Introduction

Despite evidence of important differences in drug use experiences and access to harm reduction services for women and men, gender-sensitive interventions have not yet been fully integrated into these services around the world. However, research and experience suggest that the provision of enhanced harm reduction services for women can increase uptake and improve the outcomes of these interventions.

This chapter provides an overview of the risks and harms experienced by women who inject drugs, and of women's access to harm reduction and related health services.[a] Drawing on programmes from around the world, the chapter proposes a 'menu' of gender-sensitive services for women who inject drugs.[b] These services aim to provide more accessible, comprehensive and effective care for women by addressing their needs in an holistic way and respecting their human rights and freedom of choice. The chapter concludes with recommendations for policies that support gender-sensitive harm reduction.

Risks and harms experienced by women who inject drugs

Due to a mix of social and biological factors, women and men have different experiences of injecting drug use (IDU) and its accompanying risks and harms.[1-2] A recent systematic review of international research on the risks, experiences and needs of women who inject drugs found the following major themes:

» Compared to their male counterparts, women who inject drugs experience significantly higher mortality rates; an increased likelihood of injecting-related problems; faster progression from first drug use to dependence; higher rates of HIV; and higher levels of risky injecting and/or sexual risk behaviours.[1]

» For women who inject drugs, there is greater overlap between sexual and injecting social networks than there is for men who inject drugs. This may increase women's risk of acquiring HIV through sexual transmission as well as through unsafe injecting. Women who inject drugs are more likely than their male counterparts to have a sexual partner who injects drugs, and to be dependent on them for help acquiring drugs and injecting. Relationship dynamics can make it difficult for women to access harm reduction services, enter and complete drug treatment (if desired) or practise safer drug use and safer sex.[1]

» Intimate partner violence (IPV) is more commonly reported among women who inject drugs than among women in the general population.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug injecting, and can contribute to continued drug use.

» There is significant overlap between women's engagement in IDU and in sex work, especially street-level sex work. Participation in sex work has been associated with syringe sharing and inconsistent condom use, as well as other risks posed by the dangerous circumstances in which sex work often takes place.[1]

» There are a number of differences between men's and women's motivations to enter and complete opioid substitution therapy (OST) and other drug treatment modalities, and in the personal dynamics that play a part in treatment success. Many women cite pregnancy as a central reason for entering treatment, although punitive policies that separate women who use drugs from their children can deter pregnant women and mothers from entering drug treatment. A partner's entry into treatment is another key factor that can facilitate treatment entry for women. OST and certain other types of drug treatment have been found to be especially effective in helping women to reduce their drug use, while detoxification alone is significantly less successful for women who inject drugs than for men.[1]

A systematic review of studies from 14 countries found a significantly higher prevalence of HIV among women who inject drugs than among their male counterparts in settings with high HIV prevalence.[3] Studies in nine EU countries found that the average HIV prevalence was more than 50% higher among women who injected drugs than among their male counterparts.[4]

Access to services

The intense social stigma attached to women's IDU and HIV infection can pose a formidable barrier to their access to harm reduction services, drug treatment, HIV treatment, sexual and reproductive health care, and other medical services, especially in culturally conservative societies.[5-6] As a minority of people who inject drugs (PWID), women are not always included in medical or social programmes for drug users. For example, anti-retroviral treatment (ART) and OST are sometimes available in men's penal institutions, but not in women's.[5,7,8] Many programmes for drug users do not respond to the specific needs of women.

a The scope of this article is limited to women who inject drugs, rather than all women who use drugs. It should be noted that there is also a significant amount of research on women who use drugs without injecting. For a discussion of the general literature on women who use drugs and the implications for future HIV prevention efforts, see El Bassel N, Wechsberg W and Shaw S (2012) Dual HIV risk and vulnerabilities among women who use or inject drugs: no single prevention strategy is the answer, *Current Opinion on HIV/AIDS* (7):326–331.

b For reasons of space, the scope of this article does not address the specific needs of transgender people who use drugs.

Limited data on injecting drug use among women

Women have been estimated to represent roughly 40% of people who *use* drugs in the USA and some parts of Europe, and 20% in Eastern Europe, Central Asia and Latin America.[9, 10] However, data on women as a percentage of people who *inject* drugs are sparse, due in part to the difficulties of estimating the size of a hidden population engaged in an illicit activity. There has been no systematic analysis of the prevalence of IDU among women internationally. While data on the prevalence of IDU and HIV among PWID are available for more than 148 countries, for the most part these data are not disaggregated by gender. In the global data holdings on IDU and HIV maintained by the Reference Group to the UN on HIV and Injecting Drug Use, none of the countries that report IDU have data disaggregated by gender. This failure to collect gender-disaggregated country-level data on IDU makes it difficult to evaluate the precise scope and nature of needs among women who inject drugs, and should be remedied.

Similarly, the Reference Group's global data holdings show that countries that provide HIV prevention, treatment, care and support services for PWID generally fail to report on the number of women served by OST, ART and needle and syringe programmes (NSPs). This lack of data is disquieting, as it makes it difficult to assess whether at a country level there are gendered disparities in access to these essential services, or the degree to which available services are responsive to women's needs. This may have a negative impact on efforts to improve harm reduction service coverage and, consequently, on efforts to curtail the HIV epidemic within this population.

Despite these significant data gaps, evidence suggests that there is indeed a substantial population of women who inject drugs worldwide. In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that, while precise data on women as a proportion of out-of-treatment PWID were not available, women comprised 22% of new patients for OST and 33% of new patients for amphetamine dependence treatment.[11] This suggests that women are a sizable minority of PWID in the region as a whole. Estimates of the gender balance among PWID in various countries (see Table 3.1.1) show that women are a very sizable minority of PWID in Russia, home to at least 1.8 million PWID, of whom more than 37% are living with HIV;[12] China, where 6.4% of the country's 2.35 million PWID are living with HIV;[12] and Ukraine, which has the highest HIV prevalence in Europe and an epidemic largely concentrated among PWID.[13] This points to the importance of addressing the needs of the large populations of women who inject drugs in these areas. The wide variation among and within countries also points to the importance of geographical difference, and the need for services that are adjusted accordingly.

Table 3.1.1: Women as percentage of all people who inject drugs in selected countries

Country/territory	Women as an estimated (%) of all PWID[14]
Cambodia	10
Canada	33[15]
China	20
Estonia	9[11c]
Georgia	10
Indonesia	11
Kenya	11
Kyrgyzstan	10
Malaysia	10
Russian Federation	30
South Africa	27
Ukraine	26
Vietnam	18

Sexual and reproductive health and pregnancy

While harm reduction programmes usually include condom distribution, information on sexual health and sexually transmitted infections (STI) testing and sometimes treatment, many do not address other aspects of sexual and reproductive health, even though many women who inject drugs experience unplanned pregnancies.[5, 6, 8, 16] Some women do not realise they are pregnant until relatively late, making it more difficult for them to access appropriate prenatal care, harm reduction services, drug treatment (if desired) or other support, or to terminate their pregnancies safely if they so choose.[6, 8, 17]

Faced with pressure to have abortions and high levels of stigma, women who inject drugs sometimes have reduced access to prenatal care.[5, 6, 8] This can lead to reduced levels of prevention of mother-to-child transmission (PMTCT) services among women living with HIV who inject drugs, among other negative effects. A 10-year study in Western and Central Europe of ART during pregnancy found that a history of IDU was associated with the risk of not receiving ART, and with being diagnosed with HIV late in pregnancy.[18]

The comprehensive package for the prevention, treatment and care of HIV among people who use drugs, produced by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), does not include contraceptive methods other than condoms; pregnancy tests; pre- and post-natal care; or links between harm reduction, drug treatment and prevention of vertical transmission of HIV.[19] Adding these services to the comprehensive package

c Based on estimated 10:1 ratio of male to female drug users, based on IDU estimates from HIV reference laboratory, police arrests, overdoses and drug treatment.

could help women who inject drugs to better manage their sexual and reproductive health, thus preventing unplanned pregnancies and improving pregnancy outcomes, including through improved access to prevention of vertical transmission of HIV.

Pregnant women who inject drugs may wish to begin OST or other forms of drug treatment, and prompt, easy access to these services is essential in improving outcomes for these women and their children. While there has been some scale-up of OST worldwide, information and protocols on OST provision during pregnancy and post-partum (including during stays in maternity hospitals) are not always in place.[5, 6, 8, 20] This risks treatment interruptions and makes it difficult for women to access the 'treatment of choice' during pregnancy.[9] Long waits to enter OST and other drug treatment programmes in some countries, and the complete lack of OST in others (notably Russia), threaten the health of all PWID, but are especially troubling in the case of pregnant women.[9]

Sexual and intimate partner violence

Problematic drug use among women is often associated with a history of sexual abuse,[6, 9] and women who inject drugs experience elevated rates of IPV.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug use, and contributes to continued drug use. A history of violence can make women feel uncomfortable in certain situations – for example, in a support group where the majority of participants are men, or when receiving pelvic examinations.[23] Where a history of trauma contributes to problem drug use or risky behaviours, it is important that harm reduction and drug treatment programmes take this into account and that staff are aware of how to deal appropriately with these issues.[9]

Women, injecting drug use and prisons

Just as women's experience of drug use often differs from that of men, women occupy a different stratum of the drug economy. A meta-synthesis of qualitative literature found that the drug economy is gender-stratified and hierarchical, with women mainly confined to the lower levels.[24] Low-level dealers and drug 'mules' are easier to arrest than higher-level traffickers. In addition, they often have fewer resources for legal defence. This, combined with the low thresholds for criminal responsibility for drug possession in many countries, means that low-level players (many of them women) receive long prison sentences.

An increasing number of women are being incarcerated for drug-related offences worldwide.[25-30] A recent study found that more than one in four female prisoners in Europe and Central Asia had been convicted of a drug offence, and that the number of women incarcerated for drug-related offences in Russia is more than double the total number of female prisoners in all EU countries combined.[31] In Tajikistan, up to 70% of all female prisoners have been incarcerated for drug-

Comprehensive care for women and their children

Vancouver, Canada

Recognising that women's social and economic environment has the greatest impact on maternal and foetal health, Sheway brings together representatives from the government and the community to provide comprehensive, non-judgemental health and social services to pregnant and parenting women with current or past issues with substance use. Sheway provides education, referrals and support to help women access prenatal care and reduce risk behaviours – in particular, reducing or ceasing the use of alcohol and other drugs during pregnancy. It also supports the health, nutrition and development of participants' children for up to 18 months after their birth. The programme is absolutely voluntary, and based on the choices women make for themselves.

Sheway's services include:

- Outreach and drop-in services
- Hot lunch, food bags and coupons, formula, clothing, infant items
- Accompaniment to appointments, transportation assistance (taxi vouchers, bus tickets)
- Assistance with securing housing, day care, emergency funds
- 12 transitional housing units
- Pre- and post-natal health care
- Advocacy and counselling
- Needle and syringe exchange (NSP)
- Methadone maintenance therapy (MMT)

Sheway works in partnership with the combined care unit at the Fir Square British Columbia Women's Hospital, which provides flexible, non-judgemental services for pregnant women with a history of drug use. It offers continuous care for mother and child before, during and after birth, including help stabilising and withdrawing from substances if necessary. The multidisciplinary team includes physicians, a senior practice leader, nurses, a social worker, an addictions counsellor, a nutritionist and a life skills/parenting counsellor. Fir Square aims to improve perinatal outcomes, increase the percentage of mothers able to safely retain custody of their babies, increase the number of women seeking drug treatment and their readiness to enter treatment, and increase access to medical services for substance-using women.[21, 22]

related crimes.[31] The dual criminalisation of sex work and drug possession puts sex workers who use drugs at exceptionally high risk of police harassment, extortion and arrest.[26]

In multiple settings, rates of IDU and problematic drug use[d] have been found to be higher among incarcerated women than among their male counterparts.[32, 33] In some settings, HIV prevalence among women prisoners is higher than among men.[34] However, health programmes for male prisoners sometimes do not extend to women's facilities. Because of financial constraints and logistical or bureaucratic obstacles, programmes sometimes prioritise male prisoners, operating only in men's prisons and leaving women without essential care.[5, 7, 8] For example, a 2008 survey of women's access to OST in prisons found that in Georgia, methadone was available in some men's prisons but not in women's prisons.[8] In Kyrgyzstan, though methadone programmes were planned for women's prisons, funding cuts have meant that they are still unavailable, and as a result OST is available only in men's prisons.[5]

Increased advocacy is urgently needed to ensure that all prisoners, regardless of gender, have access to necessary interventions (including NSP, OST, and ART) while incarcerated, including during pre-trial detention, and that no interruptions of ART and OST occur in these settings.[27]

Other needs of incarcerated women who inject drugs include general medical care, mental health care and vocational preparation.[35] Decriminalisation of personal possession of drugs would substantially reduce the number of women who are incarcerated unnecessarily, thus eliminating harms associated with incarceration for women as well as for their children and other family members.

Designing harm reduction services for women who inject drugs

To date, there has been limited research on the efficacy of interventions specific to women who inject drugs. This is partly because gender-sensitive services often mix multiple approaches, are tailored to the individual and are relatively long-term. Services that combine structural, biomedical and behavioural interventions can be more difficult to evaluate through randomised controlled trials (RCTs) measuring HIV incidence, the current 'gold standard' of research on the efficacy of HIV prevention interventions, especially given large data gaps on the epidemiology of drug use and HIV among women. Limited research funding poses another obstacle. Finally, even simpler services, such as NSP, need to achieve considerable coverage before they can have a substantial impact on HIV incidence or prevalence.[36] In some cases, lack

Reaching out to women who inject drugs

St. Petersburg, Russia

Humanitarian Action provides preventive health services to PWID in St. Petersburg. Of 5,000 annual clients, about 2,000 are women, 51% of whom are living with HIV and 30% are supporting their drug use through sex work. (In 2011, there were an estimated 15,000 women who inject drugs in the city.) Russia's extremely punitive drug policies drive drug users underground, incarcerate them en masse, and pose major obstacles to harm reduction services. OST has never been legal in Russia, and NSP faces mounting opposition. Most donors no longer fund NSP in Russia, compromising the crucial first point of contact between drug users and medical services.

In 2008 Humanitarian Action developed a project promoting equal access to prevention, treatment, care and support for women who inject drugs. Mobile street outreach in a special bus provides safer injection and safer sex supplies, including sanitary napkins and women-specific information materials; consultations with doctors, psychologists and social workers; express HIV and pregnancy tests; STI tests; and referrals.

Legal aid helps respond to the frequent loss of parental rights, physical and sexual violence and discrimination in medical settings experienced by clients. Project staff members accompany women to appointments and help them navigate medical and social services. A network of trusted doctors provides women with low-threshold care in a non-judgemental atmosphere. In the past five years, 11,346 women have received services from the project, with in-depth case management for 372 women.

There are no rehabilitation centres in St. Petersburg for women with children, and the city's shelters do not accept women living with HIV or those who actively inject drugs. Because this group of women often faces unstable housing and domestic violence, Humanitarian Action opened a 'Crisis Apartment' where women can live for up to three months. Pregnant women and mothers of small children have priority, since they are most vulnerable and have the most difficulty finding work. Women receive structured assistance with medical, legal, bureaucratic and family problems and in seeking employment and permanent housing.[e]

d The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines 'problem' drug use as "injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines." Definitions of 'problem', 'hard' or 'heavy' drug use can vary, but generally fit this basic description.

e Case study information provided by Anna Ivanova, Programme Coordinator, Humanitarian Action.

of evidence of impact may reflect external limitations, such as a cap on the number of syringes provided daily, rather than a problem with the intervention design.[37]

These limitations have led some experts to push for new methodologies to assess the impact of health promotion programmes, arguing that a lack of data on HIV incidence should not deter programmes that have positive results in practice and could be essential to reducing HIV risk and other harms.[38] Alternative measures of effectiveness could include baseline-to-follow-up reductions in reported risk behaviours and incarceration rates; improvement in health status, family relations, housing, self-efficacy and well-being as reported by clients; and increased uptake of medical and social services. Such indicators are easier to measure, though they cannot be used as proxies for reduced HIV transmission. Community randomised trials that compare a basic intervention to an enhanced intervention pose fewer ethical problems than standard RCTs, and help reduce the biases of observational studies by randomising by group.[37] Some of these methods and indicators were used in evaluating the programmes described below.

To date, HIV risk-reduction interventions among women who inject drugs have been more successful in reducing drug-related risks than unsafe sexual behaviours, likely because of structural factors that shape sexual relationships and limit condom use among vulnerable women.[39-41] This points to a need for interventions that address these broader, structural factors, increasing self-efficacy and autonomy as well as awareness of the importance of safer sex.

The following interventions[f] have documented success among women who inject drugs:[g]

» A woman-focused intervention in an inpatient detoxification programme in St. Petersburg, Russia, found that in comparison with the control group (which received nutritional counselling), women receiving the HIV-focused intervention reported a lower frequency of partner intoxication during their last sexual act and a lower average number of unprotected vaginal sex acts with their main sexual partner who injects drugs. Both groups reported lower levels of injection frequency. The two-session intervention consisted of educational activities, skills-building demonstrations, guided practice and roleplaying, covering topics including drug use and relationships; physical and sexual abuse; rape and violence prevention; ways of discussing and negotiating safer sex; and developing a personalised action plan to help women reduce alcohol and drug use and HIV risk and avoid sexual and physical violence.[42]

» In Baltimore, USA, the JEWEL intervention combined HIV prevention education and skills building with economic enhancement to reduce HIV risk among women who use drugs (injecting and non-injecting) who traded sex for drugs or money. The HIV component aimed to increase women's knowledge about HIV, STIs and drugs, improve their risk reduction knowledge and skills, and enhance self-efficacy and negotiation and communication skills to support safer sex. The economic component taught women how to make and sell jewellery, giving them practical skills while aiming to increase their self-efficacy in relation to licit employment. Self-reports three months after the intervention showed significant reductions in the exchange of drugs or money for sex, the median number of sex trade partners per month, daily drug use and daily crack use, the amount of money spent on drugs daily, and IDU. There was also a small increase in the percentage of women reporting that they never shared needles (from 86.7% to 93.7%). Income from jewellery sales was associated with a reduction in the number of sex trade partners at follow-up. The study suggested that exposing women to the possibility of gaining legal employment could support positive behaviour change, and that sustainability of these positive behaviours would likely require women's access to job training programmes and job opportunities.[43]

» In Miami, USA, a study with female sex workers who traded sex for drugs and used heroin or cocaine regularly compared a standard HIV prevention intervention for drug users with a new sex-worker focused (SWF) intervention. The standard intervention provided pretest counselling on HIV, Hepatitis B and C (HBV/HCV), transmission routes, risky drug use, unsafe sex practices, male and female condom use, disinfection of injection equipment, and the benefits of drug treatment. The SWF intervention was developed through a collaborative process with sex workers, including focus groups and engaging sex workers as outreach workers. It covered many of the topics in the standard intervention but discussed them in language recommended by sex workers themselves, addressing specific misconceptions and needs identified during the focus groups – notably, the need to avoid violence. Both study groups reported significant decreases in the number of days using alcohol and other drugs between baseline and three- and six-month follow-ups. Mean occasions of sex work while drunk or high declined significantly for both groups at six-month follow-up. Group averages for unprotected vaginal and unprotected oral sexual contact decreased significantly at both follow-up time points for both intervention protocols. Both physical and sexual

f A review of the evidence for harm reduction interventions in general is outside the scope of this article. For information on harm reduction interventions in general, see, for example: WHO (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Evidence for action technical papers*. Geneva: WHO; WHO/UNODC/UNAIDS (2004) *Joint Position Statement: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva: WHO; International Harm Reduction Development Program (2007) Delivering HIV Treatment and Care to People Who Use Drugs. New York: Open Society Institute; Hunt N (2003) *A review of the evidence-base for harm reduction approaches to drug use*, http://www.forward -thinking-on-drugs.org/review2-print.html.

g For other examples, see Gay J, Hardee K, Croce-Galis M et al. (2010) What Works for Women and Girls: Evidence for HIV/AIDS Interventions. New York: Open Society Institute. www.whatworksforwomen.org.

victimisation were reduced significantly at three and six months among participants in both intervention protocols. The SWF intervention was significantly more effective in reducing sexual violence at the six-month contact, with participants nearly twice as likely as those in the standard intervention to report a decrease in sexual abuse/victimisation.[44]

» In 2005, Family Health International Bangladesh established drug treatment services especially for women, leading to increasing numbers of women accessing treatment. Because OST was not available, treatment consisted of clonidine-assisted detoxification followed by three months of in- or outpatient care and follow-up. Women received HIV risk-reduction counselling and VCT; screening and treatment of STIs; overdose prevention education; and information on HBV and HCV. Counselling services were based on cognitive behavioural therapy and client-centred approaches. The services were free of charge, targeting homeless women with a history of drug-related harms. They were provided by specially trained female staff members and included childcare, prenatal care and vocational rehabilitation. Treatment for male drug-using partners was offered to reduce barriers to treatment and poor treatment outcomes. A study of the programme found that participation was significantly associated with correct use of condoms, use of condoms during the last sexual act, HIV testing, and correct assessment of risk. A possible association was found between programme participation and reduced borrowing or lending of injecting equipment during the last injection, correct knowledge about where to receive STI treatment, and correct knowledge about where to get VCT for HIV.[45]

» One review analysed studies of alcohol and drug treatment programmes for women that included childcare, prenatal care, women-only programmes, supplemental services and workshops that addressed women-focused topics, mental health programming and comprehensive programming. These components were positively associated with better treatment outcomes, reduced mental health symptoms, improved birth outcomes, employment, improved self-reported health status, and HIV risk reduction. One randomised study of pregnant methadone clinic patients who received prenatal care, therapeutic childcare during visits and relapse prevention support found improved outcomes at delivery and a threefold increase in the number of prenatal visits.[46]

» A qualitative meta-synthesis of studies of US and Canadian integrated drug treatment programmes for pregnant or parenting women and their children found that these programmes, which combined medical and social support, increased women's sense of self and personal agency, engagement with the programme staff and sense of giving and receiving support, openness about feelings, recognition of patterns of destructive behaviours and goal setting. These psychosocial processes were reported to play a role in women's recovery and contribute to favourable outcomes. The motivating presence of children during treatment was also found to support women in their recovery. Perceived outcomes of programmes included improved maternal and child well-being and enhanced parenting capacity.[47]

Women supporting women

Hanoi, Vietnam

In Vietnam, PWID are highly stigmatised. Many are forced into rehabilitation centres that violate international human rights law, and where relapse rates are very high. Women who inject drugs are even more marginalised than men, since drug use runs counter to cultural ideals of motherhood and femininity. Women are also a minority of PWID. They are often neglected by interventions, have less access to harm reduction services and are at greater risk of HIV.

In 2005 the Medical Committee Netherlands-Vietnam (MCNV), in partnership with the Red Cross and others, established a support group for women who inject drugs. Called the 'Cactus Blossoms', the group originally consisted of 10 women with a history of IDU, and aimed to provide mutual support, help give women access to the services they required, and raise public awareness of this issue. Today the group has over 200 members who conduct outreach work with other women who use drugs and sex workers, meet with women in compulsory rehabilitation centres and work with providers to ensure that health services are delivered in a non-discriminatory manner. The Cactus Blossoms provide information within the rehabilitation centres and a mutually supportive environment after release, helping to reduce relapse rates. The group has organised high-profile media events to fight stigma and discrimination within society.

Since the group began, 130 women have received help in finding employment. Women have reported increased self-esteem and confidence. One member said, "After coming back from a rehabilitation centre and going home, I had no rope to cling to. But joining the group provided me with support. Now I feel reborn."[h]

h Case study information provided by Ian Bromage, HIV Programme Manager, MCNV.

Greater involvement of women who use drugs

In recognition of the need for more active involvement of women who use drugs in the international harm reduction and drug policy reform community, two international networks are now in operation.

The International Network of Women Who Use Drugs (INWUD) represents the interests of women who use drugs in the International Network of People Who Use Drugs (INPUD). INWUD actively seeks to collaborate with relevant UN and other international groups and bodies to give greater voice to issues affecting women who use drugs. INWUD helps channel the views and experiences of women who use drugs into advocacy efforts.

The Women and Harm Reduction International Network (WHRIN)[i] is a global platform that seeks to reduce harms for women who use drugs and to develop an enabling environment for the implementation and expansion of harm reduction resources for women. WHRIN provides a forum to discuss the needs of and challenges faced by women who use drugs. It advocates for national, regional and international bodies to adopt and implement policies and programmes that promote and support harm reduction interventions for women and girls. It also aims to provide access to high-quality resources (including educational material) to help women who use drugs and/or the people who work with them to improve access to gender-sensitive harm reduction services.

i To register, visit www.talkingdrugs.org/user/register.

Developing a 'menu' of services for women who inject drugs

The following table draws on examples of existing gender-sensitive harm reduction services to provide a 'menu' of options to improve and expand care for women who inject drugs. Ideally, services should be targeted according to the documented needs of women in a given context. Women who use drugs should always be involved in the design and implementation of these programmes, to ensure that programmes are effective, appropriate, and respectful of the human rights of women who use drugs.[j]

It should be noted that the establishment of gender-sensitive harm reduction services depends on the pre-existence of standard harm reduction services, which remain unavailable in many settings. Basic harm reduction services should be provided on a scale adequate to need and based on internationally endorsed WHO, UNODC and UNAIDS coverage targets necessary for an impact on HIV transmission rates.[36] Gender-sensitive services should then be added as required.

Because the resources available in different settings vary widely, the services are sorted into three groups based on the rough magnitude of cost, time and effort required for implementation.[k] It should be noted that some of the proposed services do not require any additional expenditure – for example, establishing staff gender balance, designating a time when only women visit the drop-in centre, or organising self-help groups specifically for women.

j Recommendations on service provision and advocacy goals are also provided in Pinkham (2007) op cit.; EHRN (2011) op cit.; Global Coalition on Women and AIDS (2011) *Women who use drugs, harm reduction and HIV*. Geneva: GCWA http://www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx Accessed 27 June 2012; and International Harm Reduction Development Program (2011) *By Women, For Women*. New York: Open Society Institute.

k These are very rough estimates; real costs would vary widely depending on location.

	SERVICE
Adjustments and small additions to existing services: Added commodities distributed, additional staff training, designation of special activities for women clients	» Addition of women-specific items to basic harm reduction kits (women's hygiene materials and female condoms along with syringes, male condoms, wipes, lubricant)[6, 48, 49] » Additional basic services/material assistance for women at harm reduction sites (pregnancy tests; diapers and other supplies for children; short-term babysitting while women get counselling/participate in support groups; informational materials specific to women; help learning to inject oneself and thereby eliminate dependence on partners) [6, 48, 49] » Staff training on gender issues (counselling techniques for women, needs of women who use drugs etc.)[9, 48, 49] » Gender balance in harm reduction staff, including active involvement of women drug users in service provision and design[48, 49] » Special time for women only ('Ladies' Night')[k] » Women-only support groups, women-specific counselling programmes (including structured HIV prevention counselling interventions)[42] » Relationships with trusted gynaecologists, obstetricians and other specialists for client referrals[49] » Secondary-syringe exchange programme focusing on expanding coverage of women[26] » Training OST providers and OB-GYNs on drug use and drug treatment in pregnancy[9] » (For OST programmes/policymakers): take-home doses, flexible clinic hours[5, 9] » Basic training on drug use for primary care and women's healthcare providers, to enable effective and prompt referrals to harm reduction and related services when needed[50] » Links between services for people who use drugs and for sex workers, including discreet provision of harm reduction for sex workers unable to openly visit a harm reduction site[26, 35]
New services added by existing organisations: Hiring a new staff member, adding new types of services to an existing programme, designating permanent space or significant equipment to women	» Specialist to work with women's children and give counselling on parenting skills[9, 21, 35] » Counselling services to respond to sexual violence, IPV, other trauma, and to address the links between trauma and risky behaviours[9, 35, 48] » Women-only drop-in centre or space in the harm reduction centre devoted specially to women[9, 51] » Appointments with a gynaecologist, other medical specialists at the harm reduction site[6, 51] » Multidisciplinary case management for women and their children, including pregnant women[6, 52] » Mobile harm reduction, OST, basic medical services for women unable to visit service-sites[6, 53] » Legal aid to help women resolve problems with documents, access to social support, legal problems etc.[6, 49] » Free, low-threshold sexual and reproductive healthcare, including PMTCT » Job training, job placement assistance and economic empowerment programmes to increase women's economic independence[35, 43] » Social support for women released from prison, including support related to parenting[35]
New stand-alone services: Creation of an entirely new centre/service site	» Open separate rehabilitation centres for women (if possible, where children can also stay)[9] » Establish comprehensive maternity and post-natal services for pregnant women who use drugs[52] » Provide short-term/transitional housing for homeless women and their children[21, 35]

Building a supportive policy environment

Access to services depends on a supportive policy environment. The following actions are recommended to support effective health and social services for women who inject drugs:

- Whenever feasible, collect gender-disaggregated data on the epidemiology of drug use and HIV; coverage and uptake of essential HIV and harm reduction services such as NSP, OST and ART; health service provision in prisons and incarceration for drug-related crimes; and other relevant subjects.
- Continuously and meaningfully engage women who use drugs in policy and programme design, monitoring and evaluation.
- Establish a system that guarantees free or low-cost, non-judgemental sexual and reproductive health services, including PMTCT, for vulnerable women, including women who use drugs.
- Provide NSP, OST, psychosocial support and ART in women's prisons and pre-trial detention centres, as well as sexual and reproductive healthcare and other forms of gender-sensitive care.
- Eliminate punitive approaches toward pregnant women who use drugs; introduce policies that improve access to voluntary, evidence-based drug treatment on demand and to perinatal care and other supports.
- Establish clinical protocols on OST and other care for pregnant women who use drugs, and provide OST in maternity hospitals.
- Eliminate laws that make drug use, a history of drug use or participation in an OST programme (as opposed to negligence or abuse) grounds for the removal of parental rights, as this is a strong deterrent to mothers in need of care.
- Support links between harm reduction programmes and primary and women's healthcare systems.
- Establish stronger protections for patient confidentiality.

It has become clear that the HIV epidemic demands an approach that addresses multiple health and social factors, on the structural as well as individual level. This lesson should be applied to harm reduction for women who inject drugs. A gender-sensitive approach to harm reduction will benefit not only women but their children, families and communities.

I See Magee C & Huriaux E (2008) Ladies' night: Evaluating a drop-in programme for homeless and marginally housed women in San Francisco's Mission district. International Journal of Drug Policy 19, 113–121.

References

1. Roberts A, Mathers B & Degenhardt L on behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) *Women who inject drugs: A review of their risks, experiences and needs.* Sydney, Australia: National Drug and Alcohol Research Centre (NDARC), University of New South Wales.
2. El Bassel N, Terlikbaeva A & Pinkham S (2010) HIV and women who use drugs: double neglect, double risk, *Lancet,* Vol. 376, Issue 9738, 312–314.
3. Des Jarlais DC et al. (2012) Are females who inject drugs at higher risk for HIV infection than males who inject drugs: An international systematic review of high seroprevalence areas, *Drug and Alcohol Dependence*, doi:10.1016/j.drugalcdep.2011.12.020.
4. European Monitoring Centre for Drugs and Drug Addiction (2006) *Annual report 2006: the state of the drugs problem in Europe.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
5. Shapoval A & Pinkham S (2011) *Technical Report: Women and Harm Reduction in Central Asia*. Quality Health Care Project in the Central Asian Republics. Cambridge, MA: Abt Associates Inc. http://www.aidsprojects.com/current-work/current-projects/quality-health-care-project-central-asia/quality-healthcare-project-technical-reports/ Accessed 27 June 2012.
6. Pinkham S & Malinowska-Sempruch K (2007) *Women, Harm Reduction, and HIV*. New York: International Harm Reduction Development Program of the Open Society Institute.
7. Fair H (2009) International review of women's prisons. *Prison Service Journal,* Issue 184.
8. Burns K (2009) *Women, Harm Reduction, and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine.* New York: International Harm Reduction Development Program of the Open Society Institute.
9. UNODC (2004) *Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned*. New York: UNODC.
10. Xinhua News Agency (2004) Female IDUs, key population for fighting AIDS in China: experts, in UNODC (2005) *World drug report*. Vienna, UNODC.
11. European Monitoring Centre for Drugs and Drug Addiction (2006) *A gender perspective on drug use and responding to drug problems*. Luxembourg: Office for Official Publications of the European Communities, 29.
12. Cook C (2010) *Global State of Harm Reduction 2010: Key issues for broadening the response*. London: IHRA.
13. UNAIDS (2009) *Ukraine Country Situation 2009*. Geneva: UNAIDS. http://www.unaids.org/ctrysa/EURUKR_en.pdf Accessed 2 May 2012.
14. Needle RH & Zhao L (2010) *HIV Prevention Among Injecting Drug Users: Strengthening U.S. Support for Core Interventions*. Washington, DC: CSIS Global Health Policy Center.
15. Canadian Centre on Substance Abuse, *Injection Drug Users Overview* http://www.ccsa.ca/Eng/Topics/Populations/IDU/Pages/InjectionDrugUsersOverview.aspx Accessed 2 May 2012.
16. Black KI, Stephens C, Haber PS & Lintzeris N (2012) Unplanned pregnancy and contraceptive use in women attending drug treatment services. *Australian and New Zealand Journal of Obstetrics and Gynaecology, Vol. 52, Issue 2, 146–150.*
17. Murphy S & Rosenbaum M (1999) *Pregnant Women on Drugs: Combating Stereotypes and Stigma.* New Brunswick: Rutgers University Press.
18. European Collaborative Study in EuroCoord (2011) Insufficient antiretroviral therapy in pregnancy: missed opportunities for prevention of mother-to-child transmission of HIV in Europe. *Antiviral Therapy,* 2011; 16:895–903.
19. 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: WHO.
20. Pinkham S & Shapoval A (2010) *Making Harm Reduction Work for Women: The Ukrainian Experience.* New York: International Harm Reduction Development Program, Open Society Institute.
21. Thumath M (2009) Creating the village for women who use drugs and their families: Lessons from the Pregnancy Outreach Project Sheway. Presentation, in Eurasian Harm Reduction Network (2009) *Developing services for women who use drugs* (training module), http://harm-reduction.org/hub/knowledge-hub/ehrn-training-modules.html Accessed 29 March 2012.
22. British Columbia Women's Hospital and Health Center, *Substance Use and Pregnancy*, http://www.bcwomens.ca/Services/PregnancyBirthNewborns/HospitalCare/SubstanceUsePregnancy.htm Accessed 29 March 2012.
23. Ordean A, Midmer D, Graves L, Payne S, Hunt G & the PRIMA Group (2008) *PRIMA (Pregnancy-Related Issues in the Management of Addictions): A Reference for Care Providers.* Toronto: Department of Family & Community Medicine, University of Toronto.
24. Maher L & Hudson SL (2007) Women in the Drug Economy: A Metasynthesis of the Qualitative Literature, *Journal of Drug Issues*, Fall 2007; 37, 4.
25. American Civil Liberties Union, the Brennan Center & Break the Chains (2005) *Caught in the Net: The Impact of Drug Policies on Women and Families* http://www.aclu.org/files/images/asset_upload_file431_23513.pdf Accessed 29 March 2012.
26. Anderson, R. "Satellite (Secondary) Syringe Exchangers." In Eurasian Harm Reduction Network (2009), *Developing services for women who use drugs* (training module), http://harm-reduction.org/hub/knowledge-hub/ehrn-training-modules.html (last accessed March 29, 2012).
27. WHO-Euro & UNODC (2009) *Women's health in prison: Correcting gender inequity in prison health*. Copenhagen: WHO-Euro http://www.unodc.org/documents/commissions/CND-Session51/Declaration_Kyiv_Women_60s_health_in_Prison.pdf Accessed 29 March 2012.
28. UNODC & UNAIDS (2008) *Women and HIV in prison settings.* Vienna: UNODC http://www.unodc.org/documents/hiv-aids/Women%20and%20HIV%20in%20prison%20settings.pdf Accessed 27 June 2012.
29. Columbia Human Rights Law Review (2011) Special Issues of Women Prisoners, in *A Jailhouse Lawyer's Manual.* New York: Columbia Law School.
30. Willis K & Rushforth C (2003) The Female Criminal: An Overview of Women's Drug Use and Offending Behavior, *Trends and Issues in Crime and Criminal Justice.* Canberra: Australian Institute of Criminology.
31. Iakobishvili E (2012) *Cause for Alarm: The Incarceration of Women for Drug Offences in Europe and Central Asia, and the Need for Legislative and Sentencing Reform*. London: International Harm Reduction Association/Harm Reduction International http://www.ihra.net/files/2012/03/11/HRI_WomenInPrisonReport.pdf Accessed 27 June 2012.
32. Quaker Council for European Affairs (2007) *Women in Prison*, Brussels: QCEA http://www.qcea.org/wp-content/uploads/2011/04/rprt-wip1-main-en-feb-2007.pdf Accessed 30 March 2012).

33. European Monitoring Centre for Drugs and Drug Addiction (2004) *Annual report 2004: the state of the drugs problem in the European Union and Norway.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
34. WHO, UNODC, UNAIDS (2007) *Interventions to Address HIV in Prisons: Comprehensive Review*. Evidence for Action Technical Paper. Geneva: WHO.
35. Brentari C, Hernandez B & Tripodi S (2011) Attention to Women Drug Users in Europe (DCDII guidelines), European Project 'Democracy, Cities and Drugs II – 2008–2010', *Thematic Platform 'Women and drugs'* (in press), p. 17.
36. WHO, UNODC, UNAIDS (2012) *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users: Updated 2012*. Geneva: WHO.
37. Palmateer N, Kimber J, Hickman M et al. (2010) Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews. *Addiction,* 105, 844–859.
38. Laga M, Rugg D, Peersman G & Ainsworth M (2012) Evaluating HIV prevention effectiveness: the perfect as the enemy of the good, *AIDS*, 2012, 26**.**
39. Gollub E (2008) A Neglected Population: Drug-Using Women and Women's Methods of HIV/STI Prevention, *AIDS Education and Prevention,* 20(2), 107–120.
40. Latka M (2003) Drug-using women need comprehensive sexual risk reduction interventions, *Clinical Infectious Diseases,* 37 (Suppl. 5), S445–S450.
41. Semaan S, Des Jarlais DC & Malow R (2006) Behavior change and health-related interventions for heterosexual risk reduction among drug users, *Substance Use and Misuse,* 41, 1349–78.
42. Wechsberg WM, Krupitsky E, Romanova T et al. (2012) Double jeopardy – drug and sex risks among Russian women who inject drugs: Initial feasibility and efficacy results of a small randomized controlled trial, *Substance Abuse Treatment, Prevention, and Policy,* 2012, 7:1.
43. Sherman SG, German D, Cheng Y, Marks M & Bailey-Kloche M (2006) The evaluation of the Jewel project: an innovative economic enhancement and HIV prevention intervention study targeting drug using women involved in prostitution, *AIDS Care,* 18:1–11.
44. Surratt H & Inciardi J (2010) An Effective HIV Risk-Reduction Protocol for Drug-Using Female Sex Workers, *Journal of Prevention and Intervention in the Community,* 2010, 38: 118–131.
45. Kumari MS & Sharma M (2008) Women and Substance Use in India and Bangladesh, *Substance Use & Misuse*, 43:1062–1077.
46. Ashley OS, Marsden ME & Brady TM (2003) Effectiveness of substance abuse treatment programming for women: a review, *American Journal Of Drug And Alcohol Abuse*, Vol. 29, No. 1, 19–53.
47. Sword W, Jack S, Niccols A, Milligan K, Henderson J & Thabane L (2009) Integrated programs for women with substance use issues and their children: a qualitative meta-synthesis of processes and outcomes, *Harm Reduction Journal,* 2009, 6:32.
48. Global Coalition on Women and AIDS (2011) *Women who use drugs, harm reduction and HIV*. Geneva: GCWA http://www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx Accessed 27 June 2012.
49. International Harm Reduction Development Program (IHRD) (2011) *By Women, For Women*. New York: Open Society Institute..
50. Morse B, Gehshan S & Hutchins E (2000) *Screening for Substance Abuse During Pregnancy: Improving Care, Improving Health*. Arlington, VA: National Center for Education in Maternal and Child Health.
51. Magee C & Huriaux E (2008) Ladies' night: Evaluating a drop-in programme for homeless and marginally housed women in San Francisco's Mission district. *International Journal of Drug Policy* 19, 113–121.
52. Burns K (2009) *Opioid Substitution Therapy for Pregnant Drug-Users: A Critical Component to supporting maternal, newborn and child health.* UNICEF, unpublished document.
53. Gay J, Hardee K, Croce-Galis M et al. (2010) *What Works for Women and Girls: Evidence for HIV/AIDS Interventions.* New York: Open Society Institute.

EXCLUDING YOUTH?
A global review of harm reduction services for young people

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Introduction

UNICEF estimates that there are nearly 2.2 billion children and young people under 18 years of age, accounting for more than a third of the world's population.[1] The UN Convention on the Rights of the Child requires that state parties take 'appropriate measures' to protect this age group from the illicit use of drugs. However, the 'war on drugs' often trumps young people's rights.[2,3] This chapter will provide a global snapshot of the harms experienced via injecting drug use (IDU) among young people aged under 18 and existing harm reduction responses targeted at this population.

Alcohol, cannabis and 'club drug' use remain much more prevalent than IDU among this population. However, this chapter focuses specifically on youth injecting, which continues to represent a significant blind-spot in terms of research and public health responses. The chapter begins by outlining recent trends in IDU among young people. As part of the Global State of Harm Reduction 2012 survey, new international data were collected from civil society and researchers, and this chapter reports our analyses of these data to provide a unique and timely study of legal age restrictions and other barriers to young people accessing harm reduction services. This chapter also highlights case studies of best practice for meeting the needs of this population in different settings, to inform our recommendations for improving policies and services to reduce drug-related harm.

Young people who inject drugs: prevalence and harms

Although overall levels of youth drug use appear to be stabilising or decreasing in many high-income countries[4,5,6] surveys of the general population conceal the drug-related harms experienced by the most vulnerable groups of young people. This includes young people who are not in education and street-involved youth – populations whose drug use is less likely to be transitory and more likely to progress onto more problematic patterns of use, such as IDU.[7] The impact of current economic recessions is likely to further increase the vulnerability of young people,[8] and record levels of child poverty and youth unemployment have already led some commentators to describe a new 'lost generation' of young people devoid of jobs and hope. [9]

Furthermore, drug use is a universal and globalising phenomenon. Young people in Western Europe and North America represent a small fraction of the total global youth population: more than four-fifths of the world's children and young people aged 18 years and younger live in low- and middle-income countries in Eastern Europe, Asia, Africa and South America. Recent reports have drawn attention to a 'historic high' in youth drug use globally,[10] and IDU has spread to new regions. For example, the Pangaea Global AIDS Foundation estimates that there are now over 25,000 people who inject drugs (PWID) in Tanzania, and that over 40% of this population is living with HIV.[11] HIV transmission via unsafe injecting in sub-Saharan Africa is a relatively new phenomenon, and young people are likely to be among the most vulnerable.[12]

While IDU still only represents a small proportion of drug use reported by under-18s overall, in many regions of the world the age of initiation of injecting now appears to be decreasing.[13] Those young PWID who are sharing injecting equipment can transmit blood-borne viruses including HIV and Hepatitis C. These youth are also at greater risk of other preventable diseases such as tuberculosis. Research consistently shows that young injectors are more likely than older ones to report sharing equipment with other injectors and less likely to access needle and syringe exchange services.[14,15] Young people also often have a lack of knowledge and misconceptions about HIV transmission.[16]

According to UNICEF in 2011,[16] globally young people account for 2,500 new HIV infections every day. Failures to meet targets on reducing HIV transmission among young people is in a large part due to unsafe injecting practices and the criminalisation of these behaviours. It is estimated that in countries such as Belarus, China, Italy, Poland, Spain and Russia more than half of HIV infections are due to unsafe injecting,[17] much of this among youth. More generally, young people are also often the first to experiment with new substances, and are often highly connected to dense drug-supply networks, making them highly susceptible to new drug-related harms.

Young people who inject drugs: current responses and data gaps

Despite increasing global coverage of harm reduction services,[18,19] there remains a lack of youth-focused harm reduction services, and a potential gap between the age of initiation of injecting and the age at which services are accessible to young people. Current responses remain dominated by prevention and punishment discourses.

In some regions, strict age restrictions on access to these services have been highlighted as a major barrier, as young people are denied access to evidence-based interventions such as needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST). Criminal laws increase that risk and other barriers to young people accessing harm reduction services have also been identified, including appointment-based service provision and a lack of youth-work expertise and training among practitioners.[20] Furthermore, youth participation in the design of policies and programmes remains rare.

However, to date, there have been no attempts to map out and synthesise these barriers globally. The Global State 2012 data collection questionnaire offers a novel lens through which to study age restrictions and other barriers to NSP and OST access among the youth population. Data were collected by surveying civil society organisations and key researchers working in the harm reduction field around the world to explore region-by-region developments in harm reduction since the previous Global State report was released in 2010. In the 2012 survey, specific questions were asked for the first time about the barriers to young people accessing services and legal age restrictions in different countries and regions (for more information see the Introduction to this report). Data on young people were available from all the Global State regions except for the Middle East and North Africa, which is, therefore, not included in these analyses.

Harm reduction services for young people: a global snapshot

Overall, of 85 countries reporting at least one NSP or OST site, data on the existence of age restrictions were available for 77 countries. Of those countries that reported data on age restrictions, 18 countries reported an age restriction for accessing NSPs, and 29 for accessing OST. Most commonly the age restriction was 18 years, but in some cases it was much higher (e.g. Georgia, Norway and Sweden). Even in countries with no legal age restrictions, the application of other requirements, such as compulsory parental consent or evidence of previous failed attempts at detoxification or other drug treatment modalities, and 'aiding and abetting' laws limit access to harm reduction services for young people. Table 1 provides more information on the existence of age restrictions by country, and the survey responses have also been synthesised in narrative form and are presented, region-by-region.[a]

a Please see section 2: Regional Overviews for a comprehensive list of countries considered as part of each of the world regions.

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
ASIA		
Afghanistan	Data n/a	No
Bangladesh	Data n/a	Yes (18)
Cambodia	No	Yes (18)
China	Yes (18)	No
Hong Kong	No NSP	No
India	Yes (18)	Yes (18)
Indonesia	Data n/a	Yes (18)
Macau	No	No
Malaysia	No	No
Maldives	No NSP	No
Mongolia	Data n/a	No OST
Myanmar	No	No
Nepal	No	Yes (18)
Pakistan	Yes (18)	No OST
Philipinnes	Data n/a	No OST
Taiwan	Data n/a	Data n/a
Thailand	No	No
Vietnam	Yes (18)	Yes (18)
LATIN AMERICA		
Argentina	No	No OST
Brasil	No	No OST
Colombia	No NSP	No
Mexico	No	No
Paraguay	No	No OST
Uruguay	No	No OST
CARIBBEAN		
Puerto Rico	No	No
SUB-SAHARAN AFRICA		
Kenya	Data n/a	Data n/a
Mauritius	Yes (18)	Yes (18)
Nigeria	No NSP	Data n/a
Senegal	No NSP	Data n/a
South Africa	Yes (18)	Data n/a
Tanzania	No	No
EURASIA		
Albania	No	No
Armenia	No	Data n/a
Azerbaijan	Data n/a	Yes (18)
Belarus	No	Yes (18)
Bosnia and Herzegovina	No	No
Bulgaria	No	Yes (18)
Croatia	No	No
Czech Republic	Yes (15)	Yes (15)
Estonia	Yes (18)	No
Georgia	No	Yes (21)
Hungary	No	Yes (18)
Kazakhstan	No	Data n/a
Kosovo	No	No
Kyrgyzstan	No	No
Latvia	Data n/a	Data n/a
Lithuania	Yes (18)	Yes (18)
Macedonia	Yes (18)	Yes (16)

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
Moldova	Data n/a	Yes (18)
Montenegro	Data n/a	Data n/a
Poland	No	No
Romania	Yes (18)	Yes (16)
Russia	No	No OST
Serbia	Yes (15)	Yes (15)
Slovakia	No	Yes (18)
Slovenia	No	Yes (16)
Tajikistan	No	No
Turkmenistan	Data n/a	No OST
Ukraine	Yes (14)	Yes (14)
Uzbekistan	Data n/a	No OST
WESTERN EUROPE		
Austria	Data n/a	Data n/a
Belgium	No	Yes (18)
Cyprus	No	No
Denmark	No	No
Finland	No	No
France	Yes (18)	Yes (15)
Germany	Yes (18)	Yes (18)
Greece	Data n/a	Data n/a
Iceland	No NSP	Data n/a
Ireland	No	No
Italy	No	No
Luxembourg	Data n/a	Data n/a
Malta	Data n/a	Data n/a
Netherlands	No	No
Norway	Data n/a	Yes (25)
Portugal	No	Yes (18)
Spain	Yes (18)	Yes (18)
Sweden	Yes (20)	Yes (20)
Switzerland	No	No
Turkey	No NSP	Data n/a
United Kingdom	No	No
OCEANIA		
Australia	No	No
New Zealand	Yes (16)	No
NORTH AMERICA		
Canada	No	No
United States	No	Yes (18)

Asia

Despite a scale-up in services overall in the last two years, it was reported that harm reduction services in Asia almost always target male, adult PWID. A major barrier to service provision targeted at youth in the region appears to be their relative invisibility as a drug-using population. Few or no data are collected on this population in most countries in the region at present. Young people are, therefore, rarely a focus for intervention, and the vast majority of programmes lack any clear strategy for reaching and engaging under-18s. Even in Bangladesh, which has relatively high levels of NSP coverage in South Asia according to recent reviews,[19,21] there are no data on, or provision for, younger PWID. Furthermore, many young injectors in Asia are using methamphetamine and pharmaceutical drugs (e.g. benzodiazepines), and their needs will not be addressed through OST.[22]

Legal age restrictions are also a barrier in the region. For example, in Nepal and Pakistan harm reduction projects can only work with those aged 18 and above, despite Article 33 of the UN Convention on the Rights of the Child requiring that state parties take 'appropriate measures' to protect under-18s from drug-related harms. This is of particular concern in Pakistan, where the age of initiation into drug injecting is decreasing, according to a recent rapid assessment exercise.[23] Meanwhile, in China and Vietnam, despite an expansion of harm reduction service provision overall, age restrictions prevent under-18s from accessing these new services.

It was reported that legal age limits are a common reason for refusal by services, as they provide an objective way of rationing limited supply in the region. Stigma was also reported to be a major barrier, and many young PWID in the region deny they are dependent on drugs and need harm reduction services. At present, there is a mandate to disclose one's identity, and service-users often have to effectively 'register' with authorities, as is the case in China. This is a clear impediment to accessing OST services and may disproportionately affect younger people. Furthermore, most OST clinics have yet to be integrated into general health services, with the consequence that those accessing treatment can easily be identified and stigmatised.

The 'Opening Doors' project: increasing access to youth-friendly harm reduction in Asia[b]

'Opening Doors' is a response to current legislation across Asia which mostly prohibits access to harm reduction services for young people, as well as the stigmatising and punitive nature of current treatment approaches which exacerbate social exclusion. The project is funded by Aids Fonds, a Dutch NGO, and is a partnership between Access Quality International and the National Drug and Alcohol Research Centre, University of New South Wales, Australia.

Where community options do exist, young people have tended not to engage with these adult-oriented services. Informed by the World Health Organization's model of 'youth-friendly health services',[24] the primary aim of the project is to increase access to harm reduction services for young PWID and those who are at risk of initiating IDU. The target age group is 10–25, with special attention paid to the engagement of difficult-to-reach young people. The project has been implemented in three sites so far: Bangkok, Thailand; Kunming, China; and Kathmandu, Nepal.

In all three sites, participatory focus group research with young PWID has been used to identify local needs, engage them in service design and increase access to locally appropriate harm reduction services. For example, in Kunming, the main drug of concern remains heroin, with significant unmet needs identified following consultation with young people. The project site in Kunming has aimed to increase participation in 'youth-friendly' methadone maintenance therapy (MMT), alongside other activities such as counselling groups, employment assistance, visits and recreation.[25]

An evaluation undertaken by Youth Vision in Nepal in 2010 suggested that there had been a significant increase in the engagement of young people with harm reduction services after adopting the 'Opening Doors' approach. Young people accessing the services also reported improved mental health, less involvement with crime, a reduction in sharing of injection equipment and increased condom use. The projects have helped to establish new partnerships between the health, education, vocational training and employment sectors, building greater capacity for youth-focused harm reduction interventions in the region in the long term.

Latin America

Sporadic and isolated efforts largely characterise the development of harm reduction services in Latin America at present. Similar to Asia, a lack of harm reduction services for young people under 18 was reported in this region. Youth-focused approaches to reducing the harms associated with IDU are rarely an acceptable public health strategy in either South or Central American countries, and national drugs policies do not support this approach. Harm reduction responses which do emerge are normally led by NGOs, and it was reported that even where these do exist stigma, discrimination and criminalisation pose significant barriers to service use, especially for young people.

Despite these barriers, new examples of youth-focused harm reduction projects were reported. For example, in Rio de Janeiro a project was established in 2010 in an area known as 'crack land' where young people gather to use drugs. Work so far has focused on sensitising the health care system to the needs of these young PWID, including the development of a new course to train health workers, and the provision of syringes, pipes, lip balms and condoms. This project was supported by the federal government, the National Health Ministry, the Secretariat of State for Rio de Janeiro, the Federal University of Rio and the UN Office on Drugs and Crime. Also, in Mexico, the state authorities now buy and distribute syringes through centres for youth integration and in some CAPASITS (state provider of HIV, AIDS and STI services) sites.

Sub-Saharan Africa

Even more so than in Asia and Latin America, Africa is a region characterised by a paucity of both data on the number of young PWID and harm reduction services for this group. In East Africa, there are major concerns at present of both increasing IDU in general and also earlier initiation, with reports of young people as young as 11 in Kenya and as young as six in Tanzania injecting drugs.[26] Harm reduction services that target young people in East Africa, particularly in the coastal areas where IDU is concentrated (e.g. Mombasa, Dar es Salaam and Zanzibar) are urgently needed. Such services must also meet the needs of young women who are injecting drugs, who are subject to multiple vulnerabilities.[27] Although there is no official data on the prevalence of IDU and service provision for young people, anecdotal information from some parts of West Africa suggests a rapid rise in IDU among youth and a severe harm reduction service provision gap.[28] As HIV infection through IDU increases in sub-Saharan Africa, young people are a particularly vulnerable population.[12]

b The 'Opening Doors' project has developed a toolkit on enhancing youth-friendly harm reduction, available at: http://ndarc.med.unsw.edu.au/resource/opening-doors-enhancing-youth-friendly-harm-reduction-toolkit.

Eurasia

Many countries in Eastern Europe report high HIV prevalence rates among young people through the sharing of injecting equipment and unsafe sexual practices.[29] Some positive legislative changes which aim to improve harm reduction services for young people were reported in this region. For example, in Serbia a new law allows juveniles aged 15 and over to have exclusive privacy over their medical records and consent rights regarding their health issues, which means no parental consent will be required to access NSP and OST. There are now no legal age restrictions for accessing NSP in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Kosovo, Slovakia or Slovenia. However, since NSPs are often anonymous and client ages unrecorded, it is hard to assess whether PWID under 18 are being reached by these services.[30]

In other countries in the region, age restrictions remain a barrier to accessing harm reduction services. The Czech Republic and Macedonia both have legal age limits for NSPs, allowing only PWID who are at least 15 and 18 years old, respectively, to access sterile injecting equipment. Access to OST is also often subject to strict age regulations. For example, in Bulgaria and Hungary the minimum age for participation in OST is 18, and it is 21 in Georgia. The written consent of a legal representative or a parent of a minor is required prior to starting OST in Bosnia and Herzegovina, Romania and Kosovo, which also poses a significant obstacle.

Additional barriers to service access in the region include stigma, fear of the police, and a lack of funding. NSPs are also rarely, if ever, tailored to young people's needs. There are also a lack of youth-focused OST programmes, and to become eligible in many countries young people have to prove they were not successful in previous detoxification treatment.

Western Europe

The prevalence of injecting heroin and other drugs remains rare among young people in this region – typically only being reported by 1–2% or less of young people in general population surveys – while alcohol and cannabis remain the primary drugs used by young people.[5,6] The incidence of new cases of HIV among PWID is also low in Western Europe, although incidence is still relatively high in some countries (e.g. Portugal), and recent increases have been observed in others such as Sweden.[30] Furthermore, the burden of morbidity associated with IDU is not evenly distributed: certain groups of vulnerable young people are most at risk of transmission of HIV or Hepatitis C and other drug-related harms due to social and structural factors such as poverty and social exclusion.[8]

There is a mixed picture in terms of the application of age restrictions to accessing harm reduction services in Western Europe (see Table 1). For example, legal age restrictions were reported to limit access to evidence-based harm reduction services for vulnerable young people in Belgium, Germany, Norway, Portugal and Sweden. Alternatively, in countries such as the UK, specialist services to safeguard children and young people from harm were reported to have been developed, and 'minors' are not excluded from NSPs (although guidelines make it clear that the service providers should inform their parents and the local child protection agency). Likewise, community-based pharmacological interventions such as OST are now available for young people in the UK and have been developed to recognise the different context of working with young people.[31]

As in other regions, stigma, marginalisation and law enforcement practices were reported as significant barriers to HIV prevention, care and treatment for young people who use illegal drugs. This included a reluctance from young PWID to carry syringes due to social stigma, and who often adopt dangerous drug storage and concealment methods for fear of consequences of police action. Increasing incarceration of young people who inject drugs is also a major public health challenge, as access to harm reduction measures is usually limited or non-existent and HIV/Hepatitis C risk behaviours are more prevalent in prison settings.[32]

Oceania

In Australia, government support for harm reduction service provision and scale-up, and debates on drug policy reform, have become increasingly challenging. In most cases there are no age, gender-based or other criteria that restrict access to NSPs in Australia, although the only operational drug consumption room (DCR) in the country, which provides injecting equipment for use in its service, prohibits access to the service for those under the age of 18. Additional barriers which can prevent young people accessing services in Australia were also reported, including fear of stigma, the limited hours of service operation, limited service availability outside of major cities and discriminatory attitudes of staff towards younger people. While young people under 18 are not precluded from OST, doctors are discouraged from prescribing pharmacotherapies to 'minors' in Australia. Furthermore, if a 'child', that is a person under 18, is accessing injecting equipment or OST, staff are required to report this to the local child protection agency, which may be a further barrier for some young people.

In New Zealand, the minimum legal age for accessing NSPs is 16. Although there is no legal age restriction for OST, for those under 18 parental/caregiver support and consent is preferred. For those under 16, assessment and consent are also needed from an addiction medical specialist and/or a child and youth psychiatrist.

North America

Injecting drug use often starts at a young age in North America.[33] Age restrictions and limited access to NSPs for under-18s represent significant barriers to access to harm reduction services in this region. In the USA, although restrictions vary by state and by type of treatment setting, anyone under 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months in order to be eligible for OST. This inevitably limits the potential for young people to access evidence-based harm reduction programmes.

Cost is also likely to be a barrier to treatment in the USA, as Medicaid insurance can only be used to pay for MMT in some states, and even then it is often time-limited. It was reported that private insurance payment is also usually preferred by PWID to avoid exposure and stigmatisation, but this is unlikely to be an option for young PWID. Additional barriers include lengthy waiting lists for methadone clinics in some USA regions (particularly in regions far from urban centres), regulations around OST programme attendance and regular testing for other drug use, all of which are likely to pose barriers for young people.

No legal age restrictions for accessing NSPs or OST in Canada were reported. Outreach and frontline workers provide sterile equipment to young people who show evidence of use or need, although many youth in Canada still go without services, particularly in rural regions and central/northern Canada.

The TRIP! Project: Youth-Led Harm Reduction in Canada

TRIP! is a youth-led harm reduction project that has been providing peer outreach to the dance music community in Toronto, Canada for over 15 years. TRIP! aims to include young people who use drugs, street-involved and lesbian, gay, bisexual, transgender and queer (LGBTQ) youth in direct service development and delivery, and to encourage safer drug use and safer sex to reduce associated harms including the transmission of HIV, Hepatitis C and other sexually transmitted infections (STIs). TRIP! does outreach work via a variety of venues, including nightclubs, bars, warehouses, bridge parties, house parties, street parades and multi-day festivals. During outreach events, young people can pick up info-cards on dance drugs, routes of administration and safer sex, as well as a variety of harm reduction supplies including condoms, lubricant, straws, needles and syringes.

In addition to outreach, TRIP! engages youth through social networking to circulate messages about safer partying practices. Online surveys are employed to monitor patterns of drug use, injecting, and 'high-risk' behaviours. TRIP! has found that youth tend to be most honest when responding to anonymous online survey questions. As a result, an annual online survey is used to obtain accurate drug use data within this community. Information generated by this type of youth engagement allows TRIP! to monitor and identify emerging health and safety issues, as well as publish alerts about dangerous or new substances and laws affecting the communities.

While young PWID represent a minority of those with whom TRIP! works, injecting is an emerging trend within the Toronto community of young people who use drugs. The 2010 TRIP! survey found that 9% of young people were injecting drugs, with 3% considering doing it in the future. Young people who used crystal meth and ketamine were more likely to inject, with 17% of meth users and 13% of ketamine users reporting injecting. Furthermore, 83% of TRIP! youth reported having tried prescription opioids, often to deal with the come-down and other side effects reported from chronic ketamine use.

It is important to recognise the value of such projects in both increasing young people's 'voice' and also in building the existing network of safer nightlife organisations locally, nationally and internationally to share information and create a peer support network. According to the 2009 Toronto Teen Survey, many youth distrust health workers, instead turning to their friends (53%), siblings, and infolines (55%) for health questions.[34]

Increasing young people's visibility in harm reduction

IDU represents a small minority of youth drug use, but it is an acute problem affecting those most at-risk young people, and it is a much overlooked aspect of the global response to injecting-driven HIV epidemics. Young people are excluded from harm reduction services in every region of the world. Few NSPs or OST programmes target and work with young people. This was a recurring theme in the responses to the Global State of Harm Reduction 2012 questionnaire. Young people face all the same barriers to accessing harm reduction services that adults do – limited coverage, stigma and criminalisation – and these are further compounded by legal age restrictions and other barriers such as a lack of funding for youth-focused services.

At the international-level, the nine core harm reduction interventions recommended by the WHO, UNODC and UNAIDS[35] are not youth-focused, and it appears that key issues regarding young people, IDU and HIV may be falling between the priority areas of different international organisations such as UNAIDS, UNICEF, UNESCO and the WHO. Furthermore, while 'know your epidemic, know your response' has become the rallying cry of UNAIDS,[36] when it comes to young people and injecting we do not yet 'know our epidemic'. Where surveys do monitor prevalence and trends of drug use among young people, they are almost always still based on school samples, and PWID remain largely invisible in the official statistics on youth drug use.[7]

This chapter provides a much-needed global snapshot of legal age restrictions and other barriers to harm reduction services for young people. However, this picture is incomplete, and improved data collection should also be an international priority, as should significantly increased investment in youth-focused harm reduction. This review of harm reduction services for young people suggests the following priority areas:

Avoid legal age restrictions: Removing the barriers caused by legal age restrictions should be a priority, especially where the age of initiation to IDU is decreasing. Removing such restrictions is an important first step towards developing youth-focused services because, although OST provision for young people may raise specific medical concerns and abstinence-based treatments may be more appropriate in some cases, an age restriction on these harm reduction services will likely also mean there is nowhere else to go.

Youth-led, youth-friendly harm reduction: Young people may not identify with more adult-orientated models of treatment and should be involved in designing new services to meet their specific developmental needs. Our case studies highlight how it is possible to use participatory and peer-led methods to engage young PWID to inform more appropriate youth-led and youth-friendly services. International guidelines for OST (for those using opiates) and NSPs for children and young people are also required, as are clear child protection protocols and rapidly applicable legal tests for capacity to consent to treatment and to receive treatment without parental consent.

Improving data collection: Street-based surveys of young people should be more widely implemented to complement existing monitoring systems (e.g. school-based surveys), alongside rapid assessments of youth injecting and its adverse health outcomes. Furthermore, it is important that data on epidemiology and service coverage among PWID be disaggregated by age. To this end, existing recommendations by UNAIDS, WHO and other multilateral agencies to improve country-level data collection via age disaggregation are particularly relevant.[35,37] Removing legal age restrictions may also allow for an improved understanding of patterns of injecting through the collection of age-disaggregated client data.

Investment in young people most at risk: It is imperative that there is sufficient funding and training to support new responses focused specifically on the special needs of young people at highest risk from drug use. UNAIDS has already identified that this is a major problem in Asia, where 90% of the resources for young people are spent on low-risk youth, who represent just 5% of those who go on to become infected with HIV.

Structural interventions – the holistic approach: Social policies and interventions which address the broader 'risk environment' – for example, by addressing poverty, trauma, homelessness and social exclusion – are also needed and may have the greatest impact on reducing drug-related harms at a population level.[38] This is also in line with a children's rights-based approach.[39] Harm reduction in this context is about keeping at-risk youth alive and safe, while also addressing the causes of their vulnerability.

Finally, we would also emphasise that context is key: what works in the United Kingdom and Canada, where child protection services are strong, may not work in Nepal or the Ukraine. Irrespective of context, however, failing to find solutions represents a missed opportunity to protect and improve the health of the next generation of young people across the world. To do so, further questions must be asked about what information is already available, and where further investigation is required about IDU among young people and about the most appropriate responses to reduce drug-related harm among this population.

References

1. UNICEF (2004) *The State of the World's Children 2005*. New York: United Nations Children's Fund.
2. Barrett D & Nowak M (2010) The United Nations and Drug Policy: Towards a Human Rights-Based Approach, in Constantinides A & Zaikos N (Eds) The Diversity of International Law: Essays in Honour of Professor Kalliopi K. Koufa (pp. 449–477). Boston: Martinus Nijhoff Publishers.
3. Fletcher A (2011) Drug testing in schools: a case-study in doing more harm than good, in Barrett D (Ed.) Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People (pp. 196–204). New York: International Debate Press.
4. UNODC (2009) *World Drug Report 2009*. Vienna: United Nations Office on Drugs and Crime.
5. Fletcher A, Calafat A, Pirona A & Olszewski D (2010) Young people, recreational drug use and harm reduction, in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) *Harm reduction: evidence, impacts and challenges* (pp. 357–378). Luxembourg: Publications Office of the European Union.
6. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A & Kraus L (2012) *The 2011 ESPAD Report: Substance Use Among Students in 36 European Countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs.
7. Cook C & Fletcher A (2011) Youth drug-use research and the missing pieces in the puzzle: how can researchers support the next generation of harm reduction approaches?, in Barrett D (Ed.) Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People (pp. 175–185). New York: International Debate Press.
8. Arkes J (2011) Recessions and the participation of youth in the selling and use of illicit drugs, *International Journal of Drug Policy*, 22(5): 335–340.
9. Powell N (2011) Europe's Lost Generation: No Jobs or Hope for the Future, *The Globe and Mail*, 7 November 2011.
10. Lloyd CB (2005) *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*. New York: The Population Council.
11. Pangaea AIDS Foundation (2012) *Tanzania: Helping Tanzania Stop an HIV Epidemic Driven by Injection Drug Use*. http://pgaf.org/where/tanzania Accessed 23 Jun 2012.
12. McCurdy SA, Williams ML, Kilonzo GP, Ross MW & Leshabari MT (2005) The emerging heroin epidemic in Dar es Salaam, Tanzania: Youth hangouts, maghetto and injecting practices, *AIDS Care*, 17: S65–76.
13. UNODC (2005) *HIV prevention among young injecting drug users*. Vienna: United Nations Office on Drugs and Crime.
14. Donoghoe M, Dolan K & Stimson G (1992) Syringe Exchange in England: an overview. London: Tufnell Press.
15. Hickman M, Hope V, Brady T et al. (2007) Hepatitis C virus (HCV) prevalence, and injecting risk behaviour in multiple sites in England in 2004, *Journal of Viral Hepatitis*, 14: 645–652.
16. UNICEF (2011) *Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood*. New York: United Nations Children's Fund.
17. UNAIDS (2010) *Global Report: UNAIDS report on the global AIDS epidemic 2010*. Geneva: UNAIDS.
18. Cook C (Ed.) (2010) *Global State of Harm Reduction 2010: Key Issues for Broadening the Response*. London: IHRA.
19. Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA (2010) HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage, *Lancet*, 375: 1014–28.
20. Szirom T, King D & Desmond K (2004) *Barriers to service provision for young people with substance misuse and mental health problems*. Canberra: NYARS.
21. Sharma M, Oppenheimer E, Saidel T, Loo V & Garg R (2009) A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region, *AIDS*, 23 (11): 1405–1413.
22. Farrell M, Marsden J, Ali L & Ling W (2002) Methamphetamine: drug use and psychoses becomes a major public health issue in the Asia Pacific region, *Addiction*, 97: 771–772.
23. Nai Zindagi (2009) *Rapid Situation Assessments of HIV prevalence and risk factors among people injecting drugs in four cities of the Punjab*. Islamabad, Pakistan: Nai Zindagi.
24. World Health Organization (2002) *Adolescent friendly health services: an agenda for change*. Geneva: WHO.
25. Howard J (2011) 'Opening Doors' – increasing access to youth-friendly harm reduction, *Centrelines*, 29: 2–5. Sydney: National Drug and Alcohol Research Centre.
26. NASCOP (2012) *Most At-Risk Populations: Unveiling new evidence for accelerated programming*. Nairobi: Ministry of Health.
27. Nieburg P & Carty L (2011) *HIV Prevention Among Injection Drug Users in Kenya and Tanzania: New Opportunities for Progress*. Washington, DC: Centre for Strategic and International Studies.
28. Ogunrombi, A (2012) HIV-risk related behaviours among young people who use drugs in two urban communities in Nigeria. (Unpublished)
29. EHRN (2009) *Young people and injecting drug use in selected countries of Central and Eastern Europe*. Vilnius: Eurasian Harm Reduction Network.
30. Hartnoll R, Gyarmathy A & Zabransky T (2010) Variations in problem drug use patterns and their implications for harm reduction, in European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) *Harm reduction: evidence, impacts and challenges* (pp. 405–432). Luxembourg: Publications Office of the European Union.
31. National Treatment Agency (2009) *Guidance for the pharmacological management of substance misuse among young people*. London: Department of Health.
32. Global Commission on HIV and the Law (2011) *High Income Countries Issue Brief: Rights of Children and Young People to access HIV-related services*. New York: United Nations Development Programme.
33. Lifson AR, Halcon LL (2001) Substance abuse and high-risk needle-related behaviors among homeless youth in Minneapolis: implications for prevention. *Journal of Urban Health*, 78: 690-698.
34. Flicker S, Flynn S, Larkin J, Travers R, Guta A, Pole J & Layne C (2009) *Sexpress: the Toronto Teen Survey Report*. Toronto: Planned Parenthood Toronto.
35. WHO (2009) WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: WHO.
36. Wilson D & Halperin DT (2008) "Know your epidemic, know your response": a useful approach, if we get it right, *Lancet*, 372:423–426.
37. UNAIDS (2011) *Global AIDS Response Progress Reporting 2012 Guidelines: Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. Geneva: UNAIDS.
38. Rhodes T (2002) The 'risk environment': a framework for understanding and reducing drug-related harm, *International Journal of Drug Policy*, 13: 85–94.
39. Barrett D (2011) 'Counting the Costs of the Children's Drug War', in Barrett D (Ed.) *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People* (pp. 1-10). New York: International Debate Press.

DRUG USE AMONG MEN WHO HAVE SEX WITH MEN
Implications for harm reduction

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Introduction

Numerous studies have demonstrated that men who have sex with men (MSM) experience disproportionate levels of ill-health[1-3] compared to the general population, and are one of the highest risk groups for HIV in every part of the world.[4, 5] MSM frequently face significant stigma and discrimination from their families, communities and, in some countries, are the subject of systemic repression and persecution.[7] Often this repression and stigmatisation can make accessing appropriate health services, where they exist, problematic.[8, 9]

A significant concern among health professionals and advocates who work to improve the health and well-being of MSM relates to the prevalence of drug use within the population, its uses and its associated harms. The chapter begins with an overview of the range of drugs taken by MSM, followed by a description of prevalence across the world (where such data exist) and a discussion of data quality. It then assesses the reasons for drug use by MSM and the harms that may be associated with such use. The final section highlights interventions to help reduce the harms associated with drug use among MSM.

MSM, gay, homosexual, queer?

Terminology to describe men who are attracted to, or have sex with, other men is often carefully selected. Some men who are attracted to, or have sex with, other men may describe themselves as 'gay', while others do not. Some might use the term 'homosexual' (literally meaning they have a sexual orientation towards people of the same sex) or 'queer' (referring to a sexuality that deviates from the 'norm'). 'Men who have sex with men' (MSM) refers only to the act of sexual contact between two men and is rarely used by men themselves to describe their sexuality. Health professionals often use the term MSM because it relates to behaviour which, when considering issues such as HIV, other sexually transmitted infections (STIs) or drug use, is more important than the identity an individual might assign themselves. When working with this population it is important that you establish the term with which male clients or service users are most comfortable.

The range of drug use among MSM

Studies indicate that MSM utilise a broad range of drugs. This chapter relates only to non-prescription drugs that are considered illegal or otherwise 'recreational' in most countries. The following is a list of drugs known to be used by MSM, and includes street names or regional variations.[a]

- **Amphetamine** (speed, uppers, sulphate, whizz)
- **Cannabis** (marijuana, Mary Jane, dope, pot, spliff, hash(ish), weed, puff, grass, herb, draw, wacky backy, ganja, hemp)
- **Cocaine** (coke, Charlie, C, snow, blow, a toot, Bolivian/Peruvian/Colombian marching powder)
- **Crack cocaine** (rock, base) – essentially a super-strength cocaine
- **Crystal methamphetamine** (Crystal, Tina, meth, ice, crank) – essentially a super-strength amphetamine
- **Ecstasy** (E, MDMA, X, XTC)
- **GHB/GBL** (Gina, G, liquid ecstasy)
- **Heroin** (smack, skag, junk, horse)
- **Ketamine** (K, special K, vitamin K)
- **LSD** (acid, a trip)
- **Mephadrone** (MCAT, Meow-meow)
- **Poppers** (amyl, butyl, isobutyl nitrate, aromas, liquid incense) – the formula frequently changes, but they are chemicals from the alkyl nitrite family.

Prevalence of drug use among MSM

Establishing the prevalence of drug use among MSM in different parts of the world is challenging. In a large number of countries, homosexuality, or sex between men, is illegal, making the collection of data relating to sexuality challenging and complex. Even where research about MSM and drug use has been conducted, it is often difficult, or impossible, to compare because of inconsistent methodologies, such as different recruitment methods, a focus on different drugs or use in different settings or across varying time frames (e.g. within the last month, the last three months, within the past 12 months or drug use ever in life). In addition, the use of drugs may vary wildly not only from one region of the world to another but from one country to the next, between cities in the same country or even among different venues within the same city. As is the case with other populations, drug use among MSM in various areas can change significantly within short spaces of time, meaning that data collected can quickly become redundant.

The literature review that follows is written with the best data publicly available in English.

a For a detailed account of these drugs commonly used by MSM and their effects, see http://www.drugfucked.tht.org.uk/.

Africa

There has been relatively little research in general conducted with MSM in African nations, and only a small number of studies that have specifically explored drug use. Much of the research that has been conducted relates solely to injecting drug use (IDU), with rates among MSM ranging from 3.4 to 12% in Malawi and 8% in Namibia,[10] all within the last six months, and 14% within the last year among MSM in Zanzibar.[11] Drug use among MSM in South Africa has received more attention than in other countries, with one study reporting that 11% of men described having sex while under the influence of drugs within the previous 12 months,[12] and further mixed-method research suggesting significant regional variation in drug use across different cities in the country.[13, 14] For example, crystal methamphetamine was the most commonly used drug among MSM in Cape Town, but dipipanone hydrochloride was more common in Durban.

Asia

The 2010 Asian MSM Internet Sex Survey[15] included 10,861 respondents recruited online from China, Singapore, Malaysia, Taiwan, Hong Kong, Thailand, Japan, Indonesia, the Philippines, Korea and Vietnam. Table 1 displays the levels of reported drug use within the past six months (findings are not publicly available at country level). Data from this survey also indicate that drug use was significantly higher among MSM with diagnosed HIV, particularly with respect to crystal methamphetamine, ketamine and ecstasy. A 2009 study in Thailand identified an association between HIV prevalence and a history of drug use.[16]

Table 1: Levels of drug use among respondents in the Asian MSM Internet Sex Survey

Stimulant drugs	% Use in last 6 months
Crystal meth	4.0
Ecstasy	8.1
Cocaine	1.8
Poppers	6.1
Cannabis	3.6
GHB	2.3
Ketamine	5.3

Several other studies across the continent have explored lifetime usage of drugs, with levels ranging from 6% in Vietnam[17] and 11.7% in Taiwan[18] to nearly 65% in Japan[19] (although much of this variation can be accounted for by differences in sampling and recruitment).

Levels of IDU among MSM in Asia have generally been low.[17, 20, 21] There are currently no data publically available on the prevalence of drug use among MSM living in Central Asian Republics.

Australasia

Frequent gay community surveys in Australia and New Zealand provide a detailed picture of drug use among MSM in these countries, as displayed in table 2.

In Australia, the proportion of men reporting any IDU in the previous six months has remained stable at around 5–6% for the last ten years.[26] While the percentage of men using poppers has fallen slightly over the last nine years, still in 2009 an average of 31.8% of MSM across the country reported use within the previous six months. The Australian surveys typically identify higher rates of all drug use in Sydney compared to other parts of the country.

Table 2: Prevalence of drug use among MSM in Australasia within the previous 6 months

	Cocaine %	Poppers %	Cannabis %	Ecstasy %	Methamphetamine %	Ketamine %	Source
Australia (Sydney)	20.6	40.4	27.9	29.8	11.1	9.6	2011 Gay Community Periodic Survey Sydney[22]
Australia (Melbourne)	12.4	35.4	27.6	21.5	8.9	6.0	2011 Gay Community Periodic Survey Melbourne[23]
Australia (Adelaide)	7.1	21.9	34.6	17.2	9.5	2.1	2011 Gay Community Periodic Survey Adelaide[24]
New Zealand (Auckland)	7.3	40	37.5	21.2	7.9	5.7	2006 Gay Auckland Periodic Sex Survey[25]

Caribbean

Prevalence data for drug use among MSM in the Caribbean is extremely scarce. Secondary analysis of a representative general household survey data collected in Puerto Rico[27] reported lifetime use of cannabis (63.4%), amphetamines (20%) and heroin (20%). A quarter of MSM reported using cannabis (24.4%) and cocaine (24.4%) in the past 12 months. The UNAIDS-sponsored Caribbean Men for Men Internet Sex Survey (CARIMIS) is underway at the time of writing and will report its findings in the summer of 2012. This survey will provide drug use data for each of the Caribbean nations and territories and will be a useful source of information for the development of future interventions.[b]

Europe

Comprehensive data on drug use among MSM was collected as part of the European Man for Man Internet Sex Survey (EMIS). This online survey was open for completion in 25 languages in the summer of 2010 and recruited a total of 181,495 men. It asked questions about use of a range of drugs within the previous 4 weeks (as displayed in table 3). While country-level data will become available in the near future, at present EMIS data are reported on a European sub-regional level.

Research in the UK[29] that explored drug use levels among MSM within the previous 12 months reported levels ranging from 39.4% for poppers, 27.7% for cannabis, 18.5% for ecstasy and 4.7% for methamphetamine (with significant regional variations evident and highest usage in London.)[30] Drug use among MSM in Catalonia, Spain, within the previous 12 months followed a broadly similar pattern (poppers 40.8%; cannabis 26.0%; ecstasy 10.2% and methamphetamine 3.0%.)[31]

Table 3: Use of drugs among MSM across Europe within the previous four weeks

Region of residence	poppers use in last 4 weeks	cannabis (or LSD) use in last 4 weeks	Heroin/crack use in last 4 weeks	party drugs* use in last 4 weeks
West: Belgium, France, Rep. of Ireland, the Netherlands, the UK	28.3	13.8	0.4	10.6
North West: Denmark, Finland, Norway, Sweden	13.8	6.2	0.3	3.1
Central-West: Austria, Switzerland, Germany, Luxembourg	22.0	10.1	0.2	4.9
South West: Greece, Spain, Italy, Portugal	10.9	13.6	0.4	6.6
North East: Estonia, Lithuania, Latvia	6.2	4.9	0.2	2.3
Central-East: Czech Republic, Hungary, Poland, Slovenia, Slovakia	15.2	10.2	0.3	4.9
South East (EU): Bulgaria, Cyprus, Malta, Romania	7.9	5.9	0.3	3.0
South East (non-EU): Bosnia & Herzegovina, Croatia, Macedonia, Serbia, Turkey	7.7	8.6	0.4	2.5
East: Belarus, Moldova, Russia, Ukraine	8.3	5.2	0.3	2.4

** Party drugs include ecstasy, amphetamine, methamphetamines, mephadrone, GHB, ketamine and cocaine. Adapted from EMIS Network.*[28]

b See http://www.carimis.org

North America

There are no publically available national MSM drug use prevalence data for the USA: prevalence is reported only at a city or state level. This approach is appropriate in terms of influencing local harm reduction interventions but makes country-level comparison difficult. Table 4 provides a snapshot of drug use prevalence in different cities, established via multiple surveys.

Similar levels of poppers use among MSM have been observed in Canada.[35]

A significant body of research has addressed methamphetamine use among MSM in the USA. This drug is commonly associated with euphoria, decreased sexual inhibition and hypersexual behaviour.[36, 37] Analysis of data collected annually between 1996 and 2007 in Los Angeles found levels of methamphetamine use within the last 12 months varying from 11% to 53%.[38] A longitudinal study of club drug using gay and bisexual men in New York found that 64.6% of their sample reported using methamphetamine within the previous four months.[39]

Levels of IDU among MSM in both Canada and the USA have typically been very low.[2, 40, 41, 42]

South America

Between 1999 and 2002 a series of 19 sero-epidemiological cross-sectional surveys[43] were conducted among MSM in seven different South American nations: Argentina, Bolivia, Colombia, Ecuador, Paraguay, Peru and Uruguay. These surveys asked about history of drug use (ever) and analysed such usage in light of national HIV prevalence to identify significant associations. The surveys recruited a total of 13,847 MSM participants by opportunistic, community sampling, although the number of participants varied considerably between countries. Reported data from Peru appear incomplete; therefore, Peru is not included in Table 5.

Table 4: Prevalence of drug use among MSM across the USA

City/region (Year of data collection)	Methamphetamine %	Cannabis %	Ecstasy %	Cocaine %	Poppers %	Study type	Time frame of drug use	Reference
New York (2007)	6.2	27.9	8.38	12.03	24.46	Community survey of MSM (n=740)	Within the last 3 months	Carpiano et al. (2011)[32]
Chicago (2002–2003)	6	28	13	12	-	Household survey. Data from HIV-negative MSM (n=151)	Within the last 6 months	Fendrich et al. (2010)[33]
San Francisco (1999–2001)	23*	-	-	19	37	Randomised behavioural intervention of MSM accessing counselling (n=736)	Lifetime use	Colfax et al. (2005)[34]

** Includes speed and any form of methamphetamine*

Table 5: Reported drug use (ever) among MSM from six South American countries

Drug used (ever)	Colombia %	Ecuador %	Bolivia %	Argentina %	Uruguay %	Paraguay %
Cannabis	31.2	17.4	21.4	15.4	14.8	42.4
Heroin	2.4	0.6	0.0	0.4	0.2	4.3
Cocaine	14	4.9	17.2	6.7	21.9	26.4

[Adapted from Bautista et al.][43]

Broad patterns of drug use among all MSM

In reviewing this broad literature from across the globe, several patterns in MSM drug use emerge. Firstly, most drug use among MSM appears to be episodic, with weekly or monthly use far higher than daily.[15, 29, 44] This might suggest that *most* MSM who report drug use are not drug-dependent but instead use drugs for specific purposes (such as when partying, socialising or when seeking or having sex).[45] Episodic drug use may also reflect specific periods of stress or uncertainty, such as an HIV diagnosis, struggles in the process of 'coming out', or may occur in combination with periods of depression or anxiety.

Secondly, MSM, or gay men, are not a homogenous group in terms of drug use. Prevalence of use was very often higher among further marginalised or minority groups, such as ethnic minority gay men in the USA,[46-48] and is often higher among younger men.[42, 49, 50] Use of most drugs (except cannabis) tends to be higher among MSM living in large urban centres, particularly those with large gay populations such as Berlin, Sydney, London and San Francisco than it is among men in more rural areas.[26, 30]

Thirdly, polydrug use (taking more than one drug during the same session or within a fixed time frame) is common among MSM, particularly with regards to stimulants ('party drugs') such as ecstasy, cocaine, amphetamines or ketamine.[34, 51]

Fourthly, across the world, the prevalence of IDU, especially heroin, was generally very low. Other than in South Africa, reported levels of IDU in non-purposive samples rarely exceeded 5%. Previous authors[52] have suggested that the reason insufficient attention has been paid to drug use among MSM is specifically because levels of heroin use – often the focus of drug harm reduction services – have been comparatively low. In the absence of heroin-related health concerns, and those social or community harms such as crime which are often associated with problematic heroin use, the harm reduction needs of gay men have not always featured on the radar of policymakers.

Harms associated with drug use among MSM

Harms to physical and mental health

The physical and mental health harms associated with cocaine, heroin, ecstasy, cannabis, LSD and amphetamines are well documented, and are likely to be similarly represented in MSM.

Crystal methamphetamine is a super-strength amphetamine stimulant, which results in high-energy feelings of confidence, invincibility or impulsiveness. Continuous stimulation of the nervous system by crystal methamphetamine has been known to cause anxiety, depression, confusion, insomnia, psychosis and suicidal ideation,[53] and long-term use may also result in a loss of motor control or memory.[54]

GHB/GBL (Gamma-butyrolactone) is a party drug that brings a sense of euphoria. It is usually sold diluted in water, although just an extra millilitre of GBL over a moderate dose can result in an overdose, the effects of which are often unconsciousness, coma or death by respiratory depression. GBL can be addictive (although this usually only develops over longer periods of time) and, therefore, can result in significant withdrawal effects.

After-effects of inhaling poppers can include headaches, skin rashes, sinus pains and burns, but only if the liquid comes into contact with the skin. They have also been known to cause nausea and vomiting. Inhaling poppers after taking anti-impotence drugs, such as Viagra or Cialis, can result in a dangerous drop in blood pressure.[55] This may be more likely to occur if also taking a protease inhibitor as part of HIV anti-retroviral therapy (ART).

There is evidence to suggest that the use of a range of drugs, particularly methamphetamines, GBL and ecstasy, might have a detrimental impact on adherence to ART.[56, 57]

Harms to sexual health and well-being

The association between drug use (particularly methamphetamine, ecstasy and cocaine) and sexual risk behaviours is complex, and a comprehensive analysis of this literature is beyond the scope of this chapter (for a review, see Corsi et al.[58] or Romanelli et al.[59]). It is possible to say that there is a clear association between certain drug use and sex that carries a risk of HIV transmission. However, it is not clear whether this is causal or simply co-relational.

Significant attention has been paid to the role of methamphetamine in HIV transmission risk behaviours, particularly in the USA. This drug can cause feelings of hypersexualisation and is commonly utilised as part of sexual marathons (protracted periods of sexual activity) and group sex activities.[60-62] Ensuing rectal trauma facilitates the transmission of HIV. Numerous studies have suggested that the use of methamphetamine causes high-risk sexual behaviour,[63-65] perhaps via a myopic mechanism or the removal of sexual inhibitions. However, other studies have challenged this causal pathway.[66, 67]

Other associations with high-risk sexual behaviour have been identified in relation to ecstasy,[68] GHB/GBL[69] and ketamine.[70] Men who reported polydrug use in the recent past (up to three months) are more likely to report HIV risk behaviours than men who took only one drug.[44, 47]

Poppers cause blood vessels to dilate and also relax the anal sphincter muscle. This can make receptive anal intercourse more comfortable for some men. The process of vasodilatation, and the fact that sex may be rougher or last for longer while using poppers, means that their use during sero-discordant anal intercourse can increase the probability of HIV transmission by a factor of three.[71, 72]

Motivations for drug use

There has been relatively little research exploring the reasons or motivations for drug use among MSM or the personal and social context within which drug use occurs, particularly outside North America, Western Europe and Australia. Numerous authors[52, 73] have highlighted that in most settings the majority of venues to meet other men for social and/or sexual interaction are those where alcohol is served and drug use is common. Clubs and bars are the centre of most 'gay scenes', and drug use itself is normalised within this environment. Drugs often serve a very deliberate purpose in helping individuals to relax, to socialise, to mitigate social unease and to gain confidence in seeking sexual partners.[74] The value of these actions and activities should not be underestimated by those seeking to support MSM to reduce any harm that may be associated with their drug use.

Further to this, a significant body of research indicates that (crystal) methamphetamines are often used by MSM to psychologically enhance sexual experience, to maintain sexual activity over long periods of time and to facilitate sexual desires by dissipating sexual inhibitions.[75-77] Drugs may also help MSM with diagnosed HIV, in particular, to 'cognitively escape' from fear of rejection and negative self-perception and to cope with broader emotional and physical demands of living with HIV on a daily basis.[78]

The best indicator of whether drug use is problematic, or is in danger of becoming so, is if the individual concerned considers their use in this way. As already discussed, drug use among MSM in general tends to be episodic in nature, but dependency can still develop and significant harm can result. For many men, drug use becomes problematic when the costs or side-effects associated with usage impinge on their ability to live the life they are comfortable or content with.

Harm reduction interventions to meet the needs of MSM

Drug use interventions for MSM need to empower men with honest information about what the possible effects (both positive and negative) might be of taking a range of drugs. They should seek to support men, and those around them, to control or limit their use, or to limit the harms associated with such use, at times when they consider their drug use is causing harm to themselves or others. This can be accomplished in a number of ways, ranging from provision of educational information to psychotherapeutic support and pharmacological interventions. Whatever the setting, interventions should take into account each man's personal circumstances, acknowledging that drugs can serve a useful purpose in their lives, particularly in terms of mitigating psychological unease or by facilitating social or sexual contact. Health professionals should take account of these motivations and work with men to identify what level or type of drug use they are comfortable with, and help to reduce harms associated with this use.

Numerous civil society organisations in Australia, Canada, Germany, Poland, the UK and USA have developed websites or printed information booklets that explain the effects of drugs commonly used by MSM, and describe ways in which any associated harms might be mitigated. They often also include information about the legal status of each drug, and provide referral information for direct contact services if readers consider their use problematic.

Provision of psycho-therapeutic services or counselling specifically designed to address problematic drug use among MSM varies considerably across the world and within individual countries. They are known to currently exist in Australia, Canada, Germany, New Zealand, Norway, South Africa,[79] Spain, Sweden, the UK and USA. A service in Hong Kong ran between 2007 and 2009. Such therapy includes drop-in advice, motivational interviewing, support groups and cognitive behavioural therapy. Many of these interventions appear grounded in evidence from evaluations of the general population (for review, see Shearer[80]), although there have been a number of evaluations of behaviour change interventions related to methamphetamine use specifically among MSM.[81-83] In many instances, such evaluated programmes focus on reducing harms to sexual health and the likelihood of contracting or transmitting HIV, with mixed success (for review, see Rajasingham et al.[57]). In a very small number of settings, primarily the UK and USA, pharmacologic interventions exist to address methamphetamine use, but their effectiveness is still uncertain.[84, 85]

In Australia, and in many parts of Europe and North America, harm reduction services are situated within the HIV prevention sector, largely because of the association with sexual risk behaviours and because this sector is well established with strong links to the gay communities they serve. There is currently *no* provision of any harm reduction interventions specifically targeting MSM in Africa (except the Republic of South Africa), Asia, the Caribbean or South America. While MSM could access services for the general population (where they exist), previous research has reported that they often feel uncomfortable or unwelcome in such environments.[52] Drug use among MSM is frequently associated with 'gay scene' social activity or with sex, and many services for the general population may not be sufficiently knowledgeable, skilled or, indeed, accepting to help address drug use that occurs within these contexts.

Case study: antidote @ London friend

This organisation works exclusively with lesbian, gay, bisexual and transgender (LGBT) people who use drugs, the majority being gay men in their 20 and 30s, mostly employed and financially self-supporting. In the past three to four years the drug use profile of their clients has shifted towards crystal meth and GHB/GBL, with many people using them in sexual contexts. There has been a trend to inject crystal, and for GBL use to rapidly escalate to dependence levels (dosing around every two hours), so the type of intervention has had to extend to medical (mainly prescribing for GBL detox), having been mainly psychosocial. This typically involves administering benzodiazepines in high doses (often > 100mg/24hrs),[6] which they offer in partnership with the NHS Club Drug Clinic, to help clients deal with withdrawal symptoms. Dependence on GBL is an entirely new phenomenon for members of the community, who have used other drugs, often without major problems, for many years.

Most service users do not fit the typical profile of mainstream UK drug services or the typical drug patterns presenting there. By offering a targeted service they are able to remove many of the barriers of users not identifying with generic support. Being an LGBT service means that people feel less judged and more able to talk about their full range of associated problems, which they may feel inhibited to do in generic services, particularly as it may involve talking about sexual behaviours they feel ashamed of.

They work around reasons for using, dealing with cravings and trigger situations, negotiating safer boundaries and improving well-being overall; these are all typical substance misuse interventions, but it is their provision in a safe and understanding LGBT environment which sets the service apart. [c]

Conclusions

This review has highlighted the extent of drug use among MSM and summarised the range of harms that can be associated with their use**.** Drug use is common among MSM and is well established in gay social and sexual environments. Given the significant harms associated with many of the drugs that MSM use, harm reduction interventions that meet the specific needs of MSM should be prioritised in all parts of the world.

Establishing the prevalence of drug use among MSM living in Central Asian Republics, South America, the Caribbean and Africa is a research priority. Systematic population and local-level estimations for MSM populations are a necessary precursor to this. There is a need for more qualitative research in many parts of the world that explores the reasons why MSM use drugs and the personal and social context of this use.

Harm reduction practitioners should seek to understand variations in drug use among MSM in their local area and tailor interventions accordingly. They should attend to changes in such use over time, and be accepting of the social and sexual environments in which drug use often occurs. Harm reduction practitioners should also attend to ethnic or sexuality variation within MSM communities, acknowledging that further marginalised sections of the population are more likely to use drugs and for such use to be problematic. As the evidence base for prevalence, motivations, context and harms associated with drug use among MSM evolves, so it would be beneficial to develop toolkits for effective interventions for rollout in various settings.

As long as homosexuality – or acts of sex between men – is criminalised, and as long as MSM face stigma and persecution, it will remain a significant challenge to develop and deliver effective interventions to meet the complex needs that this review identifies. Legal and policy reforms relating to MSM are required in a large number of countries if prevention of HIV transmission and a reduction in other harms associated with drug use is to be realised.

References

1. Guasp A (2010) *Gay and bisexual men's health survey*. London: Stonewall.
2. Stall R et al. (2001) Alcohol use, drug use and alcohol-related problems among men who have sex with men: the Urban Men's Health Study, *Addiction*, 96(11): 1589–601.
3. Dilley JA et al. (2010) Demonstrating the importance and feasibility of including sexual orientation in public health surveys: health disparities in the Pacific Northwest, *American Journal of Public Health*, 100(3): 460–7.
4. Baral S et al. (2007) Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: a systematic review, *PLoS Medicine*, 4(12): e339.
5. Beyrer C et al. (2010) The expanding epidemics of HIV type 1 among men who have sex with men in low- and middle-income countries: diversity and consistency, *Epidemiologic Reviews*, 32(1): 137–51.
6. McDonough M et al. (2004) Clinical features and management of gamma-hydroxybutrate (GHB) withdrawal: a review, *Drug and Alcohol Dependence*, 75(1): 3–9.
7. Wolitski RJ, Stall R & Valdiserri R (2008) Unequal Opportunity: Health Disparities affecting Gay and Bisexual Men in the United States. New York: Oxford University Press.
8. Ayala G et al. (2010) *HIV prevention with MSM: Balancing evidence with rights based principles of practice*. Oakland: The Global Forum on MSM & HIV (MSMGF).
9. Wilson P et al. (2011) *Access to HIV prevention services and attitudes about emerging strategies: A global survey of men who have sex with men (MSM) and their health care providers*. Oakland: The Global Forum on MSM and HIV (MSMGF).
10. Baral S et al. (2009) HIV prevalence, risks for HIV infection, and human rights among men who have sex with men (MSM) in Malawi, Namibia, and Botswana. *PLoS One*, 4(3): e4997.
11. Johnston LG et al. (2010) HIV risk and the overlap of injecting drug use and high-risk sexual behaviours among men who have sex with men in Zanzibar (Unguja), Tanzania, *The International Journal on Drug Policy*, 21(6): 485–92.
12. Metcalfe MJ & Rispel L (2009) Exposing a hidden epidemic among men who have sex with men, *HSRC Review*, 7(2): 4–5.
13. Parry C et al. (2008) Rapid assessment of drug use and sexual HIV risk patterns among vulnerable drug-using populations in Cape Town, Durban and Pretoria, South Africa, *SAHARA Journal: Journal of Social Aspects of HIV/AIDS Research Alliance*, 5(3): 113–9.
14. Parry C et al. (2008) Rapid assessment of drug-related HIV risk among men who have sex with men in three South African cities, *Drug and Alcohol Dependence*, 95(1–2): 45–53.

c See http://www.londonfriend.org.uk

15. Wei C et al. (2012) Patterns and levels of illicit drug use among men who have sex with men in Asia, *Drug and Alcohol Dependence*, 120(1–3): 246–9.
16. Li A et al. (2008) Sexual behavior and risk factors for HIV infection among homosexual and bisexual men in Thailand, *AIDS and Behavior*, 13(2): 318–27.
17. Nguyen TA et al. (2008) Prevalence and risk factors associated with HIV infection among men who have sex with men in Ho Chi Minh City, Vietnam, *AIDS and Behavior*, 12: 476–482.
18. Ko N-Y et al. (2011) Trends of HIV and sexually transmitted infections, estimated HIV incidence, and risky sexual behaviors among gay bathhouse attendees in Taiwan: 2004–2008, *AIDS and Behavior*, 15(2): 292–7.
19. Hidaka Y et al. (2006) Substance use and sexual behaviours of Japanese men who have sex with men: a nationwide internet survey conducted in Japan, *BioMed Central Public Health*, 6: 239.
20. Colby DJ (1999) HIV knowledge and risk factors among men who have sex with men in Ho Chi Minh City, Vietnam, *Journal of Acquired Immune Deficiency Syndromes*, 32(1): 80–5.
21. He Q et al. (2009) High prevalence of risk behaviour concurrent with links to other high-risk populations: a potentially explosive HIV epidemic among men who have sex with men in Guangzhou, China, *Sexually Transmitted Infections*, 85(5): 383–90.
22. Hull P et al. (2011) *Gay community periodic survey, Sydney February 2011*. Sydney: National Centre for HIV Social Research.
23. Lee E et al. (2011) *Gay community periodic survey, Melbourne 2011*. Sydney: National Centre for HIV Social Research.
24. Lee E et al. (2011) *Gay community periodic survey, Adelaide 2011*. Sydney: National Centre for HIV Social Research.
25. Saxton P, Dickson N & Hughes T (2006) *GAPSS 2006: Findings from the Gay Auckland Periodic Sex Survey*. Auckland: New Zealand AIDS Foundation.
26. Holt M, Mao L, Prestage G, Zablotska I & de Wit J (2011) *Gay Community Periodic Surveys: National Report 2010*. Sydney: National Centre in HIV Social Research, University of New South Wales.
27. Colon-Lopez V et al. (2011) HIV-related risk behaviors among a sample of men who have sex with men in Puerto Rico: an overview of substance use and sexual practices, *Puerto Rico Health Sciences Journal*, 30(2): 65–8.
28. EMIS Network (2012 forthcoming) *The European MSM Internet Survey Final Report*. http://www.emis-project.eu/publications
29. Hickson F et al. (2007) *Consuming passions: findings from the United Kingdom Gay Men's Sex Survey 2005*. London: Sigma Research.
30. Bonell CP et al. (2010) Methamphetamine use among gay men across the UK, *The International Journal on Drug Policy*, 21(3): 244–6.
31. Folch C et al. (2010) Correlates of intensive alcohol and drug use in men who have sex with men in Catalonia, Spain, *European Journal of Public Health*, 20(2): 139–45.
32. Carpiano RM et al. (2011) Community and drug use among gay men: the role of neighborhoods and networks, *Journal of Health and Social Behavior*, 52(1): 74–90.
33. Fendrich M et al. (2010) Sexual risk behavior and drug use in two Chicago samples of men who have sex with men: 1997 vs. 2002, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 87(3): 452–66.
34. Colfax G et al. (2005) Longitudinal patterns of methamphetamine, popper (amyl nitrite), and cocaine use and high-risk sexual behavior among a cohort of san francisco men who have sex with men, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 82(1 Suppl 1): i62–70.
35. Lampinen TM et al. (2007) Nitrite inhalant use among young gay and bisexual men in Vancouver during a period of increasing HIV incidence, *BioMed Central Public Health*, 7: 35.
36. Halkitis P, Parsons J & Stirratt MJ (2001) A double epidemic: crystal methamphetamine use and its relation to HIV prevention among gay men, *Journal of Homosexuality*, 41: 17–35.
37. Green AI & Halkitis PN (2006) Crystal methamphetamine and sexual sociality in an urban gay subculture: an elective affinity, *Culture, Health & Sexuality*, 8(4): 317–33.
38. Reback CJ, Shoptaw S & Grella CE (2008) Methamphetamine use trends among street-recruited gay and bisexual males, from 1999 to 2007, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 85(6): 874–879.
39. Halkitis PN, Green KA & Mourgues P (2005) Longitudinal investigation of methamphetamine use among gay and bisexual men in New York City: findings from Project BUMPS, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 82(1 Suppl 1): i18–25.
40. Centers for Disease Control and Prevention (2008) Trends in HIV/AIDS diagnoses among men who have sex with men – 33 states, 2001–2006, *Morbidity and Mortality Weekly Report*, 57(25): 681–6.
41. Clatts MC, Goldsamt LA & Yi H (2005) Drug and sexual risk in four men who have sex with men populations: evidence for a sustained HIV epidemic in New York City, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 82(1 Suppl 1): i9–17.
42. Thiede H et al. (2003) Regional patterns and correlates of substance use among young men who have sex with men in 7 US urban areas, *American Journal of Public Health*, 93(11): 1915–21.
43. Bautista CT et al. (2004) Seroprevalence of and risk factors for HIV-1 infection among South American men who have sex with men, *Sexually Transmitted Infections*, 80(6): 498–504.
44. Halkitis P & Parsons J (2002) Recreational drug use and HIV-risk sexual behaviour among men frequenting gay social venues, *Journal of Gay & Lesbian Social Services*, 14(4): 19–38.
45. Santos GM, Das M & Colfax GN (2011) Interventions for non-injection substance use among US men who have sex with men: what is needed, *AIDS and Behavior*, 15 Suppl 1: S51–6.
46. Choi K-H et al. (2005) Substance use, substance choice, and unprotected anal intercourse among young Asian American and Pacific Islander men who have sex with men, *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, 17(5): 418–29.
47. Fernandez MI et al. (2005) High rates of club drug use and risky sexual practices among Hispanic men who have sex with men in Miami, Florida, *Substance Use & Misuse*, 40(9–10): 1347–62.
48. Grov C et al. (2006) Exploring racial and ethnic differences in recreational drug use among gay and bisexual men in New York City and Los Angeles, *Journal of Drug Education*, 36(2): 105–23.
49. Prestage G et al. (2007) Predictors of frequent use of amphetamine-type stimulants among HIV-negative gay men in Sydney, Australia, *Drug and Alcohol Dependence*, 91(2–3): 260–8.
50. Prestage G et al. (2007) Use of illicit drugs among gay men living with HIV in Sydney, *AIDS*, 21 Suppl 1: S49–55.
51. Operario D et al. (2006) Prevalence and correlates of substance use among young Asian Pacific Islander men who have sex with men, *Prevention Science: the Official Journal of the Society for Prevention Research*, 7(1): 19–29.
52. Keogh P et al. (2009) *Wasted opportunities: problematic alcohol and drug use among gay men and bisexual men*. London: Sigma Research.
53. Perdue T et al. (2003) Depression and HIV risk behavior among Seattle-area injection drug users and young men who have sex with men, *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, 15(1): 81–92.
54. Nordahl TE, Salo R & Leamon M (2003) Neuropsychological effects of chronic methamphetamine use on neurotransmitters and cognition: a review, *The Journal of Neuropsychiatry and Clinical Neurosciences*, 15(3): 317–25.
55. Carter M (2011) *Poppers* http://www.aidsmap.com/Poppers/page/1045243/ Accessed 17 April 2012.
56. Halkitis PN, Kutnick AH & Slater S (2005) The social realities of adherence to protease inhibitor regimens: substance use, health care and psychological states, *Journal of Health Psychology*, 10(4): 545–58.
57. Rajasingham R et al. (2012) A systematic review of behavioral and treatment outcome studies among HIV-infected men who have sex with men who abuse crystal methamphetamine, *AIDS Patient Care and STDs*, 26(1): 36–52.
58. Corsi KF & Booth RE (2008) HIV sex risk behaviors among heterosexual methamphetamine users: literature review from 2000 to present, *Current Drug Abuse Reviews*, 1(3): 292–6.
59. Romanelli F, Smith KM & Pomeroy C (2003) Use of club drugs by HIV-seropositive and HIV-seronegative gay and bisexual men, *Topics in HIV Medicine: a Publication of the International AIDS Society, USA*, 11(1): 25–32.
60. Prestage G et al. (2009) The role of drugs during group sex among gay men in Australia, *Sexual Health*, 6(4): 310–7.
61. Schilder AJ et al. (2005) Crystal methamphetamine and ecstasy differ in relation to unsafe sex among young gay men, *Canadian Journal of Public Health/Revue canadienne de santé publique*, 96(5): 340–3.
62. Semple SJ et al. (2009) Sexual marathons and methamphetamine use among HIV-positive men who have sex with men, *Archives of Sexual Behavior*, 38(4): 583–90.
63. Nakamura N et al. (2011) Methamphetamine use, attitudes about condoms, and sexual risk behavior among HIV-positive men who have sex with men, *Archives of Sexual Behavior*, 40(2): 267–72.
64. Fisher DG et al. (2011) Methamphetamine and Viagra use: relationship to sexual risk behaviors, *Archives of Sexual Behavior*, 40(2): 273–9.
65. Forrest DW et al. (2010) Crystal methamphetamine use and sexual risk behaviors among HIV-positive and HIV-negative men who have sex with men in South Florida, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 87(3): 480–5.
66. Grov C et al. (2008) In the shadows of a prevention campaign: sexual risk behavior in the absence of crystal methamphetamine, *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, 20(1): 42–55.
67. Rawstorne P et al. (2007) Associations between crystal methamphetamine use and potentially unsafe sexual activity among gay men in Australia, *Archives of Sexual Behavior*, 36(5): 646–54.
68. Klitzman RL et al. (2002) MDMA ('ecstasy') use, and its association with high risk behaviors, mental health, and other factors among gay/bisexual men in New York City, *Drug and Alcohol Dependence*, 66(2): 115–25.
69. Carey JW et al. (2009) Drug use, high-risk sex behaviors, and increased risk for recent HIV infection among men who have sex with men in Chicago and Los Angeles, *AIDS and Behavior*, 13(6): 1084–96.
70. Rusch M et al. (2004) Unprotected anal intercourse associated with recreational drug use among young men who have sex with men depends on partner type and intercourse role, *Sexually Transmitted Diseases*, 31(8): 492–8.
71. Buchbinder SP et al. (200) Sexual risk, nitrite inhalent use, and lack of circumcision associated with HIV seroconversion in men who have sex with men in the United States, *Journal of Acquired Immune Deficiency Syndromes*, 39(1): 82–99.
72. Macdonald N et al. (2008) Factors associated with HIV seroconversion in gay men in England at the start of the 21st century, *Sexually Transmitted Infections*, 84(1): 8–13.
73. Bauermeister JA (2008) Latino gay men's drug functionality: the role of social networks and social support, *Journal of Ethnicity in Substance Abuse*, 7(1): 41–65.
74. Fazio A, Hunt G & Moloney M (2011) "It's one of the better drugs to use": perceptions of cocaine use among gay and bisexual Asian American men, *Qualitative Health Research*, 21(5): 625–41.
75. Semple SJ et al. (2009) Sexual risk behavior associated with co-administration of methamphetamine and other drugs in a sample of HIV-positive men who have sex with men, *American Journal on Addictions*, 18(1): 65–72.
76. Halkitis PN, Fischgrund BN & Parsons JT (2005) Explanations for methamphetamine use among gay and bisexual men in New York City, *Substance Use & Misuse*, 40(9–10): 1331–45.
77. Kurtz SP (2005) Post-circuit blues: motivations and consequences of crystal meth use among gay men in Miami, *AIDS and Behavior*, 9(1): 63–72.
78. Semple SJ, Patterson TL & Grant I (2002) Motivations associated with methamphetamine use among HIV+ men who have sex with men, *Journal of Substance Abuse Treatment*, 22(3): 149–56.
79. Petersen P et al. (2009) 'Intervening to address drug use and sexual HIV risk among men who have sex with men in Cape Town and Pretoria, South Africa'. 14th National Institute on Drug Abuse International Forum, Nevada, USA.
80. Shearer J (2007) Psychosocial approaches to psychostimulant dependence: a systematic review, *Journal of Substance Abuse Treatment*, 32(1): 41–52.
81. Lyons T et al. (2010) Breaking the bond between stimulant use and risky sex: a qualitative study, *Substance Abuse*, 31(4): 224–30.
82. Rose VJ et al. (2006) Assessing the feasibility of harm reduction services for MSM: the late night breakfast buffet study, *Harm Reduction Journal*, 3: 29.
83. Knapp WP et al. (2007) Psychosocial interventions for cocaine and psychostimulant amphetamines related disorders, *Cochrane Database of Systematic Reviews*, (3): CD003023.
84. Das M et al. (2010) Feasibility and acceptability of a phase II randomized pharmacologic intervention for methamphetamine dependence in high-risk men who have sex with men, *AIDS*, 24(7): 991–1000.
85. Colfax GN et al. (2011) Mirtazapine to reduce methamphetamine use: a randomized controlled trial, *Archives of General Psychiatry*, 68(11): 1168–75.

DRUG DECRIMINALISATION POLICIES IN PRACTICE: A Global Summary

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Introduction

Decriminalisation of drug possession or use can be defined as 'the removal of sanctions under criminal law, with optional use of administrative sanctions, such as the application of civil fines or court-ordered therapeutic responses.'[2] Decriminalisation is often mistakenly understood to mean complete removal or abolition of possession offences, or confused with 'legalisation' (legal regulation of drug production and availability).[3] Under decriminalisation regimes, possession and use of small amounts of drugs are still unlawful but not *criminal* offences.

The first half of this chapter examines the harms associated with criminalising people who use drugs (PWUD) and outlines key considerations for the implementation of decriminalisation of drug possession. The second portion considers models of decriminalisation of drug possession adopted by different countries around the world. It also provides recommendations that should be taken into account when implementing decriminalisation of drug possession and highlights the growing support for adopting such a model.

International drug treaties and decriminalisation of drug possession

The modern international drug control framework was established under the 1961 UN Single Convention on Drugs,[4] but the criminalisation of personal possession was first explicitly introduced by the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances.[5] Article 3(2) of the 1988 convention states:
'...each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption.'
The commentary on the 1988 convention says explicitly that this paragraph 'amounts in fact also to a penalisation of personal consumption.' Over 180 States are parties to the three UN drug conventions (1961, 1971 and 1988), and the punitive paradigm they establish has subsequently been translated into domestic policy and law across the world.
However, the 1988 convention does not specify the nature of the sanction and additionally provides a caveat to the presumption that States must criminalise drug possession. Article 3(2) begins with the statement that any measures adopted shall be 'subject to its constitutional principles and the basic concepts of its legal systems.' State parties can, therefore, adopt a less punitive criminal justice approach to drug possession and use without breaching their international obligations.[6, a]

a For further discussion, see Bewley-Taylor D & Jelsma M (2012) The UN drug control conventions: The Limits of Latitude, *Series on Legislative Reform of Drug Policies No. 18*. Amsterdam: Transnational Institute.

Criminalisation as a risk factor in drug-related harm

The criminalisation of PWUD (directly criminalising use, or indirectly through criminalising possession) has been a central pillar of illicit drug control for over a century.

This punitive approach has come under increasing scrutiny as it has been identified as a key structural risk factor for a range of drug-related harms for people who inject drugs (PWID).[7] More commonly higher rates of HIV infection among PWID[8] are seen in environments in which injecting drug use (IDU) and other associated practices such as the provision of sterile needles are criminalised.[8] The following approaches contribute to exacerbating drug-related harms in a number of ways:

- encouraging needle sharing and hurried and higher-risk injecting – all of which increase the risk of contracting HIV, viral hepatitis and other blood-borne viruses[8]
- pushing use into unhygienic marginal environments and thus increasing the risk of infection and overdose death
- increasing the prison population of people who use and inject drugs – a high-risk environment usually with poor provision of harm reduction and HIV prevention services.[9]

Criminalisation is intended to stigmatise drug use and generate social disapproval. This has resulted in discrimination against PWUD[10] and can further increase risks by:

- undermining drug education, prevention and harm reduction efforts by alienating and marginalising key populations at higher risk of acquiring HIV, including PWID
- deterring individuals from approaching services for help or volunteering information about drug use in emergency situations such as overdose[11]
- creating informal barriers that effectively deny antiretroviral or hepatitis C treatment to people who use drugs[12, 13, 14]
- negatively impacting on wider life opportunities, including access to housing, personal finance and employment, that are all positively linked to improved health and well-being[15, b]
- justifying the continuation of counterproductive enforcement approaches, with opportunity costs for public health elements of designated drug policy budgets.

Conversely, claims for a positive deterrent effect from user-level punitive enforcement are not well supported by the limited empirical research and comparative analysis available.[16, 17] Many of the groups most vulnerable to drug-related harms

b McLaren & Mattick (2007) compared the outcomes of individuals given a non-criminal sanction in South Australia and individuals given a criminal sentence in Western Australia (pre-decriminalisation) and found that the individuals given criminal penalties were more likely to suffer negative employment, relationship and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system than the (non-criminalised) individuals in South Australia.

(including young people, PWID, those from lower socio-economic backgrounds, those with existing criminal records, and those with mental health vulnerabilities) are also likely to be among the least deterred by criminalisation.[18]

Definitions of 'decriminalisation'

'Decriminalisation' is not a strictly defined legal term, but its common usage in drug policy (and the definition used here) refers to the removal of criminal sanctions for possession of small quantities of currently illegal drugs for personal use, with optional use of civil or administrative sanctions.[2] Under this definition of 'decriminalisation', possession of drugs remains unlawful and a punishable offence (albeit not one that results in a criminal record).

A distinction is also made between *de jure* decriminalisation, involving specific reforms to the legal framework, and *de facto* decriminalisation, with a similar outcome but achieved through non-enforcement of criminal laws that technically remain in force. With the exception of some of the more tolerant policies for cannabis possession (for example, in Spain, the Netherlands and Belgium), people caught in possession under a decriminalisation model will usually have the drugs confiscated.

Policy variables

There is considerable variation in how decriminalisation models function in different jurisdictions, making international comparisons and generalisations about impacts on key indicators problematic. Each of these variables can have a significant impact on the measurable outcomes. These include:[1]

Threshold quantities

Many but not all decriminalisation policies use maximum-quantity thresholds to distinguish between trafficking or supply offences and personal possession or use offences.[19] Mexico, for example, allows possession of up to 0.5g of cocaine without prosecution, while Spain allows up to 7.5g, a fifteen-fold difference.[20] Since cocaine is usually sold in 1g units, Mexico's permissible possession level of 0.5g means it is likely that virtually everyone will exceed that threshold and be liable for criminal prosecution.

Types of administrative penalties

Non-criminal sanctions in different jurisdictions include: fines, community service orders, warnings, mandatory treatment or education sessions, driver's or professional licence suspensions, travel bans, property confiscation, associational bans, mandatory reporting, mandatory drug testing, termination of public benefits, administrative arrest, or no penalty at all.

Roles of the judiciary and police

Some jurisdictions, such as the Czech Republic and the Australian states with civil penalty schemes, allow the police to issue fines in the field for minor drug offences, similar to issuing a traffic violation. Other jurisdictions, such as Brazil and Uruguay, require individuals arrested for drug offences to appear before a judge in court to determine the charge and receive an appropriate sentence, if any.

Policy implementation

Role of medical professionals and harm reduction programmes

The effectiveness of decriminalisation of drug possession is also dependent on a number of other key considerations including investment in a wide range of harm reduction and treatment options. The relationship between a country's public health and law enforcement systems can significantly change an individual's experience following an arrest for a drug offence. For example, the significant investment in Portugal's harm reduction interventions and treatment in 2001 (see Page 5), coupled with the new decriminalisation model, saw an increase in the numbers accessing services. Many commentators have highlighted that the reduced stigma associated with drug use, due largely in part to the decision not to impose criminal sanctions, contributed to this increase.[21] As the current report shows, jurisdictions also vary greatly in the resources allocated to and availability of harm reduction and treatment programmes.

Data availability and quality

Data availability and quality are important to assess the impact for a country that has adopted decriminalisation. Incomplete, inaccurate or inconsistent data on key indicators assessing the impact of decriminalisation pose important challenges to evaluation. For example, long reporting periods between national surveys on prevalence or the manner in which drug-related deaths are recorded can make it difficult to ascertain the actual impact of the policy.

Implementation challenges

Despite the existence of a statutory, judicial or regulatory decriminalisation policy, a jurisdiction's inability or unwillingness to implement that policy in practice can make it difficult to assess a policy's merits. In Peru, for example, researchers report that police regularly arrest and detain individuals for long periods without charge for decriminalised drug offences. In practice, for those in detention, such a system does not resemble decriminalisation, despite Peruvian law instructing no penalty for certain minor possession offences. Furthermore, in some jurisdictions the impact of decriminalisation has had a 'net-widening' effect, so that while the intention of the policy is to decriminalise certain behaviour, in practice more people get caught up in the system.[22]

Social, cultural, economic and religious characteristics

A community's – or individual's – relationship to drug use is impacted by much more than a country's drug laws. Public health capacity, religiosity, cultural history, employment, inequality[23] and various other measures of social and personal well-being significantly impact drug-using behaviours in a given society. It is important to recognise that impacts and implementation of drug decriminalisation policies cannot be evaluated in a vacuum.

Growing support for decriminalisation

High-level support for decriminalisation has grown in recent years in parallel with the growing trend towards its adoption by states and jurisdictions. Alongside the development of the wider mainstream drug policy reform movement (focused primarily on recreational cannabis use), support for decriminalisation of drug possession and use in the context of HIV and other blood-borne viruses among PWID has also grown significantly among key voices in the public health community. This includes journals such as the *British Medical Journal*[24] and *Lancet*,[25] non-governmental organisations (NGOs) including the Red Cross/Red Crescent[26] and International AIDS Society (IAS),[27] and high-profile individuals including Anand Grover (UN Special Rapporteur on the Right To Health),[28] Michel Sidibé (UNAIDS Executive Director),[29] Ban Ki-Moon[30] (UN Secretary-General) and Michel Kazatchkine[31] (former Executive Director, the Global Fund to Fight HIV, Tuberculosis and Malaria). Among the UN family of agencies, UNAIDS[32] and UNDP have shown cautiously worded support in principle (but remaining reluctant to overtly use the language of 'decriminalisation'). The executive summary of the 2012 UNDP Global Commission on HIV and the Law report, for example, highlights the need to:

> Reform approaches towards drug use. Rather than punishing people who use drugs but do no harm to others, governments must offer them access to effective HIV and health services, including harm reduction programmes and voluntary, evidence-based treatment for drug dependence. [33]

Even the historically conservative UN Office on Drugs and Crime (UNODC) has increasingly adopted the narrative that 'drug use is a health problem, not a crime,'[34] and in a 2012 discussion position paper the UNODC make clear that:

> Responses to drug law offences must be proportionate. Serious offences, such as trafficking in illicit drugs must be dealt with more severely and extensively than offences such as possession of drugs for personal use. For offences involving the possession, purchase or cultivation of illicit drugs for personal use, community-based treatment, education, aftercare, rehabilitation and social integration represent a more effective and proportionate alternative to conviction and punishment, including detention.[35]

One of the highest-profile public expressions of support, in terms of signatories and media coverage, has been the Vienna Declaration,[36] which states 'The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed' and includes a call on 'governments and international organisations, including the United Nations,' to 'decriminalise drug users.'

In June 2012 the Global Commission on Drug Policy launched its second report, *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Pandemic*.[37] It highlighted that fear of criminalisation led to increased HIV risk behaviour in certain countries and that mass incarceration fuelled HIV transmission rates within prisons. The Commission, which is made up of several former presidents and other high-profile individuals, has repeatedly called for the decriminalisation of drug possession.

Decriminalisation systems around the world[c]

It is estimated that around 25–30 countries have now implemented some form of decriminalisation. Decriminalisation approaches are found mostly in Europe, Latin America and, to a lesser extent, Eurasia, as well as some parts of the USA (cannabis only) and Australia. The precise number of countries implementing such an approach depends on which definition is used, with additional problems in quantifying more localised or informal *de facto* decriminalisation policies, as well as challenges of incomplete country data. Some Southeast Asian states, such as Vietnam, nominally espouse decriminalisation of use but are not included here because, instead of criminal sanctions, they often forcibly detain drug users in 'drug detention centres' largely indistinguishable from prisons and associated with serious human rights violations.[38, 39]

The following survey is adapted from the Release report, *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*.[1]

c This information is largely taken from the report by Release: Rosmarin A & Eastwood N (2012) *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*. London: Release.

Western Europe

- Belgium decriminalised small-scale cannabis possession in 2003.[40]
- German federal law has contained decriminalisation elements since the early 1990s.[41] There is variation between different *Länder* (German states) in application.[42, d]
- Italy first decriminalised drug possession in 1975. Since then, laws and policies around drug possession have fluctuated between harsh and lenient penalties.[43]
- Spain formally decriminalised possession and private use of small amounts of drugs in 1982, following a 1974 Supreme Court ruling.[44, 45]
- The Netherlands has had a *de facto* decriminalisation policy since 1976. While remaining technically criminal, possession offences of up to 5g of cannabis (30g prior to 1996)[46] or 'one dose' of 'hard' (non-cannabis) drugs for personal use are not prosecuted.[47]

Case Study: The Portuguese decriminalisation experience

Portugal provides a useful case study, with over a decade of detailed evaluation to draw on and a policy developed and implemented in response to a perceived national drug problem with public health priorities at the fore from the outset. Notably, Portugal coupled its decriminalisation with a public health reorientation that directed additional resources towards treatment and harm reduction.[48] Those caught in possession are referred to a 'dissuasion board' that decides whether to take no further action (the most common outcome), direct the individual to treatment services if a need is identified, or impose an administrative fine.

The useful volume of data collected during and since the reform offers considerable scope for filtering through different political and ideological lenses;[49] contrast the evaluation of Portugal's prohibitionist 'anti-drug' organisations who see it as an unmitigated disaster[50] with that of the high-profile but overwhelmingly positive Greenwald report[51] from the libertarian-leaning Cato Institute. A more rigorous and objective academic study of the Portuguese experience from 2008[2] summarises the changes observed since decriminalisation as:

- small increases in reported illicit drug use among adults
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003
- reduced burden of drug offenders on the criminal justice system
- increased uptake of drug treatment
- reduction in opiate-related deaths and infectious diseases
- increases in the amounts of drugs seized by the authorities
- reductions in the retail prices of drugs.

In conclusion the authors note:

> [Portugal's experience] disconfirms the hypothesis that decriminalisation necessarily leads to increases in the most harmful forms of drug use. While small increases in drug use were reported by Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 decriminalisation. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people's drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use.

Supporting these conclusions has been a more recent Drug Policy Profile of Portugal[48] from the European Monitoring Centre on Drugs and Drug Addiction, which observed that:

> While some want to see the Portuguese model as a first step towards the legalisation of drug use and others consider it as the new flagship of harm reduction, the model might in fact be best described as being a public health policy founded on values such as humanism, pragmatism and participation.

d For the different thresholds, see: http://www.drug-infopool.de/gesetz/nordrhein-westfalen.html.

Latin America

» Argentina's Supreme Court declared criminalisation of drug possession for personal consumption unconstitutional in 2009.[52, 53] A process of formally incorporating this decision into law is underway.[54]
» Chile decriminalised possession in 2007;[55] sentencing judges can administer fines, mandatory treatment, community service requirements and/or suspension of driver's licence.[56] Although the majority of cases end in the suspension of sentences or administrative sanctions, many people caught with small quantities do go to prison. Chile is assessing possible further changes to its laws, including full decriminalisation.[56]
» Colombia decriminalised possession following a Constitutional Court ruling in 1994.[57] This decision has been subject to more recent ongoing legal and constitutional argument between the government and Supreme Court.[58, 59, e] While these tensions leave the situation in flux, *de facto* decriminalisation continues, with a formal new government decriminalisation proposal reported.[60]
» Mexico decriminalised possession of small amounts of drugs in 2009, replacing criminal sanctions with treatment recommendations, and mandatory treatment for repeat offenders.[61] The quantity thresholds have, however, been criticised as being too low and ambiguous, leaving implementation vulnerable to police corruption.[62]
» Paraguay decriminalised small-scale possession in 1988.[56]
» Peru decriminalised drug possession in 2003,[63] but research reveals a disconnect between policy and the reality of police practices in the country.[64]
» Uruguay has never criminalised possession of drugs for personal use.[56] The principle formally entered Uruguayan law in 1974. Concerns have been raised about high levels of pre-trial detention without charge for more serious drug offences.[65]
» Decriminalisation laws are also pending in Brazil and Ecuador.[f]

Eurasia

» In Armenia possession of small quantities of drugs has been decriminalised since 2008[66] and is subject to administrative fines. However, the high level of fines (100 to 200 times the minimum wage for first-time offenders) can still result in incarceration of those unable to pay.
» In Estonia possession of small quantities of drugs for personal use has been decriminalised since 2002,[47, 67] subject to court-ordered administrative fines or 30 days administrative detention (in a local police jail).
» In Kyrgyzstan small-scale possession offences have been decriminalised and subject only to administrative responses since 1998.[68]
» In Poland since May 2011 prosecutors have had discretion not to prosecute small-scale possession offences[69] or if the individual is judged to be drug-dependent.
» The Czech Republic formally decriminalised possession of all drugs for individual use in 2010.[70]
» Russia nominally decriminalised possession in 2005. Article 228 of Russia's criminal code provides that possession of less than a 'large amount' of illegal drugs face only administrative sanctions. However, since then the threshold amount that determines a 'large' quantity of drugs has oscillated from very low thresholds to slightly higher thresholds and back again, making decriminalisation in Russia an inconsistent and effectively unrealised policy.[71]

Other countries

» Between 1987 and 2004 four Australian states decriminalised possession and use of cannabis. Two of these, Northern Territory[72] and South Australia,[73] have additional treatment diversion schemes for those found in possession of other drugs for personal use (completion of the designated programme avoids a prosecution).
» Since 1973, 14 US states and a number of other local jurisdictions have decriminalised cannabis possession.

Recommendations for implementation of decriminalisation of drug possession

When adopting a decriminalisation policy, a number of factors have to be considered to ensure the framework is meaningful in its goal of not criminalising those caught in possession of drugs for their own personal use. The following section details points for consideration in terms of the actual policy/legislation and implementation of the policy:

» **Thresholds** – where threshold amounts are adopted to determine whether someone is in possession for personal use the level needs to reflect market realities and be flexible enough to ensure that the principle of decriminalisation of personal possession is properly achieved.

e The dose is not the only factor the Court can look at when considering if drugs are for personal use.
f For updates, see: http://www.druglawreform.info/en/country-information/item/261-regional-overview-of-drug-law-reform-in-latin-america.

» **Response –** the State can either decide to take no action against someone caught in possession of drugs (for example, the Netherlands or Belgium) or can respond using civil sanctions.

If a system of fines is to be adopted, they must be set at a reasonable level and not result in the imprisonment of large numbers of people for non-payment. Other forms of civil penalties, such as seizure of passport or driving licence, should be avoided, as these can have a disproportionately negative impact on a person's life. In terms of those who are dependent on drugs, Portugal's approach, in which the police work with treatment agencies to offer an individualised referral route (with a range of treatment options available, including harm reduction), appears to be a pragmatic option. Also, failure to meet the conditions of treatment should be addressed by involving the person in their treatment programme and should certainly not result in criminal sanctions. In particular, 'drug-free' conditionality is also potentially setting up a person to fail, given the relapsing nature of drug dependence.

» **Disproportionate sentencing for cases involving possession above the threshold or supply offences –** it is critical that governments recognise the principle of proportionality in sentencing for drug offences. Too often those convicted of non-violent drug supply offences receive custodial periods which are much harsher than other violent offences, such as rape and even murder.

» **Public health interventions and treatment –** countries that wish to reduce the potential harms of problematic drug use and limit long-term health costs by introducing programmes that tackle HIV transmission and other blood-borne viruses should consider coupling the decriminalisation model with such a public health investment.

» **Net-widening –** policymakers must work to ensure that decriminalisation does not result in more people coming into contact with the criminal justice system. Whether this comes as a result of expanded police powers or low thresholds, decriminalisation policies must be targeted at reducing the number of individuals who suffer from the consequences of a criminal conviction, not merely the enactment of decriminalisation in name only.

Discussion

Given the wide variation in models around the world, there are relatively few general conclusions that can be made about the impacts of decriminalisation beyond the observation that it does not lead to the explosion in use that many fear. Critics of decriminalisation will often cite drug tourism as a risk associated with the introduction of such a policy. However, there is no evidence to suggest that this occurs. More often than not, countries or states that have adopted this approach will see similar rates of prevalence as their neighbours.[22, 74-77, g]

Research from Europe,[78] Australia,[72] the USA[22] and globally[17] suggests changes in intensity of punitive user-level enforcement appear to have only a marginal influence on determining prevalence of use, although, as noted earlier, there are significant impacts on risk behaviours.

Increasingly, more countries are joining the drug policy reform debate. Latin and Central American countries such as Colombia[79] and Guatemala[80] are some of the leading proponents calling for a reform of drug laws. Australia[81] has set up a new enquiry to consider the implementation of decriminalisation of possession of all drugs. It is not surprising that this growing momentum for change is occurring; the harms caused by criminalising those who use drugs are well documented, but added to this is a global economic crisis which is seeing cuts in police budgets all over the world. In California the decriminalisation of cannabis saw the total cost of enforcement decline from $17 million in the first half of 1975 to $4.4 million in the first half of 1976.[22]

Some research has shown that beyond ending the criminalisation of PWUD there can be other positive benefits. In Portugal, the increased numbers in treatment have been linked to the reduced stigmatisation created by a non-criminal approach to drug use.[82] Research from Australia compared individuals who had been criminalised for cannabis possession against those who had received a non-criminal response. It found that individuals given criminal penalties were more likely to suffer negative employment, relationship and accommodation consequences as a result of their cannabis charge and were more likely to come into further contact with the criminal justice system.[15]

Decriminalisation is clearly no 'silver bullet'; it can only aspire to reduce harms created, and costs incurred, by criminalisation in the first place and does not reduce harms associated with the criminal trade on which it has little direct impact. If inadequately devised or implemented, decriminalisation will have little impact, even potentially creating new problems such as net-widening.[1, 83] A more critical factor appears to be the degree to which decriminalisation is part of a wider policy reorientation and resource reallocation away from harmful punitive enforcement and towards public-health-oriented and human-rights-based approaches targeted at PWUD, particularly young people and PWID. Decriminalisation can be seen as a part of a broader harm reduction approach, as well as a key to creating an enabling environment for other public health interventions.

g These studies showed that there were no statistically significant differences in prevalence of cannabis use in states throughout Australia, even though three states had decriminalised cannabis possession and cultivation.

References

1. Rosmarin A & Eastwood N (2012) *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*. London: Release, www.release.org.uk/publications/drug-decriminalisation-policies-in-practice-across-the-globe Accessed 9 July 2012.
2. Hughes CE & Stevens A (2010) What can we learn from the Portuguese decriminalization of illicit drugs?, *British Journal of Criminology*, 50:999–1022.
3. Rolles S (2009) *After the War on Drugs: Blueprint for Regulation*. Bristol: Transform Drug Policy Foundation.
4. UN International Narcotics Control Board (1961) *UN Single Convention on Drugs*. Vienna, INCB, http://www.incb.org/incb/convention_1961.html Accessed 9 July 2012.
5. UN International Narcotics Control Board (1988) *UN Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances*. Vienna, INCB, http://www.incb.org/incb/convention_1988.html Accessed 9 July 2012.
6. Bewley-Taylor D & Jelsma M (2012) The UN drug control conventions: The Limits of Latitude, *Series on Legislative Reform of Drug Policies No. 18*. Amsterdam: Transnational Institute.
7. Rhodes T, Singer M, Bourgois P, Friedman SR & Strathdee SA (2005) The social structural production of HIV risk among injecting drug users, *Social Science & Medicine*, 61:1026.
8. Strathdee SA et al. (2010) HIV and risk environment for people who inject drugs: the past, present, and future, *Lancet*, 376:268–284.
9. Jürgens R (2010) Out of Sight, out of mind? Harm reduction in prisons and other places of detention, in Cook C (ed.) *Global State of Harm Reduction 2010*. London: IHRA, http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf Accessed 9 July 2012.
10. Ahern J, Stuber J & Galea S (2007) Stigma, discrimination and the health of illicit drug users, *Drug and Alcohol Dependence*, 88:188.
11. Coffin P, Sherman S & Curtis M (2010) Underestimated and overlooked: A global overview of drug overdose and overdose prevention, in Cook C (ed.) *Global State of Harm Reduction 2010*. London: IHRA, http://www.ihra.net/files/2010/06/29/GlobalState2010_Web.pdf Accessed 9 July 2012.
12. Stoicescu C & Cook C (2011) *Harm Reduction in Europe: mapping coverage and civil society advocacy*. London: European Harm Reduction Network.
13. Foster G (2008) Injecting drug users with chronic hepatitis C: should they be offered antiviral therapy?, *Addiction,* 103 (9) 1412–1413.
14. Wolfe D, Carrieri P & Shepard D (2010) Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward, *Lancet*, 376: 9738, 355–366.
15. McLaren J & Mattick RP (2007) *Cannabis in Australia: use, supply, harms, and responses*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales, 560.
16. Weatherburn D et al. (2000) *Drug Crime Prevention and Mitigation: a literature review and research agenda*. Sydney: New South Wales Bureau of Crime Statistics and Research, 12.
17. Degenhardt L, Chiu W-T, Sampson N, Kessler RC, Anthony JC et al. (2008) Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys, *PLoS Medicine* 5(7): e141. doi:10.1371/journal.pmed.0050141, http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050141 Accessed 9 July 2012.
18. Stevens A (2011) Drugs crime and public health: the political economy of drug policy. London: Routledge.
19. European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2011) *Report of the TNI-EMCDDA expert seminar on threshold quantities, Lisbon, 20 January 2011*. Lisbon: EMCDDA, http://www.undrugcontrol.info/images/stories/documents/thresholds-expert-seminar.pdf Accessed 9 July 2012.
20. EMCDDA (2010) Threshold quantities for drug offences. Lisbon: EMCDDA, http://www.emcdda.europa.eu/html.cfm/index99321EN.html Accessed 11 July 2011.
21. Hughes CE & Stevens A (2007) *The Effects Of Decriminalization Of Drug Use In Portugal*. Beckley Foundation Drug Policy Programme.
22. Single E, Christie P & Ali R (2000) The impact of cannabis decriminalisation in Australia and the United States, *Journal of Public Health Policy*, 21(2):168.
23. Wilkinson R & Pickett K (2010) The Spirit Level: Why Equality is Better for Everyone, *Penguin Sociology*, 71.
24. Godley F (2010) Ideology in the ascendant, *British Medical Journal*, 341:c3802, 14 July 2010.
25. Lancet (2010) *HIV in people who use drugs*, http://www.thelancet.com/series/hiv-in-people-who-use-drugs Accessed 9 July 2012.
26. International Federation of the Red Cross (2012) *Plenary statement at the UN Commission on Narcotic Drugs, Vienna, March 2012*, http://www.cndblog.org/2012/03/statement-from-international-federation.html Accessed 9 July 2012.
27. International Aids Society Policy website: Policy and advocacy resources on Drug Policies, http://www.iasociety.org/Default.aspx?pageId=573 Accessed 5 June 2012.
28. Grover A (2010) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/65/255, United Nations General Assembly, August 2010.
29. TheBody.com (2010) Sidebe supporting the statement of the "Decriminalization Works, Criminalization Doesn't": Leadership Panel at the AIDS 2010 conference, Vienna, Austria, July 2010.
30. Ki-moon B (2008) *Remarks on the handover of the report of the Commission on AIDS in Asia*. UN News Centre, 26 March 2008, http://www.un.org/apps/news/infocus/sgspeeches/statments_full.asp?statID=206 Accessed 5 June 2012.
31. Wood E et al. (2010) Vienna Declaration: a call for evidence-based drug policies, *Lancet*, 376, 9738: 310–312.
32. UNAIDS (2012) *Plenary Statement at the March 2012 UN Commission on Narcotic Drugs in Vienna*, http://www.cndblog.org/2012/03/day-3-plenary-statement-by-unaids.html Accessed 5 June 2012.
33. Global Commission on HIV and the Law (2012) *Risks, Rights & Health*. New York: UNDP, HIV/AIDS Group, Bureau for Development Policy.
34. Statement by UNODC Executive Director Yuri Fedatov, 29 November 2010, http://www.unodc.org/unodc/en/frontpage/2010/November/putting-people-first-unodc-executive-director-visits-drug-treatment-centre-and-womens-prison-in-afghanistan.html Accessed 9 July 2012.
35. UN Office on Drugs and Crime (UNODC) (2012) *UNODC and the protection and promotion of human rights*. Vienna: UNODC, http://www.unodc.org/documents/justice-and-prison-reform/UNODC_HR_position_paper.pdf Accessed 9 July 2012.
36. The Vienna Declaration website, http://www.viennadeclaration.com Accessed 5 June 2012.
37. Global Commission on Drug Policy (2012) *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*. Rio de Janeiro: Global Commission on Drug Policy, http://www.globalcommissionondrugs.org/hivaids-pandemic/ Accessed 4 July 2012.
38. World Health Organization (2009) Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Vietnam: An application of selected human rights principles. Manila: WHO Western Pacific Region, www.wpro.who.int/publications/docs/FINALforWeb_Mar17_Compulsory_Treatment.pdf Accessed 9 July 2012.
39. Human Rights Watch (2011) The Rehab Archipelago Forced Labor and Other Abuses in Drug Detention Centers in Southern Vietnam. New York: Human Rights Watch, http://www.hrw.org/reports/2011/09/07/rehab-archipelago-0 Accessed 9 July 2012.
40. EMCDDA (2011) *Country Legal Profiles* – Belgium, http://www.emcdda.europa.eu/html.cfm/index5174EN.html Accessed 9 July 2012.
41. Narcotic Drugs Act (*Betäubungsmittelgesetz*) of 1981 Sec. 31a (as amended 18 December 2009), http://www.emcdda.europa.eu/html.cfm/index5173EN.html?pluginMethod=eldd.showlegaltextdetail&id=677&lang=en&T=2 Accessed 9 July 2012.
42. Max Planck Institute for Foreign and Criminal Law (2011) *Cannabis Non-Prosecution Policies in Germany*. Freiburg: Max Planck Institute for Foreign and Criminal Law, http://www.mpicc.de/ww/en/pub/forschung/forschungsarbeit/kriminologie/archiv/cannabis.htm Accessed 5 June 2012.
43. Solvetti LM (2001) *Drug Use Criminalization v. Decriminalization: An Analysis in Light of the Italian Experience*. Report prepared for the Swiss Federal Office of Public Health, 32.
44. Gamella JF & Rodrigo MLJ (2004) A Brief History of Cannabis Policies in Spain (1968–2003), *Journal of Drug Issues*, Summer 2004, 630.
45. Barriuso Alonso M (2011) *Cannabis social clubs in Spain: A normalizing alternative underway*. Amsterdam: Transnational Institute, http://www.tni.org/sites/www.tni.org/files/download/dlr9.pdf Accessed 9 July 2012.
46. Reuter P (2010) *Marijuana Legalization: What Can Be Learned from Other Countries?*. Santa Monica, CA: Rand Drug Policy Research Center, 2, http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR771.pdf Accessed 9 July 2012.
47. EMCDDA, Threshold quantities for drug offences. Lisbon: EMCDDA, http://www.emcdda.europa.eu/html.cfm/index99321EN.html Accessed 5 June 2012.
48. EMCDDA (2011) *Drug Policy Profiles – Portugal*. Lisbon: EMCDDA, 18, http://www.emcdda.europa.eu/publications/drug-policy-profiles/portugal Accessed 8 August 2011.
49. Hughes CE & Stevens A (2012) A resounding success of a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs, *Drug and Alcohol Review* (January 2012), 31, *101–113*.
50. Pinto Coelho M (2010) *The "Resounding Success" of Portuguese Drug Policy. The power of an attractive fallacy*. Cascais: Association for a Drug-Free Portugal, http://www.wfad.se/images/articles/portugal%20the%20resounding%20success.pdf Accessed 9 July 2012.
51. Greenwald G (2009) *Drug Decriminalization in Portugal: Lessons for Creating Fair and Successful Drug Policies*. Washington, DC: CATO Institute, http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf Accessed 9 July 2012.
52. Touzé G (2010) *Argentina: Reform on the way?*, Amsterdam: Transnational Institute, http://www.tni.org/sites/www.tni.org/files/download/dlr6.pdf Accessed 9 July 2012.
53. Cozac D (2009) Rulings in Argentinian and Colombian courts decriminalize possession of small amounts of narcotics, *HIV/AIDS Policy & Law Review* Vol. 14, No. 2. Dec. 2009.
54. Glynn A (2012) Senator Presents Bill to Decriminalise Drugs, *The Argentina Independent*, 30 March 2012, http://www.argentinaindependent.com/currentaffairs/newsfromargentina/senator-presents-bill-to-decriminalise-drugs/ Accessed 9 July 2012.
55. Law 20.000, Article 4, 2007, Library of the National Congress of Chile, http://www.leychile.cl/Navegar?idNorma=235507&buscar=Ley+20.000 Accessed 5 July 2012.
56. Jelsma M (2009) *Drug Law Reform Trend in Latin America*. Amsterdam: Transnational Institute, 2, http://www.druglawreform.info/images/stories/documents/country_overview_drug_laws_final.pdf Accessed 9 July 2012.
57. Guzmán DE & Yepes RU (2010) Prohibition, a backwards step: The personal dose in Colombia, *Transnational Institute Series on Legislative Reform on Drug Policies No. 4:* 3. Amsterdam: Transnational Institute.
58. Pachico E (2011) Colombia Takes Step Towards Decriminalization, *In Sight,* 25 August 2011, http://insightcrime.org/insight-latest-news/item/1465-colombia-takes-step-towards-drug-decriminalization Accessed 14 February 2012.
59. *El Tiempo* (2011) Corte Suprema defiende el porte de dosis minima de droga, 24 August 2011, http://m.eltiempo.com/justicia/corte-suprema-defiende-el-porte-de-dosis-mnima-de-droga/10219935 Accessed 25 March 2012.
60. Pacheco D (2012) Revive pulso por la doss personal, *El Espectador,* 13 March 2012, http://www.elespectador.com/impreso/temadeldia/articulo-332022-revive-pulso-dosis-personal Accessed 9 July 2012.
61. *New York Times* (2009) Mexico Legalizes Drug Possession, 21 August 2009, http://www.nytimes.com/2009/08/21/world/americas/21mexico.html Accessed 11 July 2011.
62. Hernández Tinajero J & Zamudio Angles C (2009) Mexico: The Law Against Small-Scale Drug Dealing, *Transnational Institute Series on Legislative Reform of Drug Policies No. 3.* Amsterdam: Transnational Institute, http://www.tni.org/files/download/dlr3.pdf Accessed 9 July 2012.
63. Peruvian Penal Code, Law 28,002 of 2003, Art. 299, http://www.seguridadidl.org.pe/normas/ley28002.htm Accessed 5 June 2012.
64. Garrido RS (2010) Legislation on drugs and the prison situation in Peru, in *Systems Overload: Drug Laws and Prisons in Latin America*. Washington, DC: Washington Office on Latin America (WOLA)/Transnational Institute, 77, http://www.druglawreform.info/en/publications/systems-overload/item/875-drug-laws-and-prisons-in-peru Accessed 9 July 2012.
65. Garibotto G (2010) Prisons and drugs in Uruguay, in *Systems Overload: Drug Laws and Prisons in Latin America*. Washington, DC: Washington Office on Latin America (WOLA)/Transnational Institute, 82, http://www.druglawreform.info/images/stories/documents/Systems_Overload/TNI-Systems_Overload-uruguay-def.pdf Accessed 9 July 2012.
66. National Programme on Combating Drug Addiction and Illicit Traffic in Narcotic Drugs in the Republic of Armenia in 2009–2012, draft, 12.

67. EMCDDA, *Country Legal Profile* – Estonia, http://www.emcdda.europa.eu/html.cfm/index5174EN.html Accessed 9 August 2011.
68. UNODC and Canadian HIV/AIDS Legal Network (2010) *Accessibility of HIV prevention treatment and care services for people who use drugs and incarcerated people in CA countries and Azerbaijan Summary Reports and Final Recommendations.* Vienna: UNODC and Canadian HIV/AIDS Legal Network, 228, http://www.unodc.org/documents/centralasia/Accessibility_of_HIV_prevention_treatment_and_care_services_for_people_who_use_drugs_and_incarcerated_people_in_CA_countries_and_Azerbaijan_Summary_Reports_and_Final_Recommendations_1_Eng.pdf Accessed 9 July 2012.
69. International Drug Policy Consortium (2011) Polish President approves new drug law, 27 May 2011, http://www.idpc.net/alerts/polish-president-approves-new-drug-law Accessed 8 August 2011.
70. Cunningham B (2009) New drug guidelines are Europe's most liberal, *Prague Post,* 23 December 2009, http://www.praguepost.com/news/3194-new-drug-guidelines-are-europes-most-liberal.html Accessed 8 July 2011.
71. Levinson L (2008) Half a gram – a thousand lives, *Harm Reduction Journal*, 5:22, 2, http://www.harmreductionjournal.com/content/pdf/1477-7517-5-22.pdf Accessed 9 July 2012.
72. Hughes C & Ritter A (2008) *A Summary of Diversion Programs for Drug and Drug-Related Offenders in Australia.* Sydney: National Drug and Alcohol Research Centre, 52.
73. Legal Services Commission of South Australia (1977) *Diversionary Schemes*. Adelaide: Legal Services Commission of South Australia.
74. Donnelly N, Hall W & Christie P (2009) *Effects of the Cannabis Expiation Notice Scheme on Levels and Patterns of Cannabis Use in South Australia: Evidence from the National Drug Strategy Household Surveys 1985–1995*. Parkside: Drug and Alcohol Services Council, South Australia.
75. Lenton S, Christie P, Humeniuk R et al. (1999) *Infringement Versus Conviction: the social impact of a minor cannabis offence under a civil penalties system and strict prohibition in two Australian states*. Parkside: Drug and Alcohol Services Council, South Australia.
76. Lenton S (2000) Cannabis policy and the burden of proof: is it now beyond reasonable doubt that cannabis prohibition is not working?, *Drug and Alcohol Review* 19(1):95–100.
77. Brettville-Jenson AL & Williams J (2011) *Decriminalization and Initiation into Cannabis Use*. Melbourne: University of Melbourne.
78. EMCDDA (2011) Looking for a relationship between penalties and cannabis use, *2011 Annual report on the state of the drugs problem in Europe*. Lisbon: EMCDDA, http://www.emcdda.europa.eu/online/annual-report/2011/boxes/p45 Accessed 9 July 2012.
79. Mulholland J (2011) Juan Manuel Santos: "It is time to think again about the war on drugs", *The Observer,* 13 November 2011, http://www.guardian.co.uk/world/2011/nov/13/colombia-juan-santos-war-on-drugs?INTCMP=SRCH Accessed 9 July 2012.
80. Perez Molina O (2012) We have to find new solutions to Latin America's drugs nightmare, *The Observer,* 7 April 2012, http://www.guardian.co.uk/commentisfree/2012/apr/07/latin-america-drugs-nightmare Accessed 9 July 2012.
81. Willingham R (2012) Trio of MPs to push for probe into drugs laws, *The Sydney Morning Herald*, 26 June 2012, http://www.smh.com.au/opinion/political-news/trio-of-mps-to-push-for-probe-into-drugs-laws-20120626-210iu.html Accessed 9 July 2012.
82. Van het Loo M, van Beusekom I & Kahan JP (2002) Decriminalization of Drug Use in Portugal, *The Annals of the American Academy of Political and Social Science,* 582: 49–63, 60.
83. Levine H & Siegel L (2011) *$75 Million a Year.* New York: Drug Policy Alliance, http://www.drugpolicy.org/docUploads/_75_Million_A_Year.pdf Accessed 11 May 2012.

HARM REDUCTION AT THE CROSSROADS:
Case examples on scale and sustainability

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Introduction

In the 25 years since the development of the first harm reduction programmes, a harm reduction approach has been adopted in policy or practice to varying degrees in 94 countries worldwide.[a] The majority of these countries, however, do not have comprehensive harm reduction programmes[1] operating at the scale necessary to impact on HIV,[2] or even more challenging, hepatitis C epidemics. Those countries that are containing or reducing HIV epidemics among drug-injecting populations are largely high-income and overwhelmingly European. There are notable successes in implementation in a variety of political, religious and economic contexts, but the vast majority of low and middle-income countries around the world lack adequate harm reduction responses.[2]

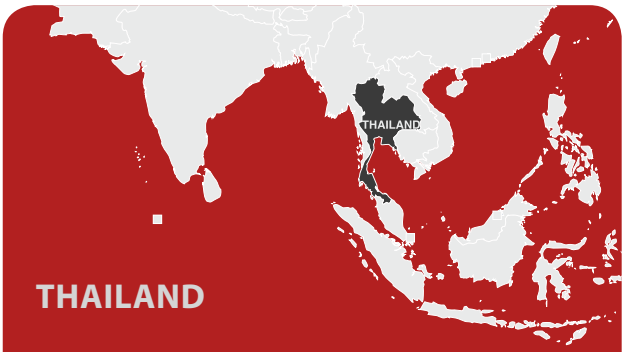
Threats to sustained harm reduction responses are multiple and vary within and across countries, but the financial and political contexts are often the underlying factors that determine the life or death of a programme. Although harm reduction interventions are evidence-based,[3] cost-effective[b] and a fundamental element of the international HIV response,[4] government investment in low and middle-income countries remains limited.[5] Of the $160 million estimated to be invested in HIV-related harm reduction in low and middle-income countries in 2007, approximately 90 per cent came from a small number of international donors[5] (see the Global Overview section of this report for a more in-depth analysis of global financing for harm reduction). Bilateral and multilateral funding for harm reduction has been crucial to introducing and sustaining the response to some of the most severe HIV epidemics among people who inject drugs (PWID) around the world. However, reliance on international funds is becoming increasingly insecure as the global economic crisis impacts upon development and HIV funding. Middle-income countries with large numbers of PWID and governments hostile to harm reduction have been left particularly vulnerable. With recent developments at the Global Fund, and depleting funds available from several other major donors, the sustainability of harm reduction is under threat like never before.

Political support for harm reduction remains key to ensuring that investments are strategic and proportionate to need, particularly in the current financial environment. Many countries continue to emphasise drug control over public health, resulting in policy and legal contexts which hinder public health responses, increase potential for infections and lead to overburdened prison systems. While this approach is being questioned and openly debated by governments more than ever before, poor political backing for harm reduction remains one of the most crucial barriers to an effective response to epidemics among PWID. In addition to the countries where political support has long been lacking, the phenomenon of regression or backsliding in support for harm reduction in policy and practice is beginning to emerge in several countries where programmes have been long established and enjoyed long-standing government support. Given this backdrop, it is important to investigate the ways in which harm reduction programmes can be scaled up, or continue to operate to scale while adapting to changing policy and funding environments.

This chapter presents a series of case studies to examine the different strategies and responses that have emerged to secure the survival of harm reduction policies and practices. It will explore, through these case studies, strategies for ensuring sustainability in harm reduction programmes. Two of the case studies focus on protecting harm reduction during periods of wider political change, while a further two examine ways of overcoming stalled implementation or 'death by pilot'. Overall they look to encapsulate the interplay between harm reduction, local and national policies and politics. The final section of the chapter summarises these developments and attempts to identify successful and innovative strategies for overcoming the barriers to the survival and scale-up of harm reduction programmes.

a As reported in Section 1 of this report, 94 countries and territories worldwide now employ a harm reduction approach (compared to 93 and 82 countries in 2010 and 2008, respectively). This support is explicit either in national policy documents and/or through the implementation or tolerance of harm reduction interventions such as needle and syringe exchange programmes (NSPs) or opioid substitution therapy (OST).

b For example: National Centre in HIV Epidemiology and Clinical Research (2010) *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia 2009.* Sydney: University of New South Wales.



THAILAND

HIV was first reported among PWID in Thailand in the late 1980s, and the epidemic increased dramatically within this population in a few years. Despite successes in other areas of HIV prevention, the Thai response to HIV and drugs has failed to have an impact on this epidemic. The latest data indicate that between 40,300[6] and 160,528[7] people inject drugs in Thailand. HIV prevalence among PWID remains among the highest in Asia at 21.9 per cent.[8c] The majority of PWID in Thailand are living with hepatitis C (89.8 per cent).[9] The Thai government's response has focused on criminal justice approaches centred on the incarceration and compulsory detention of people who use drugs (PWUD) and characterised by several 'wars on drugs'. This case study outlines the acquisition and implementation of a Global Fund grant since 2009 and the challenges that have been faced by implementing civil society organisations operating in an environment that remains hostile to harm reduction.

Official policy language labels PWUD as patients;[10] however, practice at the community level in Thailand suggests that they continue to be treated as criminals. The government's response to drugs, guided by principles of prohibition and repression, has been consistently implemented with little regard to the health and human rights of PWUD.[11-14] Law enforcement initiatives have led to incarceration and compulsory detention with accompanying abuse of PWUD, both in community and closed settings.[15] The recently elected Pheua Thai party announced a new 'war on drugs'[16, 17d] with objectives of rehabilitating 400,000 'users' in compulsory 'treatment' centres, primarily run by military and law enforcement agencies.[18] The Thai government's reluctance to address drug-related issues through public health measures is embodied in the absence of national harm reduction policy instruments, mechanisms and measures beyond the national HIV/AIDS strategy. The Thai Office of Narcotics Control Board (ONCB) drafted a national harm reduction policy in 2010, but this has not yet been deployed. In spite of this unsupportive environment, some level of harm reduction services have been delivered in Thailand at least since 2003.

c This figure refers to men who inject drugs only.

d The 2003 campaign in particular illustrates the scale of the Thai government's approach to the war on drugs, including human rights violations and arbitrary killings that took place as a result, for more information: Human Rights Watch (2004) *Thailand: Not Enough Graves. The War on Drugs, HIV/AIDS, and violations of Human Rights*, Vol. 16, No. 8, http://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf.

At present, the national response to HIV transmission among PWID is essentially limited to the CHAMPION-IDU project, supported by the Global Fund Round 8 grant and implemented by PSI Thailand alongside civil society partners including Raks Thai Foundation, the Thai AIDS Treatment Action Group, the Thai Drug Users' Network, Alden House and the Thai Red Cross. This grant is for an approved total of US$17 million for the period 2009–2014 – US$6 million for the first phase of funding, and US$11 million for 'Phase 2' – and covers 19 of the 76 Thai provinces. Earlier, in 2003, the Global Fund also provided a US$1 million grant to Thai civil society groups to address HIV transmission among PWID.[e] Without support from the Global Fund, the national response to HIV transmission among PWID would be limited to small-scale community-led programmes whose operations have been under continued threat from police and government crack-downs.

During the first two years of operations, the CHAMPION-IDU project reached over 6,000 PWID across Thailand, providing them with education, information and behaviour change communication, safer injecting kits, condoms, referrals to voluntary HIV counselling and testing (VCT), diagnosis and treatment for sexually transmitted infections (STIs), and opioid substitution therapy (OST). In parallel, over 130 health service providers and approximately 50 prison guards received training to be sensitised to the needs of PWID, while over 1500 people have participated in advocacy activities to improve the operating environment. Meanwhile, CHAMPION-IDU supports 12D – a civil society coalition working to improve the drug and HIV policy environment – in coordinating and implementing additional advocacy activities, as well as the Foundation for AIDS Rights to develop effective legal aid services for PWID. The successes of the CHAMPION-IDU project largely belong to active and recovering PWID who comprise a large proportion of the implementing field teams.

However, the sustainability of these successes is constantly under threat. There continues to be a lack of support from all government sectors for effective and evidence-based interventions to address HIV transmission among PWID, which undermines the project. Government agencies have not signed identity cards that would protect field teams from arrest, which leads to peer outreach workers being routinely harassed and arrested by law enforcement officers. There are also anecdotal reports from implementing agencies in Thailand suggesting that law enforcement officers can benefit from financial incentives for drug seizures and the arrest of PWUD, as well as penalties if quotas are not met.

A further challenge has been posed by target-setting following the CHAMPION-IDU grant's mid-term review in 2011. As the Global Fund is a funding (rather than technical)

e For a more nuanced discussion of the challenges around this grant, please refer to Kerr T et al. (2005) Getting Global Funds to Those Most in Need: The Thai Drug Users' Network, *Health and Human Rights*, 8(2) 170–186.

body, it follows the agreed normative guidance to assess the quality of programmes – in this case the UN target-setting guide for PWID.[1] However, this guidance is 'primarily intended for national target-setting'[1] whereas the CHAMPION-IDU programme is a nongovernmental initiative that operates in just 19 provinces. The guidance also states that interventions should be implemented 'in an enabling environment created by supportive legislation, policies and strategies'[1]: this is clearly not the case in Thailand. In negotiations between PSI and the Global Fund to agree targets for Phase 2, the Global Fund requested high coverage levels in the 19 provinces in line with the UN target setting guide (i.e. 60% for NSP and 40% for VCT). The performance based funding (PBF) model is based on the principle that 'to receive subsequent financing, [projects] must demonstrate results against defined performance targets'. This has raised concern that, despite its successes in health service provision, the CHAMPION-IDU programme may struggle to meet its performance targets and would therefore be rated by the Global Fund as 'inadequate' or 'unacceptable' (see Table 1).[f]

Table 1: CHAMPION-IDU key indicator targets (October 2011 – June 2014)[19]

Indicator	Phase 1 Targets	Phase 1 Performance	Phase 2 Targets	Increase between Phase 1 and 2 targets (%)
Number of PWID reached	6,574**	6,191	9,762***	148
Number of people trained (and retrained)# to implement HIV prevention activities for PWID	223**	137	258***	115
Number of condoms distributed to PWID	319,879*	170,411	986,364*	308
Number of needles/ syringes distributed to PWID	1,151,495*	319,879	5,698,315*	495
Number of PWID referred for HIV testing and counselling (and have received their results)	602*	351	6,391***	1062
Number of STI cases referred and received their diagnosis result	577*	411	8,171***	1988

In Phase 2, CHAMPION-IDU partners were allowed to count people re-trained, whereas in Phase 1, once a person received training, they could not be re-counted against indicator performance.
* Not cumulative
** Cumulative over project life
*** Cumulative annually

f See Global Fund (2012) Performance-based Disbursements, www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/3.

A further concern is that the Government, already unresponsive to harm reduction efforts, could potentially use this assessment as further justification to avoid deploying future interventions to reduce HIV among PWID. The Global Fund is a leading source of international support for harm reduction programmes[20] and remains the sole and best possible option for supporting the response to HIV transmission among PWID in Thailand. In order to maximize the Global Fund's significant investment in HIV prevention among PWID in Thailand, it will be critical to balance the quantitative results of the CHAMPION-IDU project against the hostile operating environment. At the same time, it is important to provide flexibility to implementing agencies to re-program funds to support advocacy efforts towards the deployment of an evidence-based policy, while efforts are also needed to harmonize law enforcement and public health objectives so that these challenges can be transformed into genuine successes for the benefit of Thai society as a whole.

AUSTRALIA

There are an estimated 149,591 PWID in Australia.[7] Early adoption and high coverage of harm reduction interventions is often credited for the consistently low HIV prevalence among them (1 per cent).[8] This case study outlines the important role of user organisations in shaping Australia's harm reduction response, both historically and in the face of recent shifts in government policy agendas.

Australia has benefitted greatly from the early adoption of harm reduction as an effective way to reduce the impact of HIV and other blood-borne viruses such as hepatitis B and C that can result from sharing contaminated injecting equipment. Harm reduction initiatives including the implementation and rapid scale-up of NSPs and OST began in the mid- to late 1980s. These effective programmes have helped maintain low HIV prevalence of approximately 1 per cent among PWID in Australia for almost 30 years.[21]

In the early days of harm reduction, drug use was seen as a criminal issue to be stamped out by police arrests and customs seizures of imported drugs. The adoption of harm reduction shifted much of the rhetoric to one of drug use as a health issue. Language became an important way to convey ideas about 'managing drug use' and 'reducing harm'. However, the

rhetoric did not entirely reflect the reality. Examining funding for drug-related interventions in Australia reveals a very different picture of the priorities of the country's leaders. The majority of funding goes to supply and demand reduction measures, and just 3 per cent of funding has consistently been allocated to harm reduction.[22]

Despite this disparity, just one of the harm reduction measures, NSP, is recognised as one of the most cost-effective health interventions ever funded. For every $1 spent on NSP, $27 is saved just on health care costs,[23] and increased spending would result in a corresponding further reduction in blood-borne virus transmissions, other adverse health outcomes for PWID and overall health care costs, with the maximum benefit being achieved at increasing funding by 150 to 200 per cent of its current levels.[23]

To assess their impact, the Federal Department of Health commissioned two major cost–benefit analyses of NSPs in Australia. The first of these showed overwhelming evidence for the financial and health benefits of investing in NSPs in the first decade and a half of their existence. According to the second *Return on Investment Report*, published in 2010, these savings have continued to grow. Between 2000 and 2009, NSPs alone directly prevented approximately 32,000 HIV transmissions and almost 100,000 hepatitis C transmissions, and saved the Australian government over $1 billion in health care costs.[23]

Integral to the success of the Australian harm reduction response has been the involvement of PWUD in providing services, conducting formal and informal peer education, and representing the needs of PWUD in Australian policy dialogue. From the earliest days of implementing the first pre-legal NSP to today, PWUD have done everything they can to be part of Australia's harm reduction response. PWUD have challenged stereotypes by developing their own organisations, advising on policies and procedures, developing resources and working in every area relevant to PWUD, from NSPs to outreach to government health departments. They have proved that not all illicit drug use is problematic and chaotic, and that PWUD have valuable skills and care about their peers and communities. Without the voluntary and paid work of these people, and the willingness of PWUD to take the necessary steps to look after themselves and their peers, Australia's response to HIV would have had a far less successful outcome. Drug users were organising themselves even before the identification of HIV and hepatitis C as potential concerns for PWUDs. The recognition that PWUD might pose a 'threat' to the 'general community' through sexual transmission of HIV meant that the drug user organisations that had been operating voluntarily began to receive some funding.

As drug user organisations at the state and national level gained experience and proved their worth by developing successful programmes and resources, more funding was made available to allow these organisations to educate the PWUD community about blood-borne viruses. Australia, unlike many other countries, can rely on neither international donors nor philanthropic organisations to support community work. Almost all community organisations, including all harm reduction and drug treatment services, are primarily funded by the government, and the government is not very interested in funding organisations to look critically at its policies. Most of the advocacy work and lobbying for policy change remains unfunded, limiting the opportunities drug user organisations can take outside programmes to prevent transmission of blood-borne viruses.

Australia has rightly been proud of its record on implementing brave programmes in the mid-1980s that prevented an HIV epidemic. It has also been proud of what is called the 'partnership approach',[24] referring to the inclusion of affected communities such as PWUD organisations in the response to HIV. The Australian response has been promoted and modelled in Australia's aid development programmes around the world, particularly in Asia where HIV has devastating impacts on the lives of millions of PWUD and their communities.

Australian aid has funded many harm reduction programmes in Asia where the health and human rights of PWUD had previously not been considered. Meanwhile, in Australia, drug user organisations have despaired at government and community attitudes to PWUD and the lack of forward movement in our own programmes. More frightening is the fact that Australia appears to be going backwards towards denial and abstinence-oriented programming.

An 11-year conservative rule of the country from 1996, led by Prime Minister John Howard, produced the 'Tough on Drugs' strategy. Howard portrayed himself as a strong conservative, frequently talking about the evils of drugs and what he wanted to do about it. The 'Tough on Drugs' strategy emphasised supply reduction measures and language that pandered to stigma about PWUD. Increasing stigma is obviously damaging, particularly for already marginalised and criminalised communities such as PWUD. However, the 'Tough on Drugs' rhetoric was accompanied by continued harm reduction funding, and in some cases increased funding, although few new harm reduction programmes.

It was hoped that the election of a Labour government in 2007 might make the language and policies more progressive and compassionate. Instead, rhetoric around harm reduction and drug use has regressed further. A recent report developed by prominent Australians including politicians, medical professionals and parents of children who had died of overdose called on Australia to rethink the 'war on drugs' and reform drug policy.[25] The report, entitled *The Prohibition on Drugs is Killing and Criminalising Our Children and We Are All Letting It Happen*, received a lot of media and public attention. The only people unwilling to even acknowledge the idea,

let alone engage in a conversation about drug law reform, seemed to be the politicians responsible for the well-being of its citizens. Media questions about the report were met by blanket refusals from the ruling parties to discuss either the report or the ideas contained in it. Labour's silence has created confusion about where PWUD stand, and changes to budgeting have been even worse for many PWUD and harm reduction organisations.

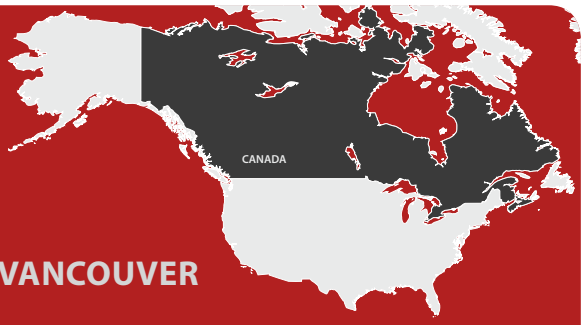
The 'Tough on Drugs' strategy has gone, but it is being replaced by something drug user organisations are finding equally disturbing. 'New Recovery', following an agenda implemented in the United Kingdom (UK) in recent years, seems to be the new Australian strategy. 'New Recovery' promotes many ideas that seem positive such as increasing treatment programmes for PWUD. It sounds like people will have more choices in their treatment options. However, a closer reading of the current Australian *National Drug Strategy, 2010–2015: A framework for action on alcohol, tobacco and other drugs* reveals an increasing emphasis on abstinence-based outcomes for people who use drugs. It lists demand reduction as its 'First Pillar' and supply reduction as its 'Second Pillar' for responding to issues related to drug use. It also includes ideas such as 'outcomes-based funding', and 'episodes of care', which, experience from the UK shows us, can lead to rewarding numbers rather than quality outcomes. The number of times a person is told to see a particular professional does not mean they will enjoy quality or relevant treatment for their needs.

Harm reduction is slipping further into the background. Although evidence-based programmes are frequently mentioned, the actual objectives of the drug strategy concentrate far more on programmes that have proved to be costly and ineffective such as education campaigns to prevent young people trying drugs. The language used for people who are dependent on drugs emphasises 'reducing and/ or ceasing the use of drugs (to) … help them lead more stable, healthy and productive lives'.[26]

Characterising any drug use as 'problematic' and linking drug use and mental health issues is appearing as a dominant discourse in both health and political forums. In this environment, we are seeing services and programmes for PWID moved into the mental health sector and harm reduction quickly losing its place in Australia's health sector.

We are also already seeing the first major signs of the effect such pathologising of drug use may have on the ability of drug user organisations and PWUD to be involved in the decisions being made around their lives and choices. Although drug user organisations have been a part of Australia's harm reduction response, the future is not assured. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) has been integral to the newest initiatives in Australia including advocating for, designing and receiving funding to run Australia's first naloxone peer distribution programme. The first training sessions for PWUD and their friends and family were held a few weeks before CAHMA was told that its 2012–2013 funding application for the organisation had been rejected by the Federal Department of Health, along with many other significant but small community organisations. It was only through intense lobbying by the national drug user organisation, the Australian Injecting and Illicit Drug Users League (AIVL), CAHMA and supportive local and national agencies that CAHMA's funding was reinstalled and its ability to implement these new programmes realised.

Australia has not yet regressed to the time when drug users could not advocate for their communities for fear of imprisonment, but complacency could have devastating effects. The pathologising of drug use seems to be dominating policy and legislation, whereas harm reduction, involvement of the people affected by the issues, and evidence-based policy used to have a much stronger place. This is a time when drug user organisations are more important than ever.



VANCOUVER

There are reported to be 286,987 PWID in Canada. HIV prevalence among them is estimated to be 13.4 per cent. Coverage of key harm reduction interventions such as NSP and OST remains lower than in Australasia and most Western European countries.[2] The current government has prioritised a law enforcement approach to drugs, which has overshadowed public health responses. Vancouver is home to two projects not only crucial for the local community of PWUD but also for their contributions to the international evidence base for two important harm reduction interventions – safer injecting facilities and heroin-assisted treatment. This case study outlines these two very different projects, the structural barriers they have encountered and the reasons why, despite substantial evidence of effectiveness, these pilots have not been scaled up in the Canadian context.

Beginning in the mid-1990s, Vancouver's Downtown Eastside neighbourhood became the focus of unprecedented levels of harms related to illicit drugs, including an explosive outbreak of HIV transmission and an extremely high fatal overdose rate.[27] In response, a broad coalition of PWID, community-based advocates, public health professionals and elected officials coalesced around support for the implementation of a broad range of harm reduction interventions,[28] most notably establishing Insite, North America's first medically

supervised safer injecting facility (SIF)[29] and conducting the North American Opiate Medication Initiative (NAOMI) study, a randomised clinical trial of heroin-assisted treatment for severe heroin addiction.[30] However, despite the impressive body of scientific evidence generated attesting to the positive impacts of these programmes on the health and well-being of local vulnerable and marginalised illicit drug users, they have yet to be scaled up or implemented in a fashion consistent with their benefits and cost-effectiveness.[31, 32]

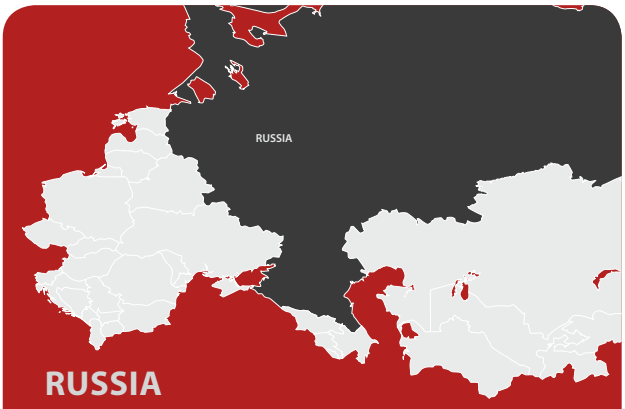
Insite opened in 2003 in a low-threshold facility located within the epicentre of the neighbourhood's open illicit drug market. A joint initiative of a social services agency and the local health authority, Insite obtained the necessary federal government-issued exemption from criminal prosecution by being set up as a pilot project to study the effects of a SIF in the Downtown Eastside.[33] The scientific evaluation produced a wealth of peer-reviewed research describing the facility's benefits, including lower levels of syringe sharing,[34] increased uptake of addiction treatment[35] and significant reductions in fatal overdoses in the area around the facility.[36] In addition, Insite enjoys broad support from its clientele, members of the surrounding community including merchants and civic leaders, as well as the Vancouver Police Department and current and former city mayors and provincial premiers. Despite these successes, the agency operating Insite and two Insite clients were forced to take Canada's federal government to court to prevent it from shutting the facility shortly before the exemption expired in 2006. Subsequently, the Supreme Court of Canada ruled in 2011 that the facility could remain open indefinitely, and plans are underway to try to expand the service by creating supervised injecting environments elsewhere in Vancouver and in other regions in Canada.

In light of the successful implementation of heroin-assisted treatment in several European countries,[37] the NAOMI study recruited over 200 out-of-treatment long-term opioid injectors and randomly assigned them to receive standard medical care (oral methadone) or a diacetylmorphine (heroin) (DAM) plus flexible doses of methadone.[38] After 12 months, individuals in the DAM group were more likely to remain in treatment, less likely to be engaged in illicit heroin use or other criminal activity, and enjoyed greater improvements in social functioning than patients receiving methadone.[39] Additional analyses concluded that treatment with DAM was cost-effective.[31] Despite these findings, DAM has not been added as a treatment modality for opioid dependence, and all participants in the DAM group were transitioned to methadone or detoxification, making the NAOMI project the only heroin prescription study to discontinue heroin-assisted treatment upon conclusion.[40]

Although it is important to note the fundamental differences between Insite and the NAOMI trial, both interventions share similar structural barriers to implementation and scale-up. First, both interventions were the subject of numerous rules and regulations rooted in political or legal considerations. For example, the City of Vancouver restricted NAOMI participation to individuals residing within one kilometre of the study site, limiting recruitment.[38] Clients at Insite are not permitted to share drugs within the facility nor assist in injections, limiting its effectiveness for a small but vulnerable group of clients.[41] Second, both interventions exist within a federal policy environment that is explicitly hostile to harm reduction interventions.[42] First elected in 2006, Prime Minister Stephen Harper has removed harm reduction from the federal government's official anti-drugs strategy and has pursued a strict prohibitionist strategy, including the implementation of mandatory minimum sentences for minor drug offences and expansion of the correctional system. Finally, the recent history of the NAOMI trial and Insite reveal the importance of community and academic advocacy in planning and implementing interventions for illicit drug users. In many respects, the establishment and continued existence of Insite is a result of the efforts of the broad coalition of clients, researchers, advocates and officials operating within legal, political, social and cultural contexts.[43] The NAOMI investigators were not similarly engaged with the community and other supporters, and patients in this study have not benefitted from similar advocacy efforts, resulting in the NAOMI intervention being halted without public education or legal efforts to prevent this outcome.

In a recent report on their experiences prepared by the NAOMI Patients Association,[44] one participant identified the marginalised status of illicit drug users as a reason for the failure to create a permanent heroin-assisted treatment programme: *'If they give you a drug for — they're experimenting with a drug for cancer and it starts working. I mean, what are they going to do? Oh, no. You can't have it any more; we're going to back off here.'*

These examples, with the success of the Insite programme resulting from collaboration between scientists, community groups and the legal and public health communities, and the closure of the NAOMI programme in the setting of researchers working largely in isolation from external stakeholders, demonstrate the importance of coalition-building between the research community, the non-profit sector, service providers and those with legal expertise to ensure that effective harm reduction programmes and other evidence-based approaches to prevent and treat harmful substance use can expand in a sustainable way.



RUSSIA

An estimated 1,815,000 PWID live in Russia. The HIV epidemic in the country is largely driven by injecting drug use. Prevalence of HIV and hepatitis C among PWID are among the highest in the world at over 37 per cent[7] and 72 per cent,[9] respectively. This case study outlines the struggles of small-scale harm reduction programmes to continue operations in the face of increasingly staunch government opposition to harm reduction and an overreliance on international donors. It highlights various strategies used by civil society actors to attempt to overcome the considerable barriers to implementing a scaled-up and sustainable harm reduction response in Russia.

The decade between 1996 and 2005 was a time full of hope for harm reduction in Russia. The country's first pilot harm reduction projects funded by the Open Society Institute (OSI) and Médicins du Monde (MdM) opened in 1996 and delivered high-quality results.[45] In 1997, Médecins Sans Frontières (MSF) Holland and OSI launched an ambitious programme to introduce harm reduction in Russia, in cooperation with the HIV/AIDS Department of the Russian Ministry of Health. As part of the new programme, MSF trained 300 doctors and NGO representatives from all over Russia in providing needle and syringe and outreach services, and OSI funded over 30 pilots.[46] To ensure sustainability, the Russian government agreed to gradually increase co-funding of the pilots, with a view to eventually fully fund and continue to scale up the project.[46] However, this did not transpire – the government continued to postpone the takeover of harm reduction services, encouraging international donors to step in and bridge the gap.[47]

In 2001 a new donor emerged – the UK Department for International Development (DFID). Its funds intended to 'bridge' the ending OSI grant programme and to fill the gap until a looming World Bank loan to meet the country's urgent health needs was agreed and signed off.[48] The DFID support included a large research project examining the effectiveness of harm reduction in Russia; it matched the funding for the 30 existing pilot projects and provided for significant scale-up of harm reduction services in two selected Russian regions looking to prove the impact of harm reduction on the HIV epidemic. However, by the end of 2003, DFID decided to move its funding to post-war development in Iraq, changing its priorities abruptly; funds were withdrawn, and scaling up did not take place.[48]

However, there was hope that the government would support harm reduction efforts within the upcoming World Bank loan. Negotiations on the loan took place for almost five years; the World Bank conducted numerous assessments, research and consultations – all with a promise that the loan would support 30 harm reduction projects.[49] However, by the time the loan was accepted, both the government and the World Bank dismissed their written plans and agreements to take over harm reduction, reallocating the money towards purchases that were more convenient for the Russian officials, such as laboratory equipment and furniture for the state AIDS centres.[49]

In 2003 a consortium of five major NGOs took the decision to stop waiting for government support and submitted Russia's first application to the Global Fund (Round 3). The grant was successful and went on to support 22 harm reduction projects. A year later, support for 30 more projects was received through the Global Fund Round 4, and again in 2006 another 33 projects were funded through the Round 5 grant. As a result, the period between 2005 and 2008 saw the beginning of scale-up for harm reduction, with over 80 projects implemented.[50] Many of the projects, however, operated only as small-scale pilots. Scepticism was also increasing around governmental support to harm reduction, as government officials became increasingly vocal in their opposition to harm reduction. For example, government representatives unanimously refused to approve harm reduction as part of national applications to the Global Fund, meaning that the Round 5 proposal did not receive the approval of the Country Coordinating Mechanism due to its focus on harm reduction.

Unexpectedly, in May 2008, at the Eastern European and Central Asian AIDS Conference the newly appointed Russian Minister for Health, Ms Golikova, announced that the government had all the resources to fully take over harm reduction projects currently supported by the Global Fund.[51] After her announcement, the audience held their breath for a moment and then burst into applause. This was the moment harm reduction advocates had been waiting over a decade for. However, just one year later in September 2009, the same Minister, at a meeting with the President and Prime Minister in attendance declared that 'distribution of sterile needles and syringes stimulates social tolerance of drug addicts, and violates the Criminal Code.'[47] This speech marked the end of political support, if even only rhetorical, to harm reduction. The national 'Anti-Drug Policy Strategy', approved another year later, ignored significant evidence around major health challenges including HIV rates of around 37 per cent[52] and hepatitis C prevalence of between 49 per cent and 96 per cent[9] among PWID and even named harm reduction as a threat to the strategy.[53]

At the end of 2011, the last Global Fund-supported programmes ceased to function. As a result, by early 2012, only six organisations across the country were able to provide harm reduction services to PWID, all struggling for small-scale funding from independent sources.[54] This is grossly inadequate for the needs of PWID; current estimates in Russia are that nearly 2 million people inject drugs, with HIV rates around 37.15 per cent among this population and much higher in some provinces [for more information see Chapter 2.1: Harm Reduction in Eurasia].

One of these organisations, the Andrey Rylkov Foundation for Health and Social Justice (ARF), maintained its outreach services supported by the International Crystal of Hope Award. However, the organisation has been severely repressed by the government. In 2012, after multiple checks by police and prosecutors, its website was shut down by the Federal Drug Control Service citing 'drug propaganda' as its reasoning – specifically concerning materials discussing substitution treatment.[55] Through this action, the Russian government suggested that it believed that not only providing services but even discussing harm reduction was illegal.

What went wrong with harm reduction advocacy in Russia? Why were small but aspirational harm reduction pilots not scaled up by the government but, rather, fiercely opposed? Traditional advocacy has been undertaken in Russia: research and evidence-building, trainings and international study tours, publications and debate. However, so far none of these activities have had an impact on mainstreaming harm reduction into national public health strategies or services. The root of this strong ideological government resistance is hard to explain, and this opposition has never been scrutinised scientifically,[47] so more research into policy resistance is recommended to determine the causes of this ongoing phenomenon.

Advocates affiliated with the ARF have taken the decision to use legal tactics to force the government to change its policies. The organisation has taken several cases to national and international courts, claiming violations of the right to health,[56] the right to be protected from torture and inhumane treatment,[57] the right to receive information[g] and the right to benefit from scientific progress.[58] However, it remains uncertain whether this approach will be successful in bringing evidence-based programmes to PWID in Russia.

g Andrey Rylkov Foundation (2012). Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice (ARF) for promoting the recommendations made by the UN Committee on Economic, Social and Cultural Rights (CESCR) to the Russian Federation in its Concluding Observations

Conclusion and recommendations

This chapter has brought together a diverse set of case studies from around the world to examine the problems of sustainability in harm reduction and to highlight successful or promising strategies for securing it. All four case studies clearly demonstrate the importance of continued advocacy, alongside sustained political support for the implementation and scale-up of harm reduction services. Although the circumstances of the four case studies differ in significant respects, there are a number of common issues that can be identified.

Each of the case studies and Vancouver, in particular highlights the importance of creating a broad and diverse coalition of advocates and supporters to ensure the survival of harm reduction services. The example of Insite demonstrates that a key element in ensuring the continuation of the facility was the broad support it received from community advocates, law enforcement officials, academics and clients, as opposed to the failed NAOMI trial which worked mostly in isolation. This case study also serves as a cautionary example, highlighting the marginal social status of PWID and the potential role this has in the 'acceptability' of rolling back on harm reduction.

The Canadian and Russian case studies highlight the importance of legal mechanisms and the value of forging connections with legal professionals to protect harm reduction. In the case of Insite the ongoing use of legal mechanisms bypassed political opposition to harm reduction and helped to ensure the survival of the project. Moreover, this ruling provided legal cover for the opening of further safer injecting facilities in other parts of Canada. Similarly in Russia the use of legal mechanisms is now being applied with the hope that it will enable NGOs to side-step political resistance to harm reduction. While these initiatives are in their early stages, it is clear from the Canadian example, in particular, that this is a strategy worth exploring further.

Several case studies highlight the fundamental role of funding (or the lack thereof) in sustaining harm reduction programmes, and the significant role of donor advocacy. The case study from Thailand emphasised the need for donors to balance performance-based quantitative indicators with less quantifiable activities such as advocacy, and for international donors to take into account hostile political environments and adjust indicators and activities accordingly. The Australian study highlighted the precariousness of government funding and the need for funding mechanisms that are independent from the state for civil society strengthening, in particular for organisations of PWUD. Autonomous funding mechanisms are clearly a common need to allow harm reduction advocates to function as 'community watchdogs'. Moreover, in Russia it is clear that international donors are the only hope for the survival of harm reduction services, not only as funders but also as independent bodies with some influence over resistant

governments to put in place evidence-based strategies for HIV prevention for PWID.

Another key theme that emerges from the case studies is the importance of involving PWUD in advocacy activities. In Australia the scale-up of harm reduction can be attributed in part to the activities of networks and organisations of drug users, including self-organising, advocating and peer support. In Vancouver the Eastside community and service users of Insite and drug user organisations such as VANDU played a vital role in keeping the facility open. In Thailand ongoing advocacy from PWUD has been vital in ensuring the expansion of harm reduction services, as well as ensuring that the regressive policies and practice of the Thai government are recorded and highlighted to donors and the international community.

The Australian case study discusses the potential threat posed by the emergence of the 'new recovery' movement. It is particularly threatening to harm reduction in Australia, as it uses the language of harm reduction yet deviates from the key principles of pragmatism, evidence-based interventions and the meaningful involvement of PWUD. It is, therefore, extremely important for harm reduction professionals internationally to ensure that harm reduction messages are delivered in clear and coherent ways to ensure they cannot be co-opted.

The Australian case study also raises concerns about mental health providers taking the lead in harm reduction services. It notes that, although mental health provision is an extremely important component of a comprehensive package for drug users, it is dangerous to subsume all drug services under this label, as it suggests that PWUD are 'unwell' and unable to make informed decisions, thereby undermining efforts to support active drug users to self-organise and advocate.

In conclusion, threats to the continued implementation of programmes at a level that can impact on epidemics among PWID are a challenge to harm reduction practitioners and advocates in various political and economic contexts. The strategies to overcome these threats are multiple and varied, but all require strong and strategic advocacy for harm reduction, particularly in the current context of uncertain international financing and wavering or poor political support for harm reduction in many parts of the world. These case studies underline the importance of donors, governments and civil society organisations themselves recognising and prioritising advocacy as key to ensuring sustainable and scaled-up harm reduction responses.

References

1. 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: WHO.
2. Mathers B et al (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.
3. Ball A et al. (eds) (2005) World Health Organization – Evidence for action for HIV prevention, treatment and care among injecting drug users, *International Journal of Drug Policy,* 16, supp 1.
4. UNAIDS (2011) *Global AIDS Response Progress Reporting 2012 Guidelines. Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS*. Geneva: UNAIDS.
5. Stimson GV et al. (2010) *Three Cents a Day Is Not Enough: Resourcing HIV-Related Harm Reduction on a Global Basis*. London: International Harm Reduction Association.
6. Aramrattana A et al. (2011) Using the Multiplier Method to Estimate the Population Size of Injecting Drug Users (IDUs) in Thailand, 2009. Presentation at the '10th International Congress on AIDS in Asia and the Pacific', 26–30 August 2011, Busan, Republic of Korea.
7. Mathers B et al. for the 2007 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): 1733–45.
8. UNAIDS (2012) Global AIDS Progress Reports, http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/progressreports/2012countries/.
9. 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.
10. Government of Thailand (2002) *Thai Narcotic Addict Rehabilitation Act* B. E. 2545. Bangkok: Government of Thailand.
11. Canadian HIV/AIDS Legal Network (2009) *Drug Use and HIV/AIDS in Thailand*. Toronto: Canadian HIV/AIDS Legal Network.
12. Open Society Institute (2009) Civil Society Reflections on 10 Years of Drug Control in Myanmar, Thailand and Vietnam: A Shadow Report, *At What Cost? HIV and Human Rights Consequences of the Global 'War on Drugs'*. New York: Open Society Institute.
13. World Bank (2011) *Harm Reduction Policies and Interventions for Injection Drug Users in Thailand*. Washington, DC: World Bank.
14. Thai AIDS Treatment Action Group and Urban Health Research Initiative of the British Columbia Centre for Excellence in HIV/AIDS (2011) *Reducing Drug-Related Harm in Thailand: Evidence and Recommendations from the Mitsampan Community Research Project*. Bangkok: Thai AIDS Treatment Action Group.
15. Canadian HIV/AIDS Legal Network (2009) *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Toronto: Canadian HIV/AIDS Legal Network.
16. National News Bureau of Thailand (2011) *Yingluck declares 6 war-on-drugs stratagems,* 11 September 2011, http://thainews.prd.go.th/en/news.php?id=255409110012 Accessed 14 July 2012.
17. *Bangkok Post* (2011) Govt drugs fight lauded, 23 September 2011, www.bangkokpost.com/news/local/257872/govt-drugs-fight-lauded Accessed 14 July 2012.
18. *The Nation* (2011) Anti-narcotics board plans crackdown, 5 October 2011, www.nationmultimedia.com/new/national/Anti-narcotics-board-plans-crackdown-30166865.html Accessed 14 July 2012.
19. Global Fund (2012) Grant Portfolio: Thailand – Comprehensive HIV prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-3), http://portfolio.theglobalfund.org/en/Grant/Index/THA-809-G11-H Accessed 14 July 2012.
20. Bridge J et al. (2012) Global Fund investments in harm reduction from 2002 to 2009, *International Journal of Drug Policy,* 23, 279–285.
21. The Kirby Institute (2011) *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2011.* Sydney: The Kirby Institute, University of New South Wales.
22. Ritter A, Lancaster K, Grech K & Reuter P (2011) An Assessment of Illicit Drugs Policy in Australia (1985–2010): Themes and Trends. *Drug Policy Modelling Program; Monograph 1.* Sydney: National Drug and Alcohol Research Centre.
23. National Centre in HIV Epidemiology and Clinical Research (2010) *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia 2009.* Sydney: University of New South Wales.
24. Australian Agency for International Development (2009) *Intensifying the response: Halting the spread of HIV. Australia's international development strategy for HIV.* Canberra: Department of Foreign Affairs and Trade.
25. Douglas R & McDonald D (2012) *The Prohibition on Drugs is Killing and Criminalising Our Children and We Are All Letting It Happen. Report of a High-Level Australia 21 Roundtable*, http://www.australia21.org.au//publications/press_releases/Australia21_Illicit_Drug_Policy_Report.pdf, Accessed 14 July 2012.
26. Ministerial Council on Drug Strategy (2011) *The National Drug Strategy, 2010–2015: A framework for action on alcohol, tobacco and other drugs*. Canberra: Commonwealth of Australia.
27. Strathdee S, Patrick DM, Currie SL, Cornelisse PG, Rekart ML, Montaner JS et al. (1997) Needle exchange is not enough: lessons from the Vancouver injecting drug use study, *AIDS*, July;11(8):F59–65.
28. MacPherson D, Mulla Z & Richardson L (2006) The evolution of drug policy in Vancouver, Canada: Strategies for preventing harm from psychoactive substance use, *International Journal of Drug Policy*, March;17(2):127–32.
29. Wood E, Kerr T, Montaner JS, Strathdee SA, Wodak A, Hankins CA et al. (2004) Rationale for evaluating North America's first medically supervised safer-injecting facility, *Lancet Infectious Diseases*, May;4(5):301–6.
30. Oviedo-Joekes E, Nosyk B, Brissette S, Chettiar J, Schneeberger P, Marsh DC et al. (2008) The North American Opiate Medication Initiative (NAOMI): Profile of Participants in North America's First Trial of Heroin-Assisted Treatment, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Aug. 29;85(6):812–25.
31. Nosyk B, Guh DP, Bansback NJ, Oviedo-Joekes E, Brissette S, Marsh DC et al. (2012) Cost-effectiveness of diacetylmorphine versus methadone for chronic opioid dependence refractory to treatment, *Canadian Medical Association Journal*, Apr. 3;184(6):E317–28.
32. Bayoumi AM & Zaric GS (2008) The cost-effectiveness of Vancouver›s supervised injection facility, *Canadian Medical Association Journal*, Nov. 18;179(11):1143–51.
33. Wood E, Kerr T, Lloyd-Smith E, Buchner C, Marsh DC, Montaner JS et al. (2004) Methodology for evaluating Insite: Canada›s first medically supervised safer injection facility for injection drug users, *Harm Reduction Journal*, Nov. 9;1(1):9.

34. Kerr T, Tyndall M, Li K, Montaner J, Wood E (2005) Safer injection facility use and syringe sharing in injection drug users, *Lancet*, Jun.;366(9482):316–8.
35. Wood E, Tyndall MW, Zhang R, Montaner JSG & Kerr T (2007) Rate of detoxification service use and its impact among a cohort of supervised injecting facility users, *Addiction*, June;102(6):916–9.
36. Marshall BDL, Milloy M-J, Wood E, Montaner JSG & Kerr T (2011) Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study, *Lancet*, Apr. 23;377(9775):1429–37.
37. Fischer B, Oviedo-Joekes E & Blanken P (2007) Heroin-assisted treatment (HAT) a decade later: A brief update on science and politics. *Journal of Urban Health*, July; 84(4):552–562.
38. Oviedo-Joekes E, Nosyk B, Marsh DC, Guh D, Brissette S, Gartry C et al. (2009) Scientific and political challenges in North America's first randomized controlled trial of heroin-assisted treatment for severe heroin addiction: Rationale and design of the NAOMI study, *Clinical Trials*, June 15;6(3):261–71.
39. Oviedo-Joekes E, Brissette S, Marsh DC, Lauzon P, Guh D, Anis A et al. (2009) Diacetylmorphine versus methadone for the treatment of opioid addiction, *New England Journal of Medicine*, Aug. 20;361(8):777–86.
40. Blanken P, van den Brink W, Hendriks VM, Huijsman IA, Klous MG, Rook EJ et al. (2010) Heroin-assisted treatment in the Netherlands: History, findings, and international context, *European Neuropsychopharmacology*, Apr.;20 Suppl 2:S105–58.
41. Small W, Ainsworth L, Wood E & Kerr T (2011) IDU perspectives on the design and operation of North America's first medically supervised injection facility, *Substance Use & Misuse*, 46(5):561–8.
42. Wood E, Kerr T, Tyndall MW & Montaner JSG (2008) The Canadian government's treatment of scientific process and evidence: Inside the evaluation of North America's first supervised injecting facility, *International Journal of Drug Policy*, June;19(3):220–5.
43. Small D, Palepu A & Tyndall MW (2006) The establishment of North America's first state sanctioned supervised injection facility: A case study in culture change, *International Journal of Drug Policy*, Mar.;17(2):73–82.
44. NAOMI Patients Association & Boyd S (2012) *NAOMI research survivors: Experiences and recommendations*. Vancouver: NAOMI Patients Association.
45. Rhodes T, Sarang A, Bobrik A, Bobkov E & Platt L (2004) HIV Transmission and HIV prevention associated with injecting drug use in the Russian Federation, *International Journal of Drug Policy*, 15: 1–16.
46. Burrows D, Trautmann F, Frost L, Bijl M, Sarankov Y, Sarang A, Chernenko O & Pogosyan L (2000) Processes and outcomes of training on rapid assessment and response methods on injecting drug use and related HIV infection in the Russian Federation, *International Journal of Drug Policy*, 11 (1-2): 151–167.
47. Rhodes T, Sarang A, Vickerman P & Hickman M (2010) Policy resistance to harm reduction for drug users and potential effect of change, *British Medical Journal*, 341:c3439 doi: 10.1136/bmj.c3439.
48. Thomson B, Campbell A, Shishkin S & Onischenko V (2007) *Evaluation of DFID Russia Programme 2001–2005*. Evaluation Report EV677. London: UK Department for International Development.
49. World Bank (2009) *Implementation Completion And Results Report On A Loan In The Amount Of US$ 150 Million To The Russian Federation For A TB AIDS Control Project*. Washington, DC: World Bank.
50. Cook C & Kanaef N (2008) *Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics*. London: International Harm Reduction Association.
51. Golikova T (2008) Speech by the Russian Minister of Health and Social Development at the 'Second Eastern Europe and Central Asia AIDS Conference', Moscow, 5 May 2008, http://2008.eecaac.org/en/index.phtml Accessed 14 July 2012.
52. Cook C (2010) *The Global State of Harm Reduction 2010: Key Issues for Broadening the Response*. London: International Harm Reduction Association.
53. Andrey Rylkov Foundation for Health and Social Justice (2011) *Report on the course of implementation by the Russian Federation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*. Moscow: Andrey Rylkov Foundation, http://rylkov-fond.org/files/2011/03/CND-Report-Russia-NGOs-ENG18.03.pdf Accessed 14 July 2012.
54. Burki T (2012) Russia's drug policy fuels infectious disease epidemics, *Lancet*, Vol 12: 275–276.
55. Iakobishvili E & Stoicescu C (2012) Russia's Free Speech and Public Health Crackdown, *The Huffington Post*, 9 February 2012, http://www.huffingtonpost.com/eka-iakobishvili/russias-free-speech-and-p_b_1265805.html Accessed 23 May 2012.
56. Andrey Rylkov Foundation (2011) *"ATMOSPHERIC PRESSURE" – Shadow Report to the UN Committee against Torture in relation to the review of the Fifth Periodic Report of the Russian Federation*. Moscow: Andrey Rylkov Foundation.
57. Andrey Rylkov Foundation (2012) *Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice (ARF) for promoting the recommendations made by the UN Committee on Economic, Social and Cultural Rights (CESCR) to the Russian Federation in its Concluding Observations*. Moscow: Andrey Rylkov Foundation.
58. Andrey Rylkov Foundation (2012) *Appeal lodged with UNESCO on Russia's violation of the right to enjoy the benefits of scientific progress*. Moscow: Andrey Rylkