs to varying degrees (see Table 2.1.1). In Cambodia, Mongolia, the Philippines and Thailand, NSP provision remains small-scale. In August 2011, the first NSPs in Laos were established at four remote health centres in the northern districts of Phongsaly and Houaphanh Provinces bordering Vietnam.¹⁵

NSPs are delivered through various modalities across the region. In some settings there has been a shift from provision through stand-alone sites targeted at PWID to service delivery integrated within existing facilities, such as health clinics and pharmacies.²⁶ Additional examples include 24-hour anonymous provision of sterile injecting equipment and condoms through self-service boxes at commune health stations and community hotspots in Vietnam,² and harm reduction services and provision through a grocery store on the China/Myanmar border.¹⁵

In some countries in Asia, the number of NSP sites has increased: for example, in Bangladesh (from 93 in 2010 to 120 in 2012), India (from 200–219 in 2010 to 261 in 2012), Indonesia (from 120 in 2006 to 194 in 2011) and Malaysia (from 117–130 to 297 in 2012).^{2, 4} Despite these increases, NSP coverage in most Asian countries remains insufficient to have an impact on HIV and viral hepatitis epidemics among PWID.⁵ Coverage of NSPs varies widely across the region, from 263.7

^r Laos PDR and Macau. Although NSPs started operating in Macau before 2010, this information was reported as 'not known' in the 2010 edition of this report.

^s The 2009 WHO, UNAIDS, UNODC *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* categorises NSP coverage levels as follows: low (<100 needles/syringes per injector per year), medium (>100–<200 needles/syringes per injector per year) and high (≥200 needles/syringes per injector per year).

^q Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Laos PDR, Philippines, Taiwan, Thailand, Vietnam.

needle-syringes per PWID per year distributed in Bangladesh – the highest level of needle-syringe distribution among low- and middle-income countries worldwide – to less than 10 needle-syringes per PWID per year in Thailand, Indonesia and the Philippines. New estimates since 2010 suggest that NSP coverage reaches medium levels in Malaysia (116 needle-syringes per PWID per year), Myanmar (118 needle-syringes per PWID per year), Cambodia (120.2 needle-syringes per PWID per year), Vietnam (140 needle-syringes per PWID per year)^t and China (180 needle-syringes per PWID per year). Coverage remains low in Pakistan and Nepal, where provision amounts to less than 100 needle-syringes per PWID per year.²

In eight countries^u in Asia with reported IDU there are no operational NSP sites. Since 2010, NSP provision was scaled back or interrupted in Pakistan,²² Nepal²³⁻²⁴ and Cambodia. In Pakistan and Nepal site closures were due to the withdrawal of national funding support.²⁵⁻²⁶ In Cambodia, the provision of needles and syringes is dependent upon the availability of NSP licences issued at the discretion of the National Authority for Combating Drugs (NACD).⁸⁴ In 2011 the government revoked or failed to renew licences for existing NSP services, as part of a move to relocate services to the government.²⁶ As of December 2011, there were no licensed NSP sites operating in Cambodia, leading to a drastic downturn in service coverage.²⁷ At the time of writing, a small number of services run by non-governmental organisations (NGOs) in Cambodia had resumed provision of sterile injecting equipment, but the reach of existing programmes remains restricted.²⁸

Fear of arrest and detention in compulsory detoxification centres that violate the human rights of PWID and fail to provide evidence-based programmes continues to deter many individuals from accessing NSP services and carrying sterile injecting equipment.²⁹

Geographical distance, costly transportation, inappropriate size of needle-syringes, lack of adequate training and limited capacity of peer outreach workers pose further barriers to access. Legal age restrictions for accessing NSPs in some Asian countries pose obstacles for PWID under 18 years old, despite evidence that age of initiation to injecting is gradually decreasing in some areas (see Chapter 3.2 for a broader discussion of legal age restrictions for harm reduction services).³⁰

Service provision cuts in Pakistan

Harm reduction service provision to a sizeable portion of PWID in Pakistan has been severely threatened since 2010. The largest harm reduction project in the country, running since 2005 with support from the World Bank, was suddenly terminated by the Government of Punjab using discretionary powers in May 2010. At the time of cancellation, the programme had reached over 14,000 PWID across eight cities in Punjab, and plans were in progress to scale up services to an additional four cities, reaching up to an estimated 22,000 PWID. Although no official reason for the programme's termination was provided, civil society advocates cite the refusal on the part of the implementing organisation (Nai Zindagi) to disclose personal details of the project's beneficiaries to government officials as part of an accountability audit as a potential trigger for subsequent official decisions. Recent surveillance data suggest that the closure of services has already begun to reverse important gains made in the past five years of implementation.³¹

A portion of the gap in harm reduction service delivery will be filled by Pakistan's Global Fund Round 9 grant scheduled to begin in 2012 and covering an estimated 28,000 people with NSP services across 24 districts in Punjab and Sindh provinces over four years. However, the crisis persists, as the eight cities in which programmes were originally terminated continue to lack harm reduction provision and will not be covered by this grant.

Opioid substitution therapy

Availability and coverage of OST has been scaled up in several Asian countries since 2010 (see Table 2.1.1). For example, provision was expanded in Myanmar (from 7 sites in 2010 to 10 by December 2011, reaching 1637 PWID),² Malaysia (from 95 in 2010 to 674 sites reaching 44,428 PWID in 2012),^v Indonesia (from 11 sites in 2006 to 74 in 2011), China (from 600–675 sites in 2010 to 738 across 28 provinces currently reaching 140,000 PWID) and India (from 61–63 in 2010 to at least 72 in 2012).^{w8} In Vietnam a small-scale methadone programme has been significantly scaled up from four clinics in two provinces in 2009³⁹ to 41 clinics across 11 provinces presently reaching 6900 PWID.³² Plans are underway to further expand access to 80,000 PWID across 30 provinces by 2015.² As of June 2011 the Ministry of Labour, Invalids and Social Affairs (MOLISA) has contributed to financing the first methadone maintenance therapy (MMT) clinic, an important development for harm reduction in the country considering the increasingly narrow resourcing landscape for PWID.³² In

t 2011 estimate based on men who inject drugs only.

u Bhutan, Brunei-Darussalam, Hong Kong, Japan, Republic of Korea, Maldives, Singapore, Sri Lanka.

v This includes provision through government hospitals and clinics (218 sites), private health care practitioners (406 sites), National Anti-Drug Agency (NADA) service centres (32 sites) and prisons (18 sites).

w This includes four MMT pilot sites initiated by UNODC between January and April 2012.

the Maldives, the second phase of OST was initiated in 2011 following a pilot methadone project established in 2009 with support from the UNODC Regional Office for South Asia (ROSA).^{2,33} Thailand's Department of Medical Services reports that there were 6085 patients enrolled on MMT during the period of April 2010 to April 2011.³⁴ Community-based and civil society organisations (CSOs) play an important role in service implementation and success in Myanmar, China and Bangladesh.

Two countries in the region have initiated OST since last reported in 2010.³⁵ The first pilot methadone clinic in Phnom Penh, Cambodia, began dosing in July 2010.²⁶ As of December 2011, 113 PWID, 20% of whom are women, were receiving methadone, with imminent plans to scale up to three sites.⁵ ²⁷ In Dhaka, Bangladesh, an OST pilot with methadone was implemented in June 2010 by the International Centre for Diarrheal Disease Research (iccr-b) in collaboration with the Government of Bangladesh. To date, 150 PWID are receiving methadone, with another 150 to be enrolled at a second site being planned through funds from Save the Children under the Global Fund RCC programme.²

Although rollout of OST to 6000 PWID in Pakistan is supported under Global Fund Round 9, implementation will be dependent upon successful piloting by UNODC planned to commence in late 2012.²⁵ In Nepal, plans to scale up the national OST programme and revise guidelines and training curricula on OST in collaboration with the German Agency for International Cooperation (GIZ) were underway at the time of writing.² Malaysia has gradually moved away from supporting compulsory detention since 2010, instead focusing its efforts on scaling up existing NSP and OST programmes, including a rare MMT programme that operates inside a mosque.³⁶⁻³⁷ Recognising the lack of services for female PWID in Afghanistan, UNODC, in partnership with Médecins du Monde (Mdm) and local Afghan NGO Nejat, has recently initiated a referral mechanism to facilitate access to MMT by women who inject drugs, and expand the capacity of local NGOs to start up and implement MMT.³

Despite recent increases in service coverage, OST provision remains very limited in some countries. Where reported, measures of OST coverage remain imprecise, using PWID as a denominator, although not all PWID inject opiates or require OST.³⁸ Available data suggest that less than 3% of PWID receive OST in Cambodia, Indonesia, Myanmar and Vietnam.³⁹ In Nepal, coverage has remained the same since last reported in 2010 (349 PWID on OST at three sites).³⁵ The only existing methadone pilot programme in Afghanistan implemented by Mdm reached 63 male clients as of November 2011.³ Scale-up was on hold as of June 2012 pending an independent evaluation conducted by Johns Hopkins University as requested by Afghanistan's Ministry of Counter Narcotics.³ OST remains unavailable in ten countries with reported IDU: Bhutan, Brunei Darussalam, Republic of Korea, Japan,

Laos PDR, Mongolia, Pakistan, the Philippines, Sri Lanka and Singapore.

The availability and scope of OST is constrained by several factors. The poor quality of programmes, including inadequate or insufficient information on OST and its benefits, lack of proper follow-up among drop-outs and inappropriate dosing are commonly cited reasons for lack of retention in OST across the region.²⁶ In Indonesia, despite increases in the number of PWID receiving OST since 2010, a significant proportion of PWID (39%) continue to inject while on MMT, particularly in the early months following the start of treatment.⁴⁰ Programme quality requires increased documentation across the region and significant strengthening if harm reduction interventions are to produce measurable results.

Legal and policy barriers that prohibit or restrict OST pose significant obstacles to implementation and scale-up in Asia.⁴¹ For example, policies requiring government approval of methadone quotas for provision in Afghanistan can cause emergency stock-outs and restrict programme scale-up.² In Vietnam, a barrier to access is posed by the requirement to register as a drug user with law enforcement authorities to receive OST.⁴² Limited service provider capacity, fear of arrest and detention, geographical distance to sites and high transportation costs,^y lack of gender-sensitive programmes⁴³ and the absence of clear strategies to reach young PWID all restrict the reach of existing programmes.²⁶

Amphetamine-type stimulant use in Asia

Use of amphetamine-type stimulants (ATS), and particularly that of methamphetamines, has significantly increased in recent years in East and Southeast Asia. ATS use is associated with a range of harms including HIV, viral hepatitis, TB and other sexually transmitted infections (STIs).⁴⁴ ATS use is predominantly found within vulnerable groups such as women, young people, sex workers and migrants.⁴⁵

ATS users tend not to access 'traditional' harm reduction services, as these are predominately aimed at people who use opiates. Moreover, services generally do not reach this group, due to differences in their drug user networks as compared with people who use opiates.⁴⁵

To meet the needs of people who use amphetamines, further research and investment is needed,⁴⁶ as well as the development of a comprehensive package of evidence-based interventions specifically tailored to the needs of amphetamine users and developed with input from the community.⁴⁵

x Estimate refers to the cumulative total and may include duplicates of individuals who dropped out and re-registered.

y As OST programmes in most Asian countries require daily visits by clients, transportation costs and time spent travelling pose significant barriers to access. For example, it is estimated that in Myanmar and Bangladesh travel time to dispensing sites for some PWID exceeds two and three hours daily.

Antiretroviral treatment

Wide variations in HIV epidemics among PWID exist among and within Asian countries. For instance, although an overall decrease in HIV prevalence among men who inject drugs from 33.85% in 2010 to 13.4% in 2012 was detected in Vietnam, prevalence continued to exceed 50% in Dien Bien and Quang Ninh provinces, while in Da Nang it was only 1% – the lowest prevalence in the country.² Rising prevalence has been recently documented in numerous cities in Pakistan,² two northern border provinces and Vientiane in Laos PDR,² and in Jakarta, Indonesia, where prevalence among PWID rose from 33% to 44% from 2007 to 2011 despite decreases in the rest of the country.⁹ The heterogeneity of the HIV epidemic in the region is similarly highlighted by the Philippines, where new estimates suggest that 13.56% of PWID are living with HIV, yet prevalence among women who inject drugs (26.98%) is more than twice as high as among their male counterparts (12.87%).² On the island of Cebu in the Philippines an emerging epidemic among PWID – HIV has shot up significantly from 0.40% in 2007 to 53.8% in 2010² – has been attributed by experts to the delayed implementation of harm reduction programmes.³⁹

Conversely, reductions in HIV prevalence among PWID in some countries in the region have been largely attributed to the early implementation and scale-up of key harm reduction programmes such as NSP and OST.³⁹ HIV prevalence among PWID has decreased significantly in Kathmandu, Nepal (from 68% in 2003 to 20.7% in 2009 and 6.3 % in 2011), in China (from 9.3% in 2009 to 6.4% in 2011) and in Indonesia (from 52% in 2007 to 36% in 2011).²

Although regional and global monitoring mechanisms have improved,² disaggregated data on ART access, coverage and treatment needs among PWID in Asia are scarce. According to the World Health Organization (WHO), 22 of 26 countries surveyed in Asia in 2010 reported ART availability for PWID.³⁹ Nevertheless, the scope and coverage of ART in the region remains limited. In 2010, the Reference Group to the UN on HIV and Injecting Drug Use reported that ART was accessed by only a small proportion of PWID living with HIV in nine countries in Asia.⁴⁷ For example, in Indonesia, the country with the highest level of coverage in the region, only 6% of PWID living with HIV were receiving ART.⁴⁷ In Afghanistan, the only two available ART centres located in Kabul and Herat are not accessed by most ART-eligible individuals due to geographical distance,² and over 40 existing drug treatment centres

(providing treatment other than OST) across the country lack any voluntary counselling and testing (VCT) services.³

Access to ART by PWID is disproportionately low compared with other key populations at higher risk of HIV, and remains restricted by systemic and structural barriers.⁴⁸ In 2010, 47% of PWID living with HIV in low- and middle-income countries came from five nations,^{aa} three of which (China, Vietnam and Malaysia) are in Asia.⁴⁸ PWID comprise 67% of cumulative HIV cases in these five countries, but only 25% of ART recipients. Systemic and structural barriers such as the continuing policy in some countries to detain people who use drugs (PWUD) in compulsory detention centres, and imprisonment for drug possession for personal use, severely restrict access to prevention and treatment services among PWID in the region.⁴⁸⁻⁴⁹ Other barriers to ART access for PWID in Asia include the lack of quality adherence counselling, effective support or follow-up plans, which are essential for treatment success among PWID,¹⁶ stock-outs⁵⁰ and lack of access to OST, among several obstacles.⁵¹

Recent studies point to increased access to HIV testing, ART and improved treatment outcomes for PWID in Vietnam⁵² and Bangladesh.² In Bangladesh, nine VCT centres designated for PWID across five cities provided ART to 2316 PWID between October 2009 and September 2011.

According to recent estimates submitted by eight Asian countries^{ab} to UNAIDS as part of the 2012 Global AIDS Progress reporting mechanism, uptake of HIV testing and counselling^{ac} ranges from less than 10% in the Philippines and Pakistan to over 50% in Indonesia – the country with the highest reported percentage of PWID accessing HIV testing.^{ad2} The generally low levels of testing among PWID in the region corroborate global data from the WHO and UNICEF, who reported in 2011 that the median uptake of VCT was only 25% in 13 reporting countries in the previous 12 months.³⁹ Given the small number of countries worldwide, and in the region specifically, that monitor and report on this indicator, greater efforts and investments are required to adequately track access to and increase uptake of VCT among PWID.

Viral hepatitis

Rates of hepatitis C (HCV) and hepatitis B (HBV) in PWID vary widely among countries in Asia. A recent systematic review reported Asia is the world region with the largest populations

z For example, in March 2012, countries reported to UNAIDS on updated indicators to monitor progress towards the targets set in the 2011 *Political Declaration on HIV/AIDS*, including halving HIV transmission among people who inject drugs by 2015. While the new set of indicators includes indicators measuring uptake of HIV testing and counselling and coverage of NSP among PWID, it does not include coverage indicators for other interventions in the WHO comprehensive harm reduction package. For more information, see UNAIDS (2011) *AIDS Response Progress Reporting 2012 Guidelines: Construction of Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS*. Geneva: UNAIDS. Additionally, there was an increase of 18% between 2009 and 2010 in the number of countries reporting to the WHO in preparation for its 2011 report, *Epidemic update and health sector progress towards Universal Access*. A total of 109 low- and middle-income countries reported information on the existence of programmes and policies targeted at and engaging people who inject drugs in 2010, compared with the 92 countries providing data in 2009. See WHO, UNAIDS, UNICEF (2011) *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access*. Geneva: WHO.

aa China, Vietnam, Russia, Ukraine, Malaysia.

ab Vietnam, Thailand, the Philippines, Pakistan, Nepal, Myanmar, Indonesia and Cambodia.

ac According to Global AIDS Progress Reporting 2012 guidance, this indicator is measured as the percentage of PWID that have received an HIV test in the past 12 months and know their results.

ad Figures from Indonesia are based on NSP and OST attendees. Among NSP participants, 56% had undertaken an HIV test. HIV test uptake among methadone clients was nearly 100%, as enrolment in MMT requires an HIV test. The high uptake of HIV testing among PWID in Indonesia is partly attributed to the increase in supportive legislation on harm reduction and to the integration of NSP into primary health services. For more information see: UNAIDS (2012) *Indonesia Global AIDS Progress Report*. Geneva: UNAIDS, http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/ce_ID_Narrative_Report.pdf Accessed 24 June 2012.

of PWID with hepatitis B surface antigen (HbsAg)^{ae} (300,000, range 100,000–700,000) and HCV (2.6 million, range 1.8–3.6 million). China is home to more than half (1.6 million, range 1.1–2.2 million) of PWID living with HCV worldwide.¹

Where estimates are available, all countries report an HCV prevalence of over 30% among PWID, and in four countries or territories^{af} rates exceed 80%. HBV prevalence among PWID ranges from 2.9% in Indonesia to 10–20% in India, Macau, Taiwan and Vietnam.¹ The quality of existing global data on viral hepatitis is variable. The large ranges of available figures indicate inexact estimates resulting from varying prevalence between different sub-populations of PWID and different recruitment settings (see Table 2.1.1).¹ Co-infection of HIV and HCV is a significant challenge in some parts of the region, particularly Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand, where 50–100% of PWID living with HIV are also co-infected with HCV.⁵³ Research indicates that co-infection with HIV and HCV and/or HBV is highly prevalent among PWID in the China–Myanmar border region.⁵⁴

Viral hepatitis testing and treatment is rarely state-funded in countries in Asia. The main medicine used in the current standard treatment for hepatitis C is Pegylated Interferon-alfa, which is patent protected by two pharmaceutical companies, Roche and Merck, and remains beyond the means of the majority of PWID in Asia, costing between US\$11,255 and \$18,202 in the region.^{55ag} Despite the inclusion of viral hepatitis diagnostics and treatment in the ‘comprehensive package’ of harm reduction services recommended by UNODC, WHO and UNAIDS for PWID, HCV is rarely addressed in the HIV response for this population.³⁸

Tuberculosis

In addition to experiencing a high burden of co-infections such as HBV and HCV, PWID living with HIV are at increased risk of developing TB, including multi-drug resistant strains (MDR-TB).⁵⁶ South-East Asia accounts for nearly 15% of the global burden of new cases of HIV/TB co-infection.⁵⁷ Although no systematic prevalence figures exist among PWID in the region, individual studies indicate that they experience high prevalence of TB and other co-infections. For example, TB rates among PWID living with HIV were 33.9% in Chennai, South India,⁵⁸ and 4.8% in Pokhara, Nepal.⁵⁹ In Vietnam, HIV infection was concentrated among PWUD with TB, particularly young men aged 15–34 years,⁶⁰ and was the most common cause of death (40%) within six months of starting ART among a cohort of PWID living with HIV.⁶¹ Transmission of TB among PWID living with HIV has been linked with a lack of adherence

support and inadequate prescription of ART, as well as with having been incarcerated.^{62–63}

Although several countries in Asia including India, Nepal, Thailand and Myanmar have increasingly taken steps to address TB/HIV co-infection more generally,⁵³ it is unclear to what extent activities target PWID specifically. For instance, in Pakistan, TB testing and treatment services can only be offered to PWID via direct linkages through harm reduction services providers, as PWID tend not to access general health services in the same manner as the general population.²⁵

Barriers to addressing TB among PWID include poor health infrastructure, administrative obstacles to effective TB and HIV programme collaboration, low awareness, stigma and discrimination by service providers and criminalisation of drug use.^{57,64} For example, in Bangladesh, PWID are generally referred for testing and treatment to specialised TB clinics, where they are often refused anti-TB treatment due to service providers’ flawed perception that PWID have low rates of adherence.²⁵ While referrals from harm reduction services to TB centres are reported to be robust in Afghanistan, there is a need to strengthen referral systems for HIV screening from TB centres.³ Additional obstacles are posed by lack of access to methadone or buprenorphine therapy in some settings, which may cause PWID to drop out of treatment when admitted to in-patient TB wards due to opioid withdrawal symptoms that go unaddressed.

Overdose

Although studies from an increasing number of countries have examined mortality among people who use opioids,⁶⁵ estimates on the occurrence of overdose mortality and non-fatal overdose outside high-income countries remains very limited.^{66–67} A recent global meta-analysis of prospective studies on mortality associated with heroin and other opioid use found that Asia had the highest crude mortality rate (CMR) at 5.23 deaths per 100 person-years, with overdose most commonly cited as the cause of death.⁶⁵ In a prospective cohort of PWID in Liangshan, Sichuan province in China, 64.3% deaths during a one-year period were attributed to overdose.⁶⁸ In Thai Nguyen province, Vietnam, drug overdose accounted for 27% of deaths among a cohort of PWID between 2005 and 2007.⁶⁹ Rates of non-fatal overdose among people who inject opioids are similarly high. For instance, in local studies 30% of heroin injectors in Bangkok, Thailand,⁷⁰ 83% in Ban Ninh, Vietnam,⁷¹ and 12% in Southwestern China⁷² reported experiencing at least one overdose.⁶⁶

The quality of available data is highly variable. Common limitations include the reporting of mortality risk estimates among PWUD and PWID derived from retrospective cohort studies, which greatly reduces their reliability, lack of standardised reporting of mortality cause among this group, and small sample sizes largely drawn from treatment centres,

ae HbsAg indicates active (either acute or chronic) infection. Approximately 95% of adults with acute HBV infection clear the virus and develop anti-HBc and hepatitis B surface antibodies (anti-HBs). People who inject drugs may have lower clearance rates for HBV than the general population because more PWID may become chronically infected. For more information see Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, *Lancet*, 378(9791): 571–583.

af Macau, Nepal, Pakistan and Thailand.

ag Generally to manage HIV/HCV co-infection, a year-long treatment with Pegylated Interferon and Ribavirin (peg-IFN/RBV) is required.

which may not be representative of out-of-treatment PWID, thus limiting the strength of international comparisons.⁶⁵⁻⁶⁶

Responses to overdose have only recently been recognised as integral components of harm reduction programmes in some Asian countries. For example, naloxone is available in a majority of hospitals and ambulances in China and Sri Lanka, and through pharmacies, harm reduction drop-in centres and outreach workers in Afghanistan.³ Although the national MMT programme in China requests that each clinic keep naloxone readily available, it is unclear to what extent this is implemented in practice.²⁶ In 2011, community naloxone distribution programmes have been piloted in Vietnam⁷³ and in four provinces in China.⁷⁴

Despite these increases in provision, availability of naloxone for peer distribution in community settings remains limited in Asia.⁶⁶ Five countries in the region (Afghanistan, China, India, Thailand and Vietnam) implement community-based naloxone programmes to some extent.⁶⁷ In most settings in Asia, naloxone is classified as a scheduled drug and cannot be sold over the counter. Shortages of naloxone, even in licensed government-run health care facilities, and a lack of skills in addressing overdose among service providers pose ongoing obstacles to the prevention and management of overdose. In Vietnam, a law prohibiting laypeople from providing injections hampers scale-up of community-based naloxone programmes.⁴² In some countries, it is challenging for NGOs to procure naloxone for distribution, whether due to high prices or due to special licences (i.e. medical licences) needed to purchase medications. Intranasal naloxone is very costly and remains unavailable throughout Asia.⁷⁵

Harm reduction in prisons

IDU is widespread in prisons and other places of detention across the region. For instance, a study on prisoners for drug-related crimes in nine prisons across Indonesia found that almost 90% had consumed an illicit drug, and more than one-third had injected heroin.⁷⁶ While some prisoners continued to inject drugs with decreased frequency, and others stopped injecting while incarcerated, 0.5–4% of PWID actually injected for the first time while in prison.² Among PWID in three cities in Afghanistan, 62.9% had previously been imprisoned, of whom 17.2% reported injecting while in prison.⁷⁷ Similarly, in a sample of 252 PWID in Bangkok, Thailand, 78% reported a history of incarceration, and approximately 30% of them injected drugs while in prison.⁷⁸

A 2010 national survey in Indonesian prisons and detention centres detected higher HIV rates among a subset of male prisoners with a history of injecting drugs (6.7%) compared with the general male prison population surveyed (1.1%). Rates were higher among women than among their male counterparts, and twice as high among women with an injecting history (12.0%) compared with incarcerated women

with no history of IDU (6.0%).² Rising HIV prevalence among Afghanistan's 23,800 prisoners and detainees also appears to be linked to the high proportion of PWID in prison.² A new report by the Cambodian human rights group LICADHO indicated that imprisonments for drug-related charges (including drug use) increased by 163% in 2011. In the 13 prisons surveyed by LICADHO, this number has nearly quadrupled since 2008.⁷⁹

Implementation of harm reduction programmes in prisons and other closed settings remains a serious challenge in most countries in Asia. There are no NSPs operating in prisons in the region. In some countries, such as Bangladesh, the distribution of needles and syringes in prisons is considered a criminal offence. OST programmes operate in four Asian countries: India, Indonesia, Malaysia and Thailand. In India, the only existing prison OST pilot launched in 2008 has been scaled up, reaching nearly 120 inmates in one prison.⁸ However, where they do exist, prison harm reduction services remain limited: only four prisons in Indonesia and 11 in Malaysia implement the intervention.⁸⁰

As of March 2012, discussions were ongoing among government and police officials in the Maldives to introduce a comprehensive harm reduction package in prisons.² Plans to initiate OST in prisons are also underway in Vietnam.² In Bangladesh, the 3rd National Strategic Plan for HIV and AIDS Response 2011–2015 now supports implementation of prison OST, noting, however, that policy advocacy and reform will be required to facilitate programme start-up.⁸¹

In Pakistan, Bangladesh and Afghanistan, limited drug treatment (other than NSP and OST) and HIV prevention services are provided in some prisons. This includes an UNODC-supported project that provides drug treatment and other health services (other than OST) to 450 female inmates out of approximately 500 female prisoners in six female prisons in Afghanistan.³

In Japan, a proposed amendment will allow PWUD in prison to qualify for early release and undergo abstinence-based drug treatment in the community. Although harm reduction services remain unavailable in both settings, the proposed amendment represents an important shift away from treating drug dependence as a crime.⁸² In June 2011 a ruling by the Supreme Court in Indonesia strengthened diversion sentencing to rehabilitation instead of prison for non-violent drug users not convicted of drug trafficking or other felony charges in the country's otherwise highly criticised narcotics law.⁸³ Diversion sentencing for PWUD in Indonesia is an important development since 2010, considering that drug-related offences greatly contribute to prison overcrowding.^{ah}

ah According to Indonesia's Ministry of Law and Human Rights, the number of prisoners for drug-related crimes in Indonesia has increased steadily as a proportion of the general prison population from 7122 (10% of prisoners) in 2002 to 37,295 (26% of prisoners) by the end of September 2009.

Policy developments for harm reduction

Harm reduction is an important component of HIV and drug strategies in most countries in Asia. Nineteen countries or territories^{ai} identify PWID as a target population for the HIV response and explicitly include harm reduction in their national plans and/or drug policies (see Table 2.1.1). This is a clear improvement since 2009 when this was the case for only 14 countries.¹⁸

Despite significant improvements in policy that have facilitated implementation and scale-up of harm reduction services, the existence of national policy on harm reduction does not equate to the provision of an adequate response in either scope or quality. Nearly two-thirds (61%) of countries in Asia Pacific still have laws and policies that pose major impediments to the provision of effective HIV prevention, care, treatment and support services for PWID.¹⁹

In many countries in the region, harm reduction efforts are undermined by inconsistencies in drug control policy, which often conflicts directly with national HIV or drug plans. For example, the government of Vietnam removed Article 199 of the Penal Code in 2009, effectively decriminalising drug use.³² However, under the new regulations PWID can still be sent to compulsory treatment centres for two years.³² In Cambodia the Commune Safety Policy introduced in August 2010 and enforced in April 2011 by the Deputy Prime Minister applies a zero tolerance approach to drug use, has further stigmatised PWID and greatly undermined harm reduction efforts.^{aj84-85} Additionally, in December 2011, the National Assembly of Cambodia approved a drug law that mandates up to two years of compulsory treatment for PWUD, and fails to recognise essential harm reduction interventions, leaving NSPs and OST programmes vulnerable to arbitrary closure.⁸⁴ Civil society advocates have strongly criticised the new drug law, pointing out that the term 'drug addict' is too broadly defined and can feasibly include anybody under the influence of drugs at any point.⁸⁴ A new amendment to Thailand's national drug policy in 2010 explicitly mentions harm reduction, yet this nominal improvement is overshadowed by the Deputy Prime Minister Chalerm Yubamrung's recent proposal to 'solve' the drug crisis in Thailand within one year.⁸⁶ This is a concerning approach to drug use and trafficking that echoes the disastrous 2003 'war on drugs' and could have serious implications for access to and scale-up of harm reduction programmes.⁸⁷

ai Afghanistan, Bangladesh, Cambodia, China, Hong Kong, India, Indonesia, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Laos PDR, Philippines, Taiwan, Thailand and Vietnam.

aj Anecdotal reports indicate that in efforts to enforce the Commune Safety Policy guideline, Cambodian police have recently become increasingly active in rounding up people who use drugs, who are in principle referred to compulsory rehabilitation treatment. If they decline treatment or are found to be engaged in crime, they are imprisoned. For further information, see Azariah S (2011) *HAARP Cambodia Annual Review 2011*. Canberra: HAAARP.⁸⁴

The continued commitment to compulsory treatment centres for PWID in several countries in the region undermines harm reduction efforts, elevates the risk of HIV transmission and violates international human rights law.⁸⁸⁻⁸⁹ Over 400,000 people in the region are arbitrarily detained in drug detention centres,⁴⁷ and up to 1000 people are executed for drug offences each year, in direct violation of international law.⁹⁰

Efforts have been taken in some Asian countries to mitigate the unintended consequences of drug policies and improve utilisation of harm reduction services through dialogue and negotiation with law enforcement officers. For example improved police practices reflecting a less punitive approach and increased understanding of harm reduction approaches have been observed in Kaski and Morang districts in Nepal as a result of joint programme implementation between law enforcement agencies and civil society.²

Civil society and advocacy developments for harm reduction

Civil society advocates in the region have played an increasingly visible role in informing and liaising with governments, law enforcement and donors on the importance of harm reduction service scale-up and the need for an enabling policy environment.

In 2010 the Asian Network of People Who Use Drugs (ANPUD) was registered in Hong Kong, a new regional coordinator was selected, and the Secretariat office was established in Bangkok, Thailand. ANPUD has since focused on developing and strengthening the network through a number of meetings and workshops, and providing its members with an avenue to become more meaningfully involved in policy and programming at the national, regional and international levels.

The Asian Harm Reduction Network

The Asian Harm Reduction Network (AHRN) has continued to develop, successfully making the transition to a federation structure with ten initial members throughout the Asian region. Since 2010 a separate organisation, Access Quality International (AQI), has emerged to take on service delivery, technical assistance and capacity-building roles previously held by AHRN, while AHRN has repositioned itself as a regional network. Following a series of strategic planning consultations between 2010 and 2011 that brought together key experts from around the world, AHRN recently launched its new five-year strategic plan for 2012–2016. In its newly defined role, AHRN seeks to provide a platform for harm reduction policy dialogue and collaboration throughout Asia and facilitate networking and communication among member networks and other key stakeholders.

At the regional level, notable events included the Asian launch of the *Lancet* special series on HIV in PWUD, organised by the University of Malaya's Centre of Excellence for Research in AIDS (CERiA) in December 2010 in Kuala Lumpur, Malaysia. The symposium featured panel discussions with local, regional and international experts on topics particularly important to region including, among others, structural risk environments, women who use drugs, human rights, drug policy reform and compulsory drug detention centres.⁹¹ The '10th International Congress on AIDS in Asia and the Pacific' (ICAAP) was held in Busan, South Korea, in August 2011. Despite widely condemned clashes between local law enforcement and community activists in Busan,⁹² the event provided an opportunity around which regional civil society groups could mobilise. AHRN, supported by the Open Society Foundations' Global Drug Policy Program (GDPP), organised a satellite session exploring how the 'war on drugs' impacts the current response to drugs and HIV in the region. The meeting was well attended by more than 100 international delegates.

Developments at the national level include the establishment of the first Afghan Drug Users' Group (ADUG) in Kabul, Afghanistan, in 2011. ADUG is a movement of Afghan current and former PWUD, representing users' interests and promoting their participation in decision-making, policy and service planning. ADUG participated in the '22nd International Harm Reduction Conference' in Beirut, Lebanon, and is a recognised member of the International Network of People Who Use Drugs (INPUD). A new group comprised of several member organisations from across Vietnam, the Vietnam Network of People Who Use Drugs (VNPUD), was established in late 2011.

Civil society in Nepal has continued to engage actively in advocacy at the local, national and regional levels. In August 2011, Nepalese civil society and local groups of PWUD produced a joint statement⁹³ responding to poor government-donor coordination that often led to interruptions to harm reduction services and serious concerns about programme sustainability.⁹⁴ In January 2011, Recovering Nepal, in partnership with the government, organised the first national harm reduction media conference, bringing together 144 active media representatives along with civil society networks, government officials and technical partners to highlight the need for sustainable and accelerated HIV and harm reduction services.⁹⁵

In an increasingly precarious funding environment, financial support for civil society advocacy in the region is extremely scarce and poses considerable challenges to sustainable and coordinated actions.

Multilaterals and donors: developments for harm reduction

The international economic crisis, combined with a shift in aid priorities toward lower-income countries (LICs), and structural changes at the Global Fund to Fight AIDS, Tuberculosis and Malaria have had a considerable impact on existing and future harm reduction funding commitments in the region.

Bilateral aid to the region has decreased markedly as countries, particularly in Southeast Asia, have transitioned to middle-income country (MIC) status. There has been a general exodus of funding from donor countries such as the UK (DFID), the Netherlands (Dutch Development Cooperation Program) and Sweden (Swedish International Development Agency). The Australian government's overseas aid programme's (AusAID) HIV/AIDS Asia Regional Program (HAARP) remained one of the most significant donors funding harm reduction in the region as of early 2012, shouldering an estimated 30–50% of harm reduction costs.³⁶ The Global Fund has played an important role in financing harm reduction programmes in the region, committing a total of US\$166.7 million for interventions targeted at PWID between 2002 and 2010 (see Table 2.1.2). Major private donors such as the Gates Foundation and OSF have filled in some of the resource gaps, but funding levels remain far below what is needed to sustain and scale up programmes.

Table 2.1.2: Approved Global Fund investments targeting people who inject drugs in Asia, Round 1 (2002) to Round 10 (2010)⁹⁶

COUNTRY / TERRITORY	TOTAL (US\$)	
Afghanistan	1,300,000	
Bangladesh	10,800,000	*
Bhutan	<100,000	
Cambodia	5,800,000	*
China	23,400,000	
India	20,800,000	*
Indonesia	14,000,000	*
Malaysia	6,100,000	*
Mongolia	100,000	
Maldives	500,000	
Myanmar	7,700,000	*
Nepal	7,600,000	*
Pakistan	13,800,000	*
Philippines	1,500,000	
Sri Lanka	200,000	*
Thailand	28,000,000	*
Timor Leste	<100,000	*
Vietnam	25,100,000	*
TOTAL	166,700,000	

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

Some governments such as China, India, Malaysia and Taiwan are filling in the gap and investing in harm reduction programmes within their own borders. In its national strategic plan 2011–2015, Laos PDR earmarks \$3.6 million to reach 60% of PWID with sterile injecting equipment and condom provision.² However, core national funding for harm reduction in the region remains comparatively low, small-scale and short-term. Sustainable financing strategies, and prioritisation of investment in high-impact, cost-effective interventions such as NSP and OST, involving increasing contributions from national governments, are essential to enable countries to develop and bring harm reduction interventions for PWID to scale. Even as there are shortfalls for harm reduction funding, new research by Harm Reduction International has

documented international donor support for drug detention centres and the death penalty for drug offences in several Asian countries.⁸⁵ For example, Australia, Luxembourg and Sweden contributed US\$1,649,800 for a UNODC project on capacity-building for drug detention centre staff in Vietnam, while the USA, Japan, Thailand, China, Brunei, Singapore, Sweden and Germany contributed funds to drug detention centre infrastructure in Laos PDR. Additionally, several countries that apply capital punishment for drug offences, such as China and Vietnam, continue to receive international funding and UN assistance for drug enforcement.⁸⁵

After the Global Fund in China: a future for civil society in the harm reduction response?

Compiled by Sarah Konopka, International HIV/AIDS Alliance

In light of a worsening HIV epidemic among increasing numbers of people who inject drugs, the Chinese government has gradually advanced a harm reduction approach and in 2004 invested in the piloting of eight OST clinics in five provinces.⁹⁶ Despite the scale-up of China's harm reduction programme in recent years, coverage remains low, and recruitment and retention are ongoing challenges. Drop-out rates are high, particularly where outreach, psychosocial support and community engagement are lacking.⁹⁷⁻⁹⁹

Harm reduction resources from the Global Fund began to fill the service provision gap in China in 2003,¹⁰⁰ directing funds through the Chinese Centre for Disease Control (CDC) for capacity development of local community-based organisations (CBOs) to supplement the government's clinic-based OST programme with peer-led interventions including outreach, peer education, drug user support groups, family support services and community education. The impact of such services on quality has been documented: CDC-affiliated OST clinics receiving funding from the national HIV prevention programme have better adherence rates and coverage than non-CDC-affiliated clinics.⁹⁷ This demonstrates how valuable CBOs are in making MMT programmes work.

In 2011 the Global Fund announced that it would no longer fund upper-middle-income countries. Remaining Global Fund monies in China will expire in the end of 2012, and with that, the end of resources for the community-based harm reduction efforts. The Chinese government has pledged to fill the HIV resource gap,¹⁰¹ but civil society groups are unclear about what their priorities will be and what this will mean for the future of a civil society role in the harm reduction response.

After 2012 it is anticipated that the government will contract the services of some CBOs and organisations/communities of people who use drugs to provide HIV and harm reduction

services. Government-imposed restrictions on the NGO registration process remain an important concern.¹⁰²⁻¹⁰³ For CBOs to register as an NGO and, therefore, be eligible to receive government funding directly, they must have a sponsoring government organisation that will share responsibility for the management of funds.¹⁰²⁻¹⁰³ With Global Fund resources, some drug-user-led CBOs were able to strengthen internal systems and structures and build relationships with local government agencies. This has been vital to their success. As the response in China shifts to a primarily government-funded response, civil society groups are concerned that their capacity development needs will be overlooked and that they will find it more difficult to engage and negotiate with local agencies.

Commitments from other donors, including AusAID, Levis Foundation and the government of the Netherlands (BUZA), will contribute to maintaining a space for the engagement of communities of people who use drugs and CBOs. For example, the multi-country Community Action on Harm Reduction (CAHR) project of the International HIV/AIDS Alliance, funded by BUZA, works with Alliance China and drug user groups in Sichuan province to partner with the local CDC to improve MMT and NSP provision and access to peer-led services.¹⁰⁴ Small-scale efforts like these will make a difference to the lives of the drug user groups involved and people who use drugs enrolled in their programme. But this will not be enough to influence policy on a national scale.

Experience in China shows that civil society engagement will be essential to the delivery of a comprehensive national harm reduction programme. With the exiting of the Global Fund, it will now be up to the Chinese government to support community-based and peer-led models of service delivery and work with communities of people who use drugs to ensure that peer-led and community-based interventions are an essential feature of the national programme.

In February 2011 the UN Regional Task Force held its meeting on IDU and HIV/AIDS in India.¹⁰⁵ Key topics discussed included compulsory rehabilitation centres, the regional strategy for harm reduction in Asia Pacific 2010–2015 and key findings and recommendations of the external review of the UNRTF. A particular need was identified around the need for a regional advocacy strategy, including a feasible estimate of costs required to realise advocacy goals, to complement national strategies.

The 'Asia-Pacific High-level Intergovernmental Meeting on the Assessment of Progress against Commitments in the 2011 Political Declaration on HIV/AIDS and the Millennium Development Goals (MDGs)' was held in Bangkok in February 2012. IDU and harm reduction were addressed in the context of insufficient coverage, continuing stigma and discrimination and legal and policy barriers that affect PWUD living with HIV, such as those that criminalise the possession of injecting equipment.¹⁰⁶

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2.2 | Regional Update

Eurasia



Table 2.2.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Eurasia

Country/territory with reported injecting drug use	People who inject drugs ^a	HIV prevalence among people who inject drugs (%) ^a	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ^b	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ^b	Harm reduction response ^c	
					NSP ^d	OST ^e
Albania	4,500–5,000 ^f	<1% ^g	29.2 ^h	nk	✓ (3)	✓ (6) ^g (M)
Armenia	3310 (2797–4057) ⁴	10.7 ⁵	nk	nk	✓ (7)	✓ (4) ^g (M)
Azerbaijan	300,000 ^h	9.5 ⁵	62.9 ⁵	10.9 ⁵	✓ (12–14)	✓ (2)(M)
Belarus	50,000 ⁵	13 ⁵	nk	nk	✓ (33) ⁵	✓ (13) ^g (M)
Bosnia and Herzegovina	nk	nk	nk	nk	✓ (6)	✓ (8)(BN,M)
Bulgaria	20,250 (16,200–24,300)	2.2 ^{(g) 7}	62.3 ^{(g) 8}	3.1 ^{(g) 9}	✓ (100)	✓ (31) ^g (BN, M, O)
Croatia	8,500 ⁹	0.0 ¹	27.1 ^{(g) 8}	2.4 ^{(g) 9}	✓ (42)	✓ (B,M)
Czech Republic	29,000 (25,494–33,823) ^(g)	0.0–0.6 ⁷	13.6 ⁸	15.1	✓ (109) (P)	✓ (150–240) ^g (B,M, BN)
Estonia	13,801 (8178–34,732)	54.3–89.9 ^{(g) h 7}	90.5	21.3	✓ (36)	✓ (10) ^g (B,M)
Georgia	40,000 ¹¹	3.9 ⁵	58.2	7.2	✓ (10)	✓ (16) ^g (BN,M)
Hungary	5,699 ¹²	0.0 ⁷	21.4 ^{(g) 8}	0.3 ^{(g) 9}	✓ (25)	✓ (10) ^g (BN,M)
Kazakhstan	119,140 ¹³	3.8 ⁵	61.3	7.9	✓ (155) ⁵	✓ (3) ^g (M)
Kosovo	nk	0	--	--	✓	✓ (3) ^g (M)
Kyrgyzstan	25,000 ¹⁵	14.6 ⁵	50 ¹⁶	nk	✓ (29–49) ⁵ (P)	✓ (17–20) ^g (M)
Latvia	nk	11.2 ⁵	50.0 ^{(g) 8}	nk	✓ (18) ⁵	✓ (10) ^g (B,M)
Lithuania	5,458 ¹⁶	0.0–21.4 ^{(g) 7}	70.3–89.7 ^{(g) 8}	3.3–8.9 ⁹	✓ (12) ¹⁷	✓ (21) ¹⁷ (B,M)
Macedonia	15,000–20,000 ¹⁷	nk	70 ¹⁸	nk	✓ (15)	✓ (10)(M, B) ³
Moldova	31,562 ⁵	16.4 ⁵	42.7	nk	✓ (31)	✓ (10) ¹ (M)
Montenegro	nk	nk	37.8 (22–53.6)	0	✓ (18)	✓ (3) ^g (M)
Poland	nk	6.8 ⁷	44.3–72.4 ^{(g) 8}	2.5–3.8 ⁹	✓ (27)	✓ (22)(B,M)
Romania	17,000 ⁵	4.2 ¹⁸	82.9 ^{(g) 8}	4.7 ⁹	✓ (3)	✓ (7)(B,M)
Russia	1,815,000	37.15 (0.3–74) ^k	72.5 (49–96)	9	✓ (4)	✗
Serbia	30,383 (2682–48,083) ⁵	2.4–4.5 ^{(g) 5}	60.5–77.4 ^{(g) 5}	nk	✓ (13)	✓ (30) ^g (B,BN,M)
Slovakia	18,841 (13,732–34,343)	0.3 ⁷	40.3 ^{(g) 8}	nk	✓ (20)	✓ (2)(BN,B,M)
Slovenia	7,310	0.4 ⁷	21.5 ⁸	3.4 ^l	✓ (17)(P)	✓ (20)(BN,B,M,O)
Tajikistan	25,000 (20,000–30,000) ¹⁹	16.3 ²⁰	61.3	nk	✓ (49)	✓ (3) ^g (M)
Turkmenistan	nk	nk	nk	nk	✓ (2)	✗
Ukraine	296,000 ⁵	21.5 ⁵	67 (60.9–73)	6.7	✓ (1667) ⁵	✓ (131) ^g (B,M)
Uzbekistan	83,500	8.4 ⁵	51.7	nk	✓ (235)	✗

nk= not known
^(g) = sub-national data

a Unless otherwise stated, data on the estimated number of people who inject drugs in each country are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745. The year of estimate is provided for each figure that is sourced from 2007 or earlier.

b Unless otherwise stated, estimates for hepatitis B and C are sourced from Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, Lancet, 378(9791): 571–583.

c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.

e The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).

f Figure based on expert opinion and based on problem drug use rather than injecting only.

g Year of estimate: 2007.

h Year of estimate: 2005.

i Year of estimate: 2006.

j Seven of these are prison NSPs.

k Year of estimate: 2003.

l Year of estimate: 2002.

Map 2.2.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



Harm reduction in Eurasia

Of the estimated 15.9 million (11–21.2 million) people who inject drugs (PWID) worldwide,²⁰ 3.7 million – nearly a quarter – live in Eastern Europe and Central Asia (Eurasia). Based on national-level estimates, the largest PWID populations are reported in Russia (1.8 million)²¹ and Ukraine (296,000).^{22 m}

Eurasia is the only region in the world where the number of people living with HIV has almost tripled since 2000, reaching an estimated total of 1.4 million (1.3 million–1.6 million) in 2009 compared with 760,000 (670,000–890,000) in 2001.²⁰ Injecting drug use (IDU) remains the leading route of HIV transmission in Eurasia.²³ An estimated one quarter of the 3.7 million PWID in Eurasia are living with HIV.²¹ In several countries, particularly in Eastern Europe, HIV prevalence among PWID in prisons is substantially higher than prevalence in the general population.²⁴

Viral hepatitis is considerably more widespread than HIV among PWID in Eurasia, with five countries in the region reporting hepatitis C (HCV) prevalence higher than 70% among this population. Estonia has the highest HCV prevalence among PWID (>90%), followed by Romania (82.9%), Serbia (77.4%), Russia (72.5%) and Lithuania (>70%).²⁵ The disproportionately high burden of HCV among PWID is exacerbated by limited access to testing and treatment, particularly for incarcerated PWID, who experience higher rates of viral hepatitis than PWID in the community.²⁶

Increasing rates of HIV/tuberculosis (TB) co-infection and limited access to treatment for both diseases contribute to the increased vulnerability of PWID in Eurasia. Fatal overdose caused approximately 21% of deaths among all people living with HIV in Russia in 2007, second only to TB.²⁷

Although harm reduction programmes across Eurasia have generally expanded since 2010, coverage remains low to medium by international targets.ⁿ Needle and syringe exchange programmes (NSPs) are available in all 25 countries of the region, but coverage varies widely among countries, from 19 syringes distributed per PWID per year in Latvia²⁸ to 174 per person per year in Estonia.²⁹ None of the 12 countries in the region for which coverage data are available reached the international recommended level of 200 syringes per person per year,³⁰ although five countries distributed between 100 and 200 syringes per person per year: Estonia, Kazakhstan, Kyrgyzstan, Slovakia³¹ and Tajikistan.^o

Twenty-six countries in the region, with the exception of Russia, Turkmenistan and Uzbekistan, implement opioid substitution

therapy (OST). Substantial scale-up of OST provision since 2010 has occurred in Bulgaria, the Czech Republic, Georgia, Lithuania, Moldova and Serbia, and new programmes were established in Tajikistan in 2010 and Kosovo in 2012.

Despite progress in several areas, harm reduction remains politically marginalised in some countries in the region, particularly Russia and Uzbekistan. Since 2010, Hungary's national drug strategy has been amended to exclude harm reduction as a priority and limit access to drug treatment instead of criminal sanctions for people who use drugs (PWUD).³²

The international financial crisis and the restructuring of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has significantly affected harm reduction efforts in many countries in Eurasia, with the notable exception of successful Round 10 applicants Kazakhstan, Kyrgyzstan, Ukraine and Uzbekistan.³³ Since the cancellation of Round 11 in November 2011, a number of countries in the region, namely Armenia, Azerbaijan and Belarus, face a different set of eligibility criteria for new funding and potentially long-term funding cuts, as is the case of Albania.³³ Despite the inclusion of harm reduction in national HIV or drug strategies in 26 countries,³⁴ the majority of governments in Eurasia do not financially support harm reduction programmes. Five countries reported non-governmental and non-Global Fund funding sources for harm reduction, while another 11 reported some governmental contributions toward the delivery of harm reduction programmes.³⁵ Overall, non-governmental organisations (NGOs) are the main implementers of NSPs, either through stand-alone sites or in the context of broader HIV prevention services, while governmental institutions tend to manage OST provision. However, in several countries, including Tajikistan and Uzbekistan, more governmental institutions have initiated NSP provision with support from the Global Fund.

Civil society organisations (CSOs) and regional networks have played an increasingly important role in advocacy for harm reduction in Eurasia. Since 2010 the European Harm Reduction Network (EuroHRN)^r which includes 13 countries in Eastern Europe,⁵ was newly established with support from the European Commission, and the International Drug Policy Consortium (IDPC) initiated a new drug policy network for South East Europe.³⁶ In 2011, several important events took place in European capitals as part of the Count the Costs Campaign,^t on the occasion of the 50th anniversary of the

m This report included both 250,000 and 296,000 PWIDs as population size estimates.

n According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage, 100–200 is medium coverage, and >200 is high coverage.

o Data extracted from UNGASS country reports, Country questionnaires, Petersen et al. (2012),¹⁶ Latypov et al. (2012)³ for: Armenia, Azerbaijan, Belarus, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Tajikistan and Ukraine.

p Figure includes Azerbaijan, which passed a new HIV law in 2010.

q Kyrgyzstan, Latvia, Romania, Russia, and Tajikistan reported additional funding sources in addition to government and GFATM, while Azerbaijan, Bulgaria, Bosnia & Herzegovina, Estonia, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland and Serbia reported governmental funding for OST/NSP and related activities.

r The European Harm Reduction Network (EuroHRN) has been recently formed by ten organisations with a shared interest in advocating for and sharing knowledge on harm reduction within Europe. It is made up of three sub-regional networks covering North, South and Eastern Europe and managed by a coordinator based at the Harm Reduction International in the UK. For more information see www.eurohrn.eu.

s Albania, Bosnia and Herzegovina, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia.

t To learn more about Count the Costs, see www.countthecosts.org.

Single Convention on Narcotic Drugs on 30 March 2011. 'Urban Drug Policies in the Globalized World', an international workshop conference that took place in Prague, Czech Republic, in 2010, brought together civil society partners and networks from Eurasia, enabling them to exchange information on policy and best practices.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

NSPs operate in all 29 countries and territories in Eastern Europe and Central Asia (see Table 2.2.1). Since 2010, three countries have scaled up provision: Kyrgyzstan, Tajikistan and Ukraine: for example, the number of NSP sites in Ukraine has increased significantly from 985–1323 reported in 2010 to 1667 in 2011.⁵ During the same period, five countries have scaled back provision due to funding cuts: Belarus, Hungary, Kazakhstan, Lithuania and Russia.

Several countries reported that an increased proportion of PWID are being reached by NSP services. These include Armenia, Croatia and Kosovo, with coverage rates ranging from 10% in Georgia³⁷ to 72% in Belarus.³⁵ A recent report by the Eurasian Harm Reduction Network (EHRN) estimates that on average only 10% of PWID in Eastern Europe and 36% in Central Asia access NSPs.³³ New data covering the period from January 2010 to December 2011 submitted by countries to UNAIDS as part of Global AIDS Progress reporting indicate that sharing of injecting equipment varies widely across the region. The number of PWID who report using sterile equipment during their last injection ranges from only 15.58% in Romania to 95.5% in Ukraine.⁵ New models of service delivery are applied in some countries including a pilot NSP in a prison in Tajikistan and a mobile NSP in Albania.^u

However, even in countries that report increased availability of NSPs, research and consultations with PWID indicate that many actively avoid seeking health services due to the risk of being stigmatised, ostracised or discriminated against by health care providers.^{16, 35, 38} Additional barriers to service access include limited or uneven geographical reach of programmes,^{35, 39} fear of being threatened, abused, extorted or arrested by the police,^{35, 41–43} criminalisation of possession of illicit substances or injecting equipment with traces of substances,⁴⁴ lack of political will and funding,⁴⁵ and limited or insufficient supply of injecting equipment.^{13, 35, 46}

Overall, harm reduction programmes that focus on women who use drugs are in place in Georgia, Kyrgyzstan, Russia and Ukraine with the support of the Open Society Foundation,

UNICEF and GIZ. However, in most cases, although NSPs do not openly discriminate against women, gender-specific NSP services that recognise and address the specific barriers faced by women who inject drugs are limited or difficult to access. In Romania, cultural stereotypes and stigma prevent many women from accessing NSP.³⁵ In Tajikistan women who use drugs experience high levels of stigma, especially from male PWID.⁴⁷ Anecdotal reports from Macedonia and Albania indicate that the lack of NSP programmes sensitive to women's needs limits women's access to these services.³⁵ The intersection between drug use and sex work, particularly in the case of Roma sex workers in Hungary and Romania, renders addressing the needs of women drug users particularly challenging.^{35, 48}

Access also appears to be limited for young PWID. Legal age restrictions or required parental consent prevent young people from accessing NSPs in Czech Republic, Estonia, Lithuania, Macedonia, Moldova and Romania.^{49–51} However, since NSP services are often anonymous and client ages unrecorded, it is hard to assess whether some PWID are under 18.⁴⁹ There are no legal age restrictions reported for accessing NSPs in 16 countries in the region.^v In Serbia a new law due to be implemented beginning in August 2012 will allow minors aged 15 and above to have exclusive privacy over their medical charts and consent rights regarding their health issues, meaning that parental consent will no longer be required when accessing harm reduction services.⁵²

Opioid substitution therapy (OST)

OST is available in various forms in 26 countries and territories, with the exception of Russia, Turkmenistan and Uzbekistan. Despite the increased availability of OST at the national level, programmes continue to have limited reach, and coverage varies significantly among and within states. Ukraine has the highest number of clients on OST (6517),³ while the Czech Republic has the highest estimated OST coverage in the region, with 40% of people who inject opiates enrolled in OST.³ It is followed by Lithuania, Bulgaria and Poland, with rates of 13.1%,⁵³ 12% and 7% of PWID enrolled in OST, respectively.³ In the majority of former Soviet countries coverage remains extremely limited, with under 5% of PWID accessing OST.³ Although most programmes continue to have limited reach and are still in pilot stages,¹⁶ the number of OST sites has increased in 16 countries and territories^w since 2010.

Greater coverage in the Czech Republic and Croatia can be partially attributed to the fact that medications used for OST (except methadone) can be prescribed by general practitioners and purchased in pharmacies.³ The opposite is the case in Estonia and Latvia, where prescription regulations limit access.^{35, 46} Positive developments in OST delivery have

u The NSP in Albania has been newly integrated into the Break the Cycle (BTC) intervention model, which aims to enable PWID to use drugs safely by providing of services, skills and information and encouraging their commitment to not recruit others to drug use.

v Slovakia, Croatia, Bulgaria, Albania, Slovenia, Serbia, Hungary, Bosnia, Kosovo, Armenia, Belarus, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine.

w Albania, Armenia, Bosnia & Herzegovina, Bulgaria, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Macedonia, Moldova, Poland, Romania, Serbia and Ukraine.

been reported in Serbia and Bosnia and Herzegovina, where services have recently been decentralised.³⁵ Additional forms of OST in addition to methadone have been introduced in Serbia (buprenorphine and buprenorphine-naloxone combination), as well as in Czech Republic and Georgia (buprenorphine-naloxone combination).³⁷ In Bulgaria the quality of OST services is presently being addressed in a new set of guidelines for good clinical practice planned to come into force in 2012.³

Despite encouraging developments in OST provision in the region, a number of barriers remain around implementation and scale-up. Only nine countries – Albania, Bulgaria, Kyrgyzstan, Latvia, Lithuania, Macedonia, Poland, Serbia and Ukraine – reported access to takeaway doses. However, even in countries where takeaway OST is available, access is limited by strict regulations:³ strict admission criteria are in place in at least seven countries, including proving a past history of opiate use, as well as one or several failed treatment attempts.⁵⁵⁻⁵⁷ Scarce provision of OST outside major urban centres results in uneven coverage within countries,³⁵ and the cost of existing OST services, limited funding^{3,40,58} and long waiting lists³⁵ pose additional barriers. Limited funding was cited as the reason why some services reportedly prescribe methadone doses below WHO recommendations in Kyrgyzstan⁵⁵ and Moldova.⁴⁰ In several Eurasian countries, protocols for administering OST are inappropriate or non-existent, and there is a need for increased capacity-building among staff.

Access to OST is also subject to strict age restrictions, with legal age restrictions in place in at least ten countries and parental consent needed for young people under 16 years old in Bosnia and Herzegovina and Slovakia.³⁵ Barriers faced by women who inject drugs are similar to those faced by men, although the limitation of civil rights, particularly the removal of parental rights, affects women disproportionately in several countries including Macedonia and Ukraine.⁵⁹⁻⁶⁰ Often this is executed through the implementation of registries of PWUD at harm reduction services for women who inject drugs, rendering them vulnerable to discrimination and the loss of parental rights during child custody cases. Fear of stigma and discrimination remains a barrier to access for all PWID.³⁵

Antiretroviral therapy (ART)

Eurasia is home to nearly 1 million PWID living with HIV.⁶¹ PWID comprise 62% of people living with HIV in the region but only 22% of those receiving antiretroviral therapy (ART).³³ The proportion of PWID living with HIV who receive ART in Eurasia varies between 3.5% in Kazakhstan and 10% in Moldova, although it should be noted that new data on exact coverage since 2010 were only available for three countries.¹⁶ The highest numbers of PWID living with HIV who access ART are in Ukraine (1732)¹⁶ and Poland (1372).⁶¹ Providing PWID with fully comprehensive prevention, treatment and care services is particularly important given the high rates of co-infection with TB and viral hepatitis among this population.⁶²

Accessing confidential voluntary counselling and testing (VCT) is an important element in increasing the uptake of ART for PWID. Recent country-level data from 2012 Global AIDS Progress reports submitted to UNAIDS indicate that the percentage of PWID who tested and are aware of their status ranged between 3.9% in Azerbaijan, 64.4% in Lithuania and 64.7% in Kazakhstan.⁶³ Barriers to testing for HIV included non-confidential VCT, parental consent requirements for those less than 18 years old,³⁵ availability of testing only in medical facilities, procedural delays,³⁵ funding issues for VCT programmes³⁵ and discrimination against PWID by health care providers.

Due to relatively low rates of HIV in Albania, Croatia, Georgia, Kosovo, Macedonia, Slovakia and Slovenia, most individuals in need of ART are reported to access it.³⁵ The requirement to undergo additional tests prior to initiating ART, the need for mandatory documentation that PWID have difficulty accessing such as local registration, national identity card and fixed residence, and lack of ART treatment guidelines for PWID all act as deterrents to their accessing ART in several countries in the region.³⁵

Challenges with adherence to ART are generally linked to limited access to OST, stigma and discrimination by police and health care providers, a lack of counselling and support, limited funding for ART, geographical distance from treatment centres and complexity of ART regimens.^{10, 64} Adherence among PWID is facilitated by socio-emotional support by family and friends and access to OST, such as methadone or buprenorphine, which attenuate the impact of active drug use on the uptake of ART.¹⁶ Fears that adherence rates among PWID will be lower than among the general population are not supported by a recent systematic review and meta-analysis, which found rates of 60% adherence among PWID, which are similar to adherence rates found among the general adult population living with HIV that do not inject drugs.⁶⁵

Viral hepatitis

A recent systematic review of the global epidemiology of viral hepatitis (B and C) among PWID concluded that Eastern Europe was home to the largest population of PWID with HCV, or 2.3 million of the total estimated 10 million PWID living with HCV globally in 2010 (range 6.0–15.2 million).²⁵ Following HIV infection trends, Russia, where the largest PWID population in Eurasia resides, had the second largest population of PWID living with HCV in the world, after China. Prevalence data for HCV are available for 24 of the 29 countries and territories in Eurasia, ranging from 13.6% in the Czech Republic to 90.5% in Estonia. Lithuania, Romania and Estonia were the three countries with the highest recorded prevalence: 76.3–89.7% among PWID in two cities in 2006,⁶⁶ 82.9% among PWID in Bucharest in 2009⁶⁶ and 90.5% in 2002, respectively.²⁵

Of the 1.2 million PWID living with hepatitis B (HBV) worldwide in 2010, 300,000 live in Eurasia; however, it should be noted

that²⁵ available data on HBV are of a lower quality than data on HCV. Only 11 of the 29 Eurasian countries and territories had ever conducted a prevalence study on HBV among PWID. Where data were available, prevalence varied widely from less than 1% in Montenegro and Hungary to over 20% in Estonia (see Table 2.2.1). The quality of prevalence data and the timing of the existing studies varied significantly among the 29 countries in the region, with no data available on either HCV or HBV from eight countries^x and several countries' latest available data being from 2001 or earlier. Systematic research on the extent of viral hepatitis, particularly in light of the limited access to testing and treatment for both HCV and HBV among PWID,²⁵ is urgently required.

Access to HCV treatment among PWID remains extremely limited in Eurasia.⁶⁷ The high cost of patented Pegylated-Interferon used in the treatment of HCV (up to \$18,000 for a 48-week course in some countries in the region) remains a critical barrier to access.⁶⁸ Few countries (such as Kazakhstan, Russia, Lithuania, Estonia and Bulgaria) are reported to provide any state-funded HCV treatment, but obtaining concrete data on the qualification criteria for receiving treatment and the number of people treated remains challenging. In Russia, HCV treatment is provided by the state for those with HCV/HIV co-infection, but access continues to remain limited for those with a history of drug use, and particularly for people actively using drugs.⁶⁸ Diagnostic tests for viral hepatitis, mainly viral load qualitative and quantitative tests and genotype tests, remain unaffordable, ranging from \$10 in Ukraine to \$121 in Georgia, and are usually paid for by the patient.⁶⁸

The WHO Regional Office for Europe (WHO-EURO) has developed HIV/HCV co-infection guidelines;⁶⁹ however, the absence of HCV mono-infection or co-infection treatment guidelines in some countries can pose an obstacle to expanding treatment access. Where such guidelines do exist, they do not address the special needs of PWID (for example, guidelines often fail to address treatment adherence and management of side effects). Additionally, some guidelines are not based on internationally recognised standards of care, which involves dual therapy with Pegylated-Interferon and ribavirin.^{70y}

Lack of political commitment to make viral hepatitis a priority poses another critical barrier to expanding access to treatment. Civil society organisations (CSOs), including harm reduction and drug user groups, have mobilised in many Eurasian countries to seek improved access to HCV treatment by demanding that national governments increase their commitment to address HCV, including providing treatment for PWUD, and that pharmaceutical companies reduce prices for Pegylated-Interferon.⁷¹

Tuberculosis (TB)

Six countries report that targeted harm reduction, HIV, viral hepatitis and TB testing and treatment services operate in an integrated manner in their country.^z Most countries indicate that in the absence of integrated services, 'strong referral systems' between different services are in place. In Slovakia the NGO Odysseus has recently introduced low-threshold HIV/TB testing through outreach for marginalised groups, including migrants and mobile populations who engage in drug use.⁵⁸

Efforts to reach PWID who may require TB testing and treatment are limited. Few countries in the region implement HBV vaccination among populations at higher risk of HIV.⁷² In Romania, for instance, PWID are not included in routine TB testing or in national TB surveillance, despite being one of the groups at higher risk of acquiring the infection.³⁵ In some former Soviet countries, people living with HIV cannot start ART if they have opportunistic infections (such as TB), as these infections need to be treated first.¹⁶ TB services in some settings also deny access to TB treatment to PWID who are living with HIV.¹⁶ In addition to limited integration among services, another key barrier to TB testing and treatment is the lack of direct observation treatment short course (DOTS) in most countries, especially integrated in NSP or OST services.^{35, 73} Barriers to accessing TB treatment vary by country: in Serbia, PWID without insurance have problems accessing TB treatment, in Kazakhstan PWID can only access treatment if they have a local registration document, and in Bulgaria, TB hospitals do not offer any drug dependence treatment, leading many PWUD to interrupt treatment and leave hospital early due to withdrawal symptoms.³⁵

Improved referral systems and integration among ART programmes, harm reduction services and testing and treatment for TB and viral hepatitis remain to be urgently addressed in this region.

Overdose responses

Overdose mortality in the region generally tends to be underestimated, and most governments in the region have not acknowledged the full extent of the overdose epidemic among PWID. For example, while national authorities in several Central Asian republics report conservative numbers of fatal overdoses, 25.1% of PWID surveyed in Kazakhstan, Kyrgyzstan and Tajikistan in 2010 reported having witnessed someone die due of an overdose in the past 12 months.⁷⁴ PWID in Eurasia also tend to have high prevalence of non-fatal overdose. For example, non-fatal overdose was experienced at least once by 59% of people injecting heroin surveyed across 16 Russian cities.⁷⁵

x Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kyrgyzstan, Macedonia and Turkmenistan.

y For example, the Russian guidelines indicate treatment with linear interferon, or other medicines, such as *phosphoglia*, which are not based on best practice or on guidelines developed by WHO.

z Bosnia & Herzegovina, Croatia, Bulgaria, Poland, Slovenia and Serbia.

For most countries where data are available, overdose prevention responses include limited or rare provision of overdose information material to PWUD, individual overdose risk assessment, overdose response training and risk education on drug-related deaths.^{58, 76} Across the region, overdose prevention programmes are often sporadic and generally run by local NGOs.

Naloxone, a highly effective opioid antagonist used to reverse the effects of opiate overdose, is registered as a medication or included in the essential medicine list in all Eurasian countries, with the exception of Albania.⁷⁶ Across the region, naloxone is mainly available via doctors in emergency departments, hospitals and ambulance workers, as well as for community-based distribution in Armenia, Belarus, Estonia, Georgia, Russia and Ukraine.³⁵ Access through peers and harm reduction services in the community, such as NSP providers, is also reported in Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Russia; however, distribution often occurs unofficially via local NGOs.^{35, 76} Despite the availability of naloxone in emergency departments and ambulances, supply is not consistent across all types of facilities and at all times.

Additional barriers to the effective implementation and scale-up of overdose responses, including naloxone provision, include laws limiting management and transportability of naloxone by non-medical personnel and delays in the provision of emergency care responses for overdose.⁵⁸ Ongoing advocacy in several countries, including Georgia, Kazakhstan, Kyrgyzstan, Russia and Tajikistan, aims to expand access to naloxone by building political commitment, ensuring local or international funding for naloxone programmes and advocating for the removal of policy and legal barriers that prevent NGOs from distributing naloxone. There is an urgent need for advocacy around scaling up the distribution of naloxone beyond medical services to harm reduction programmes, outreach workers and PWUD, their families and communities.

In December 2011, Tajikistan's Ministry of Health approved the distribution of naloxone via NGOs working directly with PWID. Three local NGOs (Apeiron, Volonter and ROST), in collaboration with Soros Foundation Tajikistan and the Global Health Research Center of Central Asia, successfully advocated for authorisation to store 500 vials of naloxone at a time at NGO locations around the country and to distribute these directly to clients as needed. In addition to issuing an order to allow NGOs to store naloxone, the Ministry of Health has also endorsed guidelines developed by civil society which formalise and legitimise naloxone distribution through community harm reduction sites. Although the decision limits activity only to NGOs that hold a pharmaceutical activity licence, prior to this decision, NGOs in Tajikistan were not legally permitted to store naloxone on their premises, posing a major barrier to access by people who need it most. Similarly, in Kyrgyzstan, civil society reports indicate that NGOs are now permitted to

distribute naloxone directly to their clients in Osh and Bishkek, through Kyrgyzstan's Global Fund Round 10 grant. Prior to this, NGOs were not allowed to store or distribute naloxone.⁷⁷

Harm reduction in prisons

Availability of harm reduction interventions in prisons is very limited across Eastern Europe and Central Asia, with wide variations in service coverage among countries and in facilities within countries. By mid-2012, five countries – Armenia, Kyrgyzstan, Moldova, Romania and Tajikistan – were implementing NSPs in prisons. OST is available in prisons in 18 of the 26 countries and territories that also provide OST in the community,^{3a} including two new OST pilots in Bosnia and Herzegovina and Latvia since the beginning of 2012.³ In several countries OST is available in prisons only to clients who were on treatment prior to incarceration; in others it is available only in custody centres, while in a third group it is only available in a limited number of centres.³⁵ For example, some degree of OST provision is reported in prisons in Croatia and pre-detention trial units in Albania, Georgia and Kyrgyzstan, although programmes are not available as an integral part of health services in Albanian prisons.

The Czech Republic, Hungary, Romania and Slovenia provide initiation of OST on entering prison and continuation of OST in the community upon release from prison to varying degrees. Continuation of OST in prison is available in Bulgaria, Estonia, Poland and Montenegro provided that the inmate was already receiving OST prior to arrest.

Data on prevalence of TB and HCV/HBV among PWID are lacking, mainly due to the lack of TB screening and HCV/ HBV testing in prisons. Nonetheless, the burden of TB, HCV/ HBV and HIV among prisoners is significant, especially given higher rates of co-morbidities than the general population.⁶² Co-infection of HIV and TB in overcrowded prisons also poses significant challenges to both detention and health systems in Russia and post-Soviet Union countries,⁷⁸ especially given the highly rigid level of vertical integration of each system, which often results in lack of coordination.⁶² Given the high proportion of PWID in prisons and correctional facilities and the high rate of re-offending among PWID, an important opportunity to reach this population is through integrated vaccination, testing and treatment for HCV and HBV within these settings.⁷⁹⁻⁸¹

Barriers to implementation and scale-up of harm reduction interventions in prisons include lack of political will, denial of the existence of drug use in prisons, shortages of staff for medical services within prisons, lack of funding and data gaps on the extent of IDU in prisons across the region.

aa Albania, Armenia, Bulgaria, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kyrgyzstan, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia and Slovenia.

Policy developments for harm reduction

In 2010, HRI reported that 25 Eurasian countries and territories had national HIV or drug policies explicitly supporting harm reduction.³⁴ Since then, seven countries – Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine – have finalised HIV strategies and national programmes that include harm reduction activities, in some cases focusing on scaling up NSP and OST, although in the case of Ukraine this strategy has yet to be approved.³⁵ The HIV law passed in Azerbaijan in 2010, which previously had no legal provisions in place regarding harm reduction, now emphasises the role of harm reduction in HIV prevention, including NSP and OST provision in penitentiaries.⁸² Additional policy developments include Serbian by-laws to the new Law on Rehabilitation, Resocialisation and Treatment that legalise harm reduction and remove parental consent as a barrier for accessing NSP and OST, relaxation of OST criteria in Belarus and plans to implement community-based naloxone in Estonia.⁷⁶

The decriminalisation of drug use in Estonia and the amendment of penalties for drug possession for personal use from incarceration to administrative offences in Kazakhstan and Poland^{35, 83-84} constitute further favourable policy developments.

Despite an overall trend toward a policy environment conducive to harm reduction implementation and scale-up, a number of important challenges remain. Since 2010 the policy context for harm reduction has deteriorated or remained highly unfavourable in Hungary, Russia and Ukraine. The national drug policy in Russia portrays NSP as a threat to effective drug control, while the 2009–2011 HIV strategic plan in Uzbekistan fails to recognise harm reduction and cites drug use and sex work as antisocial behaviours.³⁵

In December 2010, without prior consultation with civil society or medical professionals, the Hungarian government rejected the progressive harm-reduction-oriented drug strategy and introduced a new draft strategy excluding any mention of harm reduction. The new strategy does not list NSP and voluntary HIV/AIDS testing and counselling among its aims and refers to OST as a form of treatment that ‘may be necessary’ for those ‘who cannot be treated effectively with other methods.’⁸⁵ A recent review of OST provision across Eurasia evaluated Lithuania to have one of the least favourable policy environments in the region: Lithuania’s drug policy does not include services for PWID, while the national HIV programme includes no targets for NSP and OST services.^{55, 86-87}

Since 2010, stricter penalties^{ab} for drug possession have been put in place in Russia and Ukraine.⁸⁸⁻⁸⁹ For the first time, the Czech Republic introduced threshold quantities for possession of illegal drugs, with unauthorised possession for personal use continuing to hold an administrative penalty.⁹⁰⁻⁹¹ Although the impact of this policy is unclear, evidence from other settings suggests that the reduction in threshold quantities for personal use will result in reduced access to NSP and OST due to fear of police harassment and raids.⁹² Georgia remains one of a few countries where the non-medical use of controlled drugs constitutes a criminal offence. This has a direct impact on both the rights and health of PWUD: currently there are more PWUD in prisons than there are in treatment facilities.⁹³

New legal highs

The past two years have seen an exponential increase in new psychoactive substances commonly referred to as ‘legal highs’ across Europe. Between 1997 and 2010 the early-warning system of the European Monitoring Agency on Drugs and Drug Addiction (EMCDDA) identified more than 150 legal highs, 65 in the past two years (24 in 2009 and 41 in 2010).⁹⁴

Legal highs have contributed to the increased risk of HIV and viral hepatitis transmission in several countries in the region, particularly Hungary and Romania, where a significant proportion of heroin and amphetamine users have turned to injecting designer ‘legal highs’. Injection of ‘legal highs’ is often more frequent than heroin injection, with the potential to increase the sharing of injecting equipment.

The response from governments has generally been default criminalisation, even in the absence of clear evidence. Romania has criminalised 36 new substances in 2010, and over 900 shops were closed down in Poland.⁹⁵⁻⁹⁶ In 2011 the Czech Republic and Slovakia joined the race and criminalised 33 and 42 new substances, respectively, in their countries.^{97 ac} From 1 January 2012 nine new substances were banned in Hungary. Although the Hungarian government plans to introduce generic legislation aimed at preventing traffickers from creating new legal substitutes of prohibited substances, it has stated that it does not aim to criminalise PWUD, but only the distributors of new psychoactive substances.⁹⁸ This approach has led to the displacement of one substance with another, rather than a cessation of ‘legal high’ use.

ab These included harsher penalties for drug-related crimes including administrative detention for drug use for up to 15 days and life sentence for large-scale drug offences in Russia. In March 2012 the Federal Drug Control Service of the Russian Federation proposed an amendment to the Criminal Code providing for up to two years of prison or hard labour for drug use, if the episode of drug use is repeated within a year after the first drug use episode has been recorded. In addition, Ukraine’s Ministry of Health issued a resolution in 2010 setting very low threshold amounts of illicit drugs that trigger criminal liability; for instance, minimum amount of heroin is set at 0.005 g, thus making all individuals possessing one dose of heroin without intention to sell criminals.

ac Czech Republic Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011. See <http://portal.gov.cz/zakon/106/2011>.

Civil society and advocacy developments for harm reduction

Civil society has played an increasingly important role in effectively advocating for harm reduction in Eurasia and internationally. Active lobbying and advocacy from national and/or regional-level CSOs and networks has been instrumental in amending the Slovenian Penal Code to allow for the establishment of settings where illicit drugs may be consumed under medical supervision,³⁵ the development of the new HIV law in Azerbaijan and actively participating in the working group to change the law in Romania, all with varying degrees of success. Advocacy for wider availability of naloxone in Tajikistan resulted in guidelines for overdose prevention and management by the Ministry of Health,³⁵ while an aggressive campaign in Ukraine succeeded in overcoming the government's opposition to OST.³ In Bosnia and Herzegovina the Ministry of Security, in cooperation with the Ministry of Health, initiated a process of accreditation of harm reduction NGOs, although this process is based on the assumption that harm reduction programmes will be funded by these two ministries after the contract with Global Fund expires in 2014.³⁵

Advocating for drug policy change in Poland

Civil society organisations in Poland have long been campaigning to reform the country's drug law. During 2010–2011 the Polish Drug Policy Network (PDPN) initiated a national advocacy campaign that aimed to amend the restrictive drug law in Poland.⁹⁹ Advocacy activities included legal actions such as cooperation with the Office of the Ombudsman for Addicts, active participation in public debate and numerous open letters including one signed by a former Polish president and other prominent figures¹⁰⁰ addressed to the Ministry of Health, Minister of Justice, Prime Minister, Polish Sejm and Senate, and the National Bureau for Drug Prevention. PDPN also launched an online sign-on campaign targeting both Polish and international audiences to put pressure on Bronislaw Komorowski, the President of the Polish Republic, to sign the bill.

On 25 May 2011 the President signed an amendment to the country's drug law. The new amendment draws a greater distinction between drug dealers and drug users, and allows prosecutors the choice not to criminalise small-scale drug offenders. The next steps will be to ensure that the current amendment is implemented and to open a broader public debate on decriminalisation.

The Eurasian Network of People who Use Drugs (ENPUD) was established in February 2010 following a meeting of representatives of the drug user community and OST clients from Armenia, Georgia, Kyrgyzstan, Kazakhstan, Ukraine, Russia, Tajikistan, Uzbekistan and Moldova.¹⁰¹ This initiative represents the first attempt by people who use or have previously used drugs in the region to join efforts at the regional level. ENPUD aims to facilitate greater involvement of PWUD in local and international drug policy, to improve the quality of medical, social and legal services. A strategic follow-up meeting and needs assessment exercise is planned to take place in Kiev in July 2012.

EHRN has continued to actively promote harm reduction and the rights of PWUD across 29 countries in Central and Eastern Europe and Central Asia. In 2011, EHRN mobilised and supported over 30 drug user activists to testify to the Global Commission on HIV and the Law on a range of human rights violations faced by their community. Their joint statement was voiced at the Regional Consultation of the Global Commission and was delivered at the UNAIDS Programme Coordinating Board (PCB).⁹² At the 54th UN Commission on Narcotic Drugs (CND), EHRN organised a side event on overdose, 'Illicit Drug Overdose: Major Cause of Preventable Death', which was well attended by key multilateral agencies and civil society representatives. A key outcome of the event was the formation of a multisectoral initiative to develop internationally recognised overdose prevention guidelines.

In 2010 the South East Europe NGO Drug Policy Network, an initiative led by NGOs in the region and supported by the International Drug Policy Consortium, was launched. The network aims to create open and objective dialogue with experts, key policymakers in national governments, regional bodies and international organisations to promote humane and effective drug policies.

As part of the international Count the Costs campaign supported by the Open Society Foundations, the Hungarian Civil Liberties Union (HCLU) and the European Drug Policy Initiative (EDPI) coordinated actions in five European cities – Sofia, Bucharest, Warsaw, Oslo and Porto – to raise public awareness on the health and human rights costs of the war on drugs, to mark the 50th anniversary of the Single Convention on Narcotic Drugs in June 2011.¹⁰²

CSOs in Eurasia are well positioned to engage in ongoing advocacy to reverse the disproportionate focus on punitive approaches to IDU, common in countries in the region.¹⁰³ In the current precarious funding environment, the provision of adequate financing for CSOs and local organisations of PWUD to enable them to continue this important work is particularly crucial.³³

Multilaterals and donors: developments for harm reduction

Increased engagement by multilateral agencies in harm reduction implementation is reported in Albania, Bosnia and Herzegovina, Latvia, Kyrgyzstan, Serbia and Tajikistan. UNICEF is an active partner in research among young PWID and in preparation of the new Law on Rehabilitation, Re-socialisation and Treatment in Serbia but plans to scale down its activities in Romania. UNODC supports ongoing harm reduction services in prisons in Latvia and Tajikistan and at the time of publication was investigating how to best support the scale-up of harm reduction services in prisons in Albania, Serbia and Macedonia in partnership with EHRN. UNDP is the primary recipient for Global Fund grants in Kyrgyzstan and Tajikistan, both of which include support for harm reduction services.

Funding for harm reduction responses in Eastern Europe and Central Asia largely originates from the Global Fund. The Global Fund invested over US\$366 million for harm reduction in Eurasia alone – more than all other international sources combined (see Table 2.2.2).³³ Other donors that support harm reduction in the region include the European Commission, OSF, UNAIDS, UNODC, UNDP and UNICEF. Along with international donors, additional funding for harm reduction is contributed by national governments in Azerbaijan, Bulgaria, Bosnia and Herzegovina, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland, Slovenia, Slovakia and Serbia.³⁵ Overall, government funding prioritises provision of medical services and OST, as well as NSP and OST in prisons, while CSOs and international partners largely support NSP and community-based harm reduction separately or in the context of comprehensive HIV prevention programmes.^{3, 35}

Table 2.2.2: Approved Global Fund investments targeting PWID in Eastern Europe and Central Asia Round 1 (2002) to Round 10 (2010)¹⁰⁴

COUNTRY / TERRITORY	TOTAL (US\$)	
Albania	1,400,000	
Armenia	3,100,000	*
Azerbaijan	6,000,000	*
Belarus	17,500,000	*
Bosnia & Herzegovina	9,800,000	*
Bulgaria	9,500,000	
Croatia	600,000	
Estonia	2,700,000	
Georgia	12,700,000	*
Kazakhstan	29,800,000	*
Kosovo	2,000,000	
Kyrgyzstan	25,800,000	*
Macedonia	15,600,000	*
Moldova	7,200,000	*
Montenegro	1,600,000	*
Romania	4,200,000	
Russian Federation	38,400,000	
Serbia	6,500,000	*
Tajikistan	15,600,000	
Ukraine	143,900,000	*
Uzbekistan	12,200,000	*
TOTAL	366,100,000	

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

Increased state support for harm reduction is expected in Macedonia; in 2011 the Ministry of Health financed the provision of 30,000 syringes and 50,000 condoms via NSPs for the first time.⁷³ In Bosnia and Herzegovina, a new NGO accreditation process may result in more harm reduction programmes funded by the state in the coming years; currently only 40% of harm reduction programmes are funded by the national government.³⁵ In other countries where the state supports harm reduction, funding is allocated on an annual basis, and government funds are often delayed and insufficient to sustain and scale-up service coverage to levels needed to have an impact on HIV and viral hepatitis epidemics.⁵⁸ The financial crisis has had significant effects on the governmental allocations in these countries. For example, funds decreased by 50% in 2009–2010 in Latvia, with cuts disproportionately affecting populations at higher risk of HIV and the health budget for prisons,³⁵ and significant cuts were made to the NSP budget in Lithuania.⁸⁷

The cancellation of Round 11 and insufficient donor contributions to the Global Fund have had a major impact in the region. Compared with ten national and one regional

HIV grant proposals originally planned for Round 11 and the second wave of National Strategy Applications (NSAs), only Russia (two NGO grants, including the Russian Harm Reduction Network/ESVERO after a special decision by the Global Fund Board to allow it to apply), Serbia and Tajikistan applied for HIV support from the Transitional Funding Mechanism (TFM) by the 31 March 2012 deadline.³³ As of 2012, six countries are not eligible for Global Fund funding, although NGOs from Bulgaria, Latvia, Lithuania and Russia can apply for support under the NGO scheme.^{ad} Almost all harm reduction services in Azerbaijan, Bulgaria, partly in Bosnia and Herzegovina, Kosovo, Serbia, Azerbaijan and Macedonia are funded by the Global Fund.^{ae} Of significant concern is the situation in Albania, Armenia and Moldova, where harm reduction services are at risk of closure after March 2012 when the Global Fund grant comes to an end. Of the five Eurasian countries that applied for Round 10, Georgia, Kazakhstan, Ukraine and Uzbekistan were successful. Harm reduction through Round 10 funding includes planned OST scale-up in Kazakhstan; HIV prevention for most-at-risk populations, including harm reduction services for PWID in Ukraine; as well as NSP, testing and vaccination for viral hepatitis, and OST for PWID in Uzbekistan.³⁵

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2.3 | Regional Update **Western Europe**



Table 2.3.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Western Europe

Country/territory with reported injecting drug use	People who inject drugs ^a	HIV prevalence among people who inject drugs (%) ^b	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ^c	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ^d	Harm reduction response		
					NSP ^e	OST ^f	DCR ^g
Andorra	nk	nk	nk	nk	✗	✗	✗
Austria	17,500 (12,000–23,000) ^h	0.7–5.3	43.4–65.3	nk	✓ (31)	✓ (B,M,O)	✗
Belgium	5,125 (3,377–7,829) ³	3.4–6 ⁽ⁱ⁾	28.1–80 ⁽ⁱ⁾	0–2.8 ⁽ⁱ⁾	✓ (69)(P)	✓ (B,H,M)	✗
Cyprus	467 (418–539) ³	0–1.3	51.3	1.7	✓ (1)(P)	✓ (1)(B,O)	
Denmark	12,754 (10,066–16,821) ³	2.1 ⁱ	52.5	1.3 ^j 4	✓ (135) ^j	✓ (B,H,M)	✗
Finland	15,650 (12,200–19,700)	0.7 ⁽ⁱ⁾	60.5	nk	✓ (40)	✓ (B,M,O)	✗
France	122,000 ⁱ	5.1–8 ⁽ⁱ⁾ (i)	41.7 ⁽ⁱ⁾	4.8 (3.4–6.2) ^{m 4}	✓ (532)(P)	✓ (19,484)(B,M,O)	✗
Germany	94,250 (78,000–110,500)	3.4 ^j	75 ⁿ	7.2 (6–8.4) ^{o 4}	✓ (250)	✓ (2,786–6,626)(B,H,M)	✓ (27)
Greece	9,439 (8,110–11,060) ³	0.7–0.8	48.7–68.8	2.9–3.6	✓ (6)(P)	✓ (17)(B,M,O)	✗
Iceland	nk	nk	63 ^{p 4}	nk	✗	✓ (B,M)	✗
Ireland	6,289 (4,694–7,884) ¹	5.8 ^{r 4}	74.6 (72.3–76.9) ⁴	0 ^{r 4}	✓ (32)(P)	✓ (332)(B,M,O)	✗
Italy	326,000 ¹	11.5	58.5	5.1 (0.9–9.3) ^{r 4}	✓	✓ (B,M,O)	✗
Luxembourg	1,485 (1,253–1,919) ³	2.4	71.8–90.7 ²	3.9 ²	✓ (8)	✓ (B,M,O)	✓ (1)
Malta	nk	0	36.3		✓ (7)	✓ (≥2) (B,M)	✗
Monaco	nk	nk	nk	nk	✗	✗	✗
Netherlands	2,390 (2,336–2,444) ³	0 ⁽ⁱ⁾	47.6–67.4 ⁽ⁱ⁾	1–13 ⁽ⁱ⁾	✓ (175) ² (P)	✓ (B,H,M)	✓ (40)
Norway	10,238 (8,810–12,480) ³	2.4	69.9	0 ⁽ⁱ⁾	✓ (29) ^r (P)	✓ (B,M)	✓ (1)
Portugal	10,950–21,900 ^{3 s}	4.9–17.2	36.5–83.1	2–3.4	✓ (1,620)(P)	✓ (B,M)	✗
Spain	83,972 ^t	32.3	79.6 (73.3–85.9) ^{v 4}	3.6 (1.8–5.3) ^{v 4}	✓ (2,274)(P)	✓ (497–2,229)(B,H,M)	✓ (7)
Sweden	nk	2 ⁽ⁱ⁾	59.7 ⁽ⁱ⁾	2.3 ⁴	✓ (2)	✓ (B,M)	✗
Switzerland	31,653 (24,907–38,399) ²	1.4 ⁴	78.3 ^{w 4}	4 ⁴	✓ (101)(P)	✓ (B,H,M,O)	✓ (7)
Turkey	nk	0.5	5.3 ⁽ⁱ⁾	5.2 ⁴	✗	✗	✗
United Kingdom	133,112 (126,852–143,278) ^{3 x}	0–4.3 ⁽ⁱ⁾	26.1–61.2	8.9 (0–17.8) ^{y 4}	✓ (1,523)(P)	✓ (B,H,M,O)	✗

nk= not known
⁽ⁱ⁾ = sub-national data

a Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.
b Unless otherwise stated, data are sourced from European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) (2012) Statistical Bulletin 2012: Table INF-1. Prevalence of HIV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, <http://www.emcdda.europa.eu/stats12#display:stats12/inftab1>.
c Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-2. Prevalence of HCV antibody among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, <http://www.emcdda.europa.eu/stats12#display:stats12/inftab2>.
d Unless otherwise stated, data are sourced from EMCDDA (2012) Table INF-3. Prevalence of markers for HBV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2010 or most recent year available, <http://www.emcdda.europa.eu/stats12#display:stats12/inftab3>.
e The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines, pharmacy-based NSP sites and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets, and (NP) = needles and syringes not available for purchase.
f The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine, (BN) = buprenorphine-naloxone combination, (H) = heroin-assisted therapy, (O) = any other form (including morphine and codeine).
g DCR = drug consumption room.
h Year of estimate: 2000
i Year of estimate: 2006
j Year of estimate: 2007.
k Year of estimate: 2003.
l Year of estimate: 1999.
m Year of estimate: 1992–1995.
n Year of estimate 2004.
o Year of estimate: 1992–1994.
p Year of estimate: 1990–1993.
q Year of estimate: 1996.
r Year of estimate: 1990–91 and 1992–93.
s Year of estimate 2005.
t Year of estimate: 1998.
u Year of estimate: 1999–2001, 2003.
v Year of estimate: 1997.
w Year of estimate: 2002.
x Year of estimate: 2004–2010.
y Year of estimate: 1996–2000.

Map 2.3.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)



- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not known
- DCR available

Harm Reduction in Western Europe

Injecting drug use (IDU) remains common in Europe for both opioids and amphetamines, with significant user populations in Italy, France, Spain, the UK and Germany. Approximately 1 million people who inject drugs (PWID) reside in Western European countries.⁶ While low HIV prevalence among PWID in many countries in Western Europe has been linked with the early implementation of harm reduction programmes, the scope and reach of programmes remains uneven. Almost all countries in the region have operational needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST), but some national programmes are too small to have any clear impacts, and many of the larger programmes are under constant threat of closure. European countries continue to feature among those with the highest coverage of harm reduction programmes globally,² but to protect and promote these services moving forward will require concerted cooperation between harm reduction advocates and policymakers, particularly in a time of ever-increasing financial hardship.⁷

NSPs are available in all countries in the region except for Andorra, Monaco, Iceland and Turkey. Geographical coverage, however, varies greatly from country to country, with only one NSP site reported in Cyprus, for example, compared with more than 1,000 in Spain and Portugal.² No considerable expansion in NSPs has been reported in the region since 2010, although one new programme has opened in Helsingborg in Sweden, which is the first such development in over two decades in the country.

Various forms of OST are provided across the region through publicly and privately funded clinics and pharmacy dispensing programmes. These include methadone maintenance treatment (MMT), buprenorphine maintenance treatment (BMT), heroin-assisted therapy (HAT) and other forms of OST including morphine and codeine. Turkey introduced buprenorphine-naloxone combination for substitution therapy in 2010. Even though regional and national OST coverage rates vary substantially, levels of coverage in Western Europe (61% of PWID receiving OST) are high compared with other world regions.² In some countries, however, OST programmes are implemented on a very small scale. Cyprus and Malta operate only one and two OST sites, respectively.

The majority of the countries in Western Europe lead in the provision of harm reduction services in prisons. However, coverage of prison NSPs and OST varies across the region, and there is lack of data for all countries. Extensive prison NSPs are in place in Spain and Luxembourg.⁷

The decrease in new HIV infections within the EU over the last decade has been brought about by a number of factors, including more easily available harm reduction measures and a decline in IDU, as well as better prevention and treatment services. But while NSPs and OST have become widely accepted within the EU, other effective interventions such as drug consumption rooms (DCRs) and HAT remain controversial and rare. There are 85 DCRs in six countries across the region.⁸ Denmark is the first country in the world to have passed legislation to regulate the operation of such facilities via a new law adopted on 1 July 2012.

Western Europe is reported to have the highest regional level of antiretroviral therapy (ART) coverage among PWID in the world, but considerable barriers to universal access remain. Coverage of ART in prisons varies across the region,⁷ while poverty and social exclusion impede access and adherence. In some countries (such as Portugal) it has been reported that doctors have refused to allow people who use drugs (PWUD) to initiate ART.⁷

In those Western European countries that saw the first heroin epidemics, populations of PWID are growing older. Harm reduction services will need to monitor their specific health and social needs, as well as the challenges that an ageing population presents to service providers.⁹

While heroin remains the most popular drug among older users, amphetamine-type stimulants (ATS) are the most popular amongst young people.⁹ ATS users are estimated to make up 28% of those entering treatment in Sweden, 17% in Finland¹⁰ and smaller proportions in Belgium, Denmark, Germany and the Netherlands.¹⁰ Solid data on prevalence of ATS injection, however, are not available.

Indeed, while the monitoring of drug use and related harms in Europe continues to be good, there are significant gaps in knowledge, particularly in relation to young people, migrants, street-involved people and other vulnerable populations. In the case of young people, the focus on home and school surveys inevitably excludes those outside mainstream education and outside the home, and more attention and funding is needed for other forms of data collection. Drug use studies also tend to examine imprecise and problematic criteria such as lifetime or last yearly use, which may obscure specific patterns of use that may be driving drug-related harms. Service and treatment data in many countries, meanwhile, obscure non-service-using populations, contributing to a general paucity of data that diminishes the potential impact of harm reduction.

Funding for drug policies, meanwhile, has been hit hard by European governments' responses to the economic crisis. In its 2011 annual report, the European Monitoring Centre for Drugs and Drug Addiction estimates that from 2008 to 2011 these cuts ranged from 2% to 44%.¹⁰ Meanwhile, the European

² According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage; 100–200 is medium coverage, and >200 is high coverage.

Union (EU) is becoming increasingly fragmented on a political level in its approach to harm reduction. Countries such as the UK that have championed the harm reduction approach in the past are beginning to shift towards more abstinence-oriented policies.¹¹ How this will impact the EU as a whole is, as yet, uncertain, but is likely to become clearer with the drafting of the new EU drugs strategy due for completion at the end of 2012.

Developments in harm reduction implementation

Needle and syringe exchange programmes

With a few exceptions, NSPs are widely available in Western Europe (see Table 2.3.1). Across the region a variety of service delivery models are in place including stand-alone sites, pharmacy-based services, vending machines (in Austria, Denmark, France, Germany, Italy and Spain), outreach and peer outreach services,¹ and mobile NSPs exist in roughly half of the countries in the region.¹ Portugal and France have high proportions of NSP sites with outreach workers (96 and 91, respectively), while with 1,360 sites Portugal is leading the way in pharmacy-based services to supplement fixed NSP outlets.¹

Despite good levels of provision across most of Europe in comparison with other world regions, the reach of interventions remains uneven among and within countries. Only one operational NSP site is reported in Cyprus, three in Sweden and up to 2,274 in Spain and 1,620 in Portugal. The number of NSP sites has doubled in Luxembourg and Belgium, while in Sweden, a third NSP site was established in Helsingborg in 2010, and an additional site is planned to be opened in Kalmar in late 2012. No considerable expansion in other countries was reported since 2010. Furthermore, national NSP coverage estimates often hide dramatic geographical variations. This represents an important gap in accessibility in smaller cities and rural areas in, for example, Spain, Portugal, Ireland, Germany, Finland, Belgium and Austria.¹²

Another measure of service coverage, however, and one that allows for international comparisons of available data, is the number of syringes distributed per PWID per year.¹³ Luxembourg and Norway are the only two countries in the region that distribute 200 or more syringes per person per year, which represents high coverage according to the joint WHO, UNODC and UNAIDS technical target-setting guide.¹³ Coverage remains low in Sweden, Cyprus and Greece, where less than 100 syringes are distributed per person per year.¹⁴

Increased occurrence of non-opioid injecting, such as the use of anabolic steroids, has been documented in some parts of Europe (for example, Belgium and the UK). However, shortage of data on the prevalence of steroid injecting and

its low priority within national drug budgets have prevented the development of targeted strategies to address this user group's needs.¹⁵

Due to service-user anonymity there are no available data on the average age of NSP clients, but data from EMCDDA and WHO Europe indicate that, as a group, the population of PWID across the region is growing older.

Opioid substitution therapy

All countries in the region, with the exception of Andorra and Monaco, provide MMT and BMT (see Table 2.3.1). Additional OST options, including HAT, buprenorphine plus naloxone combination and slow-release morphine, are widely available across the region. Turkey is reported as providing licensed buprenorphine-naloxone combination since 2010.¹⁶ However, the number of clients currently enrolled in the programme is not known. In several countries, data on OST coverage at the national level are unavailable due to variation in the types of service provision sites, as well as a lack of strong national monitoring systems.

Fifteen EU Member States^{aa} provide 95% of the total OST in Europe, and the number of OST sites in these countries continues to increase.¹⁷ More than half – 700,000 – of Europe's population of people who use opioids are enrolled in OST.^{ab} This demonstrates a strong coverage exceeding the UN's recommended target figure of 40% as sufficient to address the spread of HIV among PWID.¹⁸ However, within Europe this coverage is far from even, with some countries such as Germany and Italy exceeding this average, and others such as Cyprus far below it at 5%.^{19,20} France has 19,484 OST sites, the highest number of any country in the region where data are available.²

In many countries OST provision includes access through general practitioners (GPs), although levels of regulation governing OST prescription by GPs vary considerably. For example, in Norway GPs can prescribe MMT and BMT to patients already enrolled in OST at a specialised centre, but they are not legally allowed to assess a patient's need for treatment. In France, experts estimate that two-thirds of GPs who are licensed to prescribe MMT and BMT are reluctant to do so, thus limiting accessibility for individuals living outside large cities.²¹

As with NSP clients, significant changes have been noted in the age profile of OST clients in Europe. In Greece 61% are aged 40 or over, while in the Netherlands the figure is around 75%, with the 40–49 age group making up almost half of all OST clients.²² This trend has also been noted, albeit to a lesser extent, in other countries where data are available.

aa Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, UK.

ab Based on estimates derived from EMCDDA regional divisions, which may be different than those of HRI in this report. For more information, please see www.emcdda.europa.eu.

Heroin-assisted treatment in Europe

Heroin-assisted treatment (HAT) has increasingly emerged as an effective second-line treatment among individuals for whom OST and other drug treatment modalities have produced limited benefit.^{18, 23} As of 2012, seven countries implemented supervised injectable heroin (diacetylmorphine) as maintenance treatment: Denmark, Germany, the Netherlands, Spain, Switzerland, the UK and Luxembourg (pilot programme). In 2011, Belgium's pilot HAT project was expanded to deliver treatment nationally.²⁴ According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), overall there were approximately 1,000 HAT patients in EU Member States and a further 1,400 in Switzerland as of April 2012.¹⁸

*For more information, see EMCDDA (2012) *EMCDDA Insights: New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*. Lisbon: EMCDDA.

Antiretroviral therapy

While Western Europe as a whole has the highest level of coverage across the globe, there is significant variation between countries.²

In Luxembourg, for example, the country with the greatest percentage of PWID living with HIV on treatment, 70% of PWID were enrolled on ART in 2010, while in Portugal only 10% of PWID living with HIV were on treatment.²

With early diagnosis of HIV, many more PWID are likely to obtain the maximum benefit from ART. For instance, a decrease in AIDS diagnoses in Austria, the Netherlands and Finland has been attributed to early diagnosis and initiation of ART.²⁵ High incidence rates of AIDS in some countries may indicate that PWID living with HIV are not accessing ART in the early stages following an HIV diagnosis.² Austria has one of the highest rates of HIV tests per capita in Europe, but it is unclear whether PWID are accessing the service in numbers comparable with other groups at higher risk of HIV.²⁵

Across the region there remain significant barriers to PWID accessing and adhering to ART, including homelessness, lack of insurance, lack of support and stigma from health professionals.²⁶ Moreover, national data on ART coverage for PWID are not universally available within Western Europe, limiting a full understanding of availability, coverage and adherence.

Responding to an HIV outbreak among people who inject drugs in Greece

In 2011 Greece reported an outbreak of new HIV infections among people who inject drugs.²⁷⁻²⁹ By the end of July 2011, 113 cases had been reported by the national surveillance system, compared with between three and 19 reported cases per year from 2001 to 2010. A rapid situation analysis by the EMCDDA found that several factors may have contributed to the increased risk of acquiring HIV, including the absence of comprehensive harm reduction programmes for HIV prevention among PWID, as well as targeting of injectors by the police, which has previously been shown in other settings to hinder service uptake and encourage increased risk-taking behaviour such as needle and syringe sharing. The rapid assessment also revealed that Greece has relatively few low-threshold programmes for PWID (OST waiting lists range from five to seven years), and coverage of NSPs and OST is low.³⁰

The response from public health authorities and civil society in Greece has included a major restructuring of the OST programme, including the immediate provision of 28 new OST units, a switch from high to low dead space syringes, and an awareness campaign targeted at injectors in Athens, where incident cases are concentrated.³¹

Drug consumption rooms

The provision of DCRs varies across the region, with nationwide coverage in Switzerland and the Netherlands, regional coverage in Germany and Spain, and DCRs in the capital cities only in Norway and Luxembourg. In total there are 85 DCRs across 56 cities in these six countries, the majority of them integrated into more general health and social service provision networks.³² With a widespread switch from injecting to sniffing drugs across the region there has been an increase in DCR booths dedicated to this purpose, including a pilot study in Luxembourg in 2012.³³

New legislation governing DCRs was introduced in Denmark in July 2012, making it the first country in the world to have legally regulated DCRs. This followed political discussion generated by a mobile DCR operated by an NGO without police interference in Copenhagen since 2011.³²

Despite the progress that has been made in the implementation of DCRs in Europe, most countries still do not allow their operation. Moreover, a number of barriers to access remain in relation to those DCRs that do exist such

as exclusion criteria that deny access to clients who receive OST (Luxembourg and Germany) and exclude non-nationals (Switzerland), as well as restricted opening hours, age restrictions for under 18s and regulations around the type of substance that can be consumed on the premises.⁷

Viral hepatitis

In contrast to low HIV prevalence among PWID in many countries in Western Europe, rates of viral hepatitis (HBV and HCV), and HCV in particular, remain disproportionately high among PWID. According to a recent systematic review on the epidemiology of viral hepatitis among PWID, there are an estimated 727,500 PWID with HCV and 480,000 PWID with HBV across the region.⁴

Prevalence of HCV varies widely across the region, from a high of 71.8–90.7% in Luxembourg, a significant public health issue, to a low of 5.3% in Turkey³⁴ (see Table 2.3.1). Rates of HCV among PWID in Cyprus have increased significantly between 2004 and 2010, with a steep rise from 9.1% to 51.3%,³⁴ based in part on widespread equipment sharing as well as a general shortage of services.³⁵ HCV rates are particularly high among new injectors, and there are reported rises in prevalence among these populations in Greece and Portugal.³⁴ Reported prevalence can also vary significantly within countries, based on sampling biases and regional variations.³⁴

Barriers to HCV testing and treatment include lack of data, lack of awareness among medical professionals of the risks of co-infection with HIV, and restrictive costs, which are often not covered by health insurance or unavailable to the uninsured. In Spain and Finland PWUD are excluded from HCV treatments.⁷

HBV rates among PWID are similarly varied across the region, although general levels of prevalence are low. The highest is in the UK with 8.9%, while Ireland and Norway report 0%.⁴ HBV vaccination programmes targeting specific high-risk groups, including PWID, operate in most countries in Western Europe, with the exception of Malta and the Flemish part of Belgium.³⁷ In Portugal, the requirement to pay for HBV vaccination is reported to prevent many PWID from accessing this service.³⁸

Tuberculosis

Data on tuberculosis (TB) prevalence among PWID in Western Europe are scarce. Estimated incidence of TB in the general population vary, but are less than 24 per 100,000 population in almost all countries for which data are available.³⁹ The only exceptions are Spain and Portugal, where TB rates exceed those in other Western Europe countries at 25 and 49 per 100,000 population, respectively.³⁹ According to the EMCDDA, high rates of TB were reported among PWID in treatment in Greece, while systematic testing in drug treatment facilities in Austria and Norway did not identify any cases.⁴⁰ An increase in the number of cases of TB among migrants who use drugs has

been reported in Ireland, Sweden and Switzerland, but data are not available for this population. In Portugal, distrust of the public health care system and fear of discrimination from health professionals are reported to pose barriers to TB testing and treatment.³⁸

Models for delivering integrated HIV, viral hepatitis and TB services are not well documented across Europe. Recently, the WHO Regional Office for Europe prioritised investigating strategies for the effective delivery of integrated HIV-TB interventions.⁴¹ A WHO-supported assessment of existing strategies in Porto, Portugal, documented two models^{ac} and emphasised the importance of a client-centred approach that combines collaboration among existing services, outreach programmes and uninterrupted provision of OST and other drug treatment while providing TB-HIV care.⁴²

Harm reduction in prisons

Data from the EMCDDA on HIV and viral hepatitis infection among PWID in prisons across the region are only available for four countries: Spain, Malta, Finland and Sweden.⁴³ HIV prevalence among prisoners who inject drugs ranges from 0.2% in Finland to a high of 39.7% in Spain.⁴³ The highest reported HCV levels among PWID in prisons are in Luxembourg, where 90.7% of PWID are HCV-positive.⁴⁴

Although data on TB among prisoners who inject drugs are scarce, studies show that the risk of TB in prisons is on average 23 times higher than in the general population.⁴⁵

Relative to other world regions, countries in Western Europe lead in the provision of harm reduction services in prisons. Prison NSPs are available in Spain, Luxembourg, Switzerland and Germany, and very limited NSP pilot programmes exist in Scotland. Only one prison, however, offers the service in Germany, and in Switzerland provision of NSP in prisons depends on the decision of each canton.⁴⁶ The only pilot NSP that was available in Portuguese prisons was terminated in 2007 due to logistical challenges and resistance from prison guards.¹

OST is available in prison settings to varying degrees in most countries in the region, with the exception of Greece. In Sweden, OST in prison started as a pilot project in 2007 and was continued as a national programme in 2010, but coverage remains poor.⁴⁷ Switzerland is the only country in the region which provides HAT in prisons, with two facilities presently offering this service.⁴⁸ In Finland, Sweden and Malta OST cannot be initiated in prison, but PWID may continue treatment if they were already accessing OST in community settings at the time of their arrest.^{49, 50}

ac The two strategies included a 'combined model' where all services are provided within a central location by a multi-disciplinary team, and a 'collaborative' model, characterised as client-centred and informal, which involves collaboration of service providers and outreach teams to deliver treatment in a location convenient to the client.

Overdose

Opioid overdoses are a major cause of mortality among PWID, accounting for between 10% and 23% of drug-related deaths in the 15–49 age group.⁵¹ The most likely periods for PWID to overdose are after release from prison or if OST is interrupted. A study of 382 PWID taking part in a prison-based OST programme documented no deaths during OST but 13 deaths when OST was interrupted – eight of them overdose-related.⁵²

Across the region, overdose prevention responses are implemented to varying degrees but include the provision of overdose information material to PWUD, individual overdose risk assessment and overdose response training. Naloxone is a registered medication in all Western European countries, but its availability varies across the region and within countries. In Scotland, for example, nurses and pharmacists can prescribe and dispense the Scottish Naloxone Programme's kits, while elsewhere in the UK the medication is only currently available through limited-scale pilot programmes, with scale-up anticipated soon.⁵³ In a new review released in May 2012 the UK Advisory Council on the Misuse of Drugs (ACMD) recommended that the government take concrete steps to make naloxone more widely available^{ad} including by easing restrictions on who can be supplied with naloxone and investigating how peers can be trained to administer it in emergencies. In 2011 Scotland promoted the availability of naloxone to approved services without prescription for use in emergencies.⁵⁴

Naloxone is only available on a takeaway basis in Italy, Germany, Spain, Scotland and Norway.⁵⁵ In Denmark a small-scale trial of peer distribution of naloxone operates in the country's capital, with a limited number of social workers prescribed the medication, and further expansion of the programme is still pending.⁵⁶

Policy developments for harm reduction

At a national level all countries in the region, with the exception of Italy and Sweden, explicitly support harm reduction in their national drug policy strategies. Implementation of harm reduction services in many countries, however, is carried out by local governments. In Sweden, for example, the provision of NSPs is reliant on local political approval, which has hindered the scale-up of new programmes, including in the country's two largest cities.⁵⁷

Despite long-standing support for harm reduction within the region, however, since 2010 there have been incidences of

policy shifts away from harm reduction from countries that have traditionally been strong advocates for the approach. For example, the UK has one of the lowest levels of HIV among PWID in Europe, which is often attributed to the early introduction of harm reduction programmes in the country.⁵⁸ But support for harm reduction in the UK has been undermined in the past two years due to leadership changes, although tensions remain between ministries. In March 2012 the UK government published a new roadmap document entitled *Putting Full Recovery First*, which strongly prioritised an abstinence-based approach. In response to the roadmap, civil society organisations (CSOs) such as the Terrence Higgins Trust, the National AIDS Trust and Release have addressed an open letter to the UK government, warning that ministers will be putting lives at risk and reversing decades of success in HIV prevention if harm reduction is undermined.⁵⁹

At the regional level, policy developments currently centre around the drafting of the new EU drugs strategy. The current strategy will come to an end in 2012, and the new drug policy framework will be the first adopted under the Lisbon Treaty. At the time of writing, the new strategy is being drafted, but it has been a relatively closed process. CSOs were not invited to provide input, and it is, therefore, not possible to comment on its content. Moreover, although harm reduction objectives are strongly present in the demand reduction area of current EU drug policy documents, the recent rollback of EU funding opportunities for harm reduction may become an obstacle for its sustainability in Europe.

The EU, as a bloc, has traditionally been a strong voice for harm reduction at the international level. But recently the EU has become increasingly fragmented. This shift can be attributed in part to ongoing advocacy from countries that are anti-harm reduction (in particular Sweden and Italy) and in part to harm reduction being viewed as less important for diplomacy for countries that had previously adopted strong leadership roles at the international level.^{ae}

^{ad} Although naloxone has been available under UK law since 2005, it remains a prescription-only drug and is only licensed for use in injectable form. As such, non-medical services and people who use drugs, their families and peers, who may be more frequently present during the occurrence of opiate-related overdoses, are not able to legally hold stocks of naloxone and administer it in emergencies.

^{ae} See section 1 'Policy Development' for further information on the EU at an international level.

Civil society and advocacy developments for harm reduction

CSOs and organisations of PWUD continue to play a central role in harm reduction advocacy and responses in the region. National harm reduction networks are active in many countries including Germany, the UK, Ireland, France and Portugal. Italian harm reduction organisations are currently in the process of forming a national network, planned to be launched in late 2012. At the time of writing, CSOs in Portugal were mobilising a national civil society forum on harm reduction to respond to significant funding cuts for harm reduction services.⁶⁰

Many CSOs are involved at the European level and internationally through participation in several networks such as the Eurasian Harm Reduction Network, EuroHRN, Correlation, the International Drug Policy Consortium and others. Regular Europe-wide events bring CSOs together to share the latest experiences on harm reduction and drug policy. Over the past two years, these have included the first European meeting on harm reduction in Marseille,⁶¹ the EU Civil Society Forum on Drugs,⁶² the EU Civil Society Forum on HIV⁶³ and the final conference of the Correlation Network in Ljubljana, Slovenia.⁶⁴

In April 2010 the European Harm Reduction Network, a project funded by the European Commission (EC), was launched with the aim of advocating for and sharing knowledge on harm reduction within Europe. The project culminated in a meeting of network members at a pan-European conference in October 2011 in Marseille, France during which the European Network of People who Use Drugs (EuroNPUD) was formed. The second phase of the project will focus on overdose prevention and advocacy, recommendations on the set-up, development, study and impact of DCRs in Europe as well as supporting harm reduction stakeholders in Europe in sharing best practices.

The Correlation Network, established in 2005 and also funded by the EC, has undertaken two phases of development. Correlation I (2005–2008) identified gaps and inequalities in access to health and social services, with a focus on marginalised groups. It looked specifically at health issues such as HCV and HIV/AIDS within most-at-risk populations, particularly drug users and young people at risk. Correlation II (2009–2012) built on this experience, focusing on the improvement of prevention, care and treatment services and targeting blood-borne viruses, in particular HCV and HIV/AIDS, among vulnerable and high-risk populations. Correlation has recently undergone an organisational restructure and has become a more sustainable network.⁶⁵

Documenting organisations of people who use drugs in Europe^{af}

In 2011, as a part of the European Harm Reduction Network (EuroHRN) project, the first comprehensive survey of organisations of people who use drugs in the European Union was carried out. The aim of the survey was to map the current state of drug user organising across Europe to inform recommendations for initiating such organisations in those countries where they are currently lacking, and to strengthen them where they are weak. The methodology used to acquire this data included the creation of a Directory of Organisations of People who Use Drugs in Europe. The second component was a detailed report of the state of drug user organising in Europe.

Results of the survey show that more than half of drug user organisations are based in Northern Europe (18 entries out of 30), and six countries from both Northern and Southern Europe are totally unrepresented. All groups surveyed are people who use/inject heroin, and the vast majority of them define themselves as activists and lobby groups who primarily represent active drug users. Many of the groups that took part in the survey came together at the first European meeting on harm reduction in Marseille and founded the European Network of People who Use Drugs.

Multilaterals and donors: developments for harm reduction

Although support for harm reduction from multilateral agencies is not targeted towards the high-income countries of this region, the EC has been an important donor for regional projects relating to injecting drug use and HIV. It has funded a range of new projects in recent years including the Access to Opioid Medication in Europe (ATOME) project which was launched in 2009 and will conclude in 2013. The overall goal of ATOME is to develop tailor-made recommendations for improving the accessibility, availability and affordability of controlled opioid medications, including OST medications. To date, the project has identified legal and regulatory barriers in the area of prescribing and dispensing opioid medication, including OST, in Cyprus, Greece and Turkey, with further country reports containing recommendations for legislative changes on their way. The EC has also funded a new project as part of its Lifelong Learning Programme (Leonardo) which will look to develop training guidelines and a professional profile for harm reduction outreach workers entitled 'Prowfile'.

^{af} The directory of organisations of people who use drugs in Europe is available online at www.eurohrn.eu.

Despite a successful record of funding harm reduction since the early 1990s, however, the EC's Health for Growth Programme 2014–2020 call for proposals does not address the issue of drugs and harm reduction.⁶⁶ Furthermore, in its Justice Programme call for proposals, the EC indicates that in future funding it will address drug demand and supply through the angle of crime prevention and anti-drug trafficking only.⁶⁶ Finally, the Drug Prevention and Information Programme will become redundant after 2013, with no plans to replace it with alternate funding opportunities for drug demand reduction at the regional European level.⁶⁶ In response to these changes, the EU Civil Society Forum on Drugs^{ag} appealed to the EC in January 2012 and urged for continuation of an effective civil society response to HIV/AIDS and drugs.

The WHO Regional Office for Europe, in collaboration with the European Centre for Disease Prevention and Control (ECDC), continues to collect data and monitor HIV epidemics across the region. In September 2011, 53 countries in the WHO European Region agreed on a new European Action Plan for HIV/AIDS 2012–2015.⁶⁷ Targets in the new action plan reflect those agreed by UN Member States at the 2011 High Level Meeting on HIV/AIDS and include reducing the number of new infections acquired through IDU by 50% by 2015. The EU drugs agency, the EMCDDA, launched its 2012 work programme⁶⁸ and is in the process of developing strategies for treatment monitoring and a new strategy for monitoring and reporting on drug-related issues in prisons across the European region.

Several European governments provide essential funds for harm reduction in low- and middle-income countries. These include the UK Department for International Development, the Netherlands MOFA, NORAD (Norway), GTZ (Germany) and the Swedish SIDA, but in this sector, too, budgets are becoming tighter.

The recent period of economic crisis has had a considerable impact on harm reduction financing at national level across the European region. In the UK, a recent survey of 540 UK drug service users and providers found that 75% have already witnessed cuts in funding for services.⁶⁹ Other countries such as Belgium, Ireland, Germany and Denmark report that funding harm reduction programmes is becoming increasingly difficult due to recent financial cuts by governments.⁷⁰ In Portugal, where harm reduction programmes were under threat of partial closure, funding from the government is regularly late, harm reduction programme workers do not receive their salaries on time, and financial resources to keep clients in programmes are more and more scarce.⁷¹ In addition, to reduce costs, the Portuguese government plans to abolish the national institute for monitoring the drug situation (IDT).⁷¹

The financial crisis is likely to lead to greater scrutiny of drug service funding, and it will be increasingly important to highlight the financial and social implications of HIV outbreaks and other likely implications of cuts to services. This is also an opportunity to advocate for the most efficient and effective drug services.

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ag The Civil Society Forum on Drugs (CSF) meets at least once a year and serves as a platform for informal exchanges of views and information between the European Commission and EU civil society organisations.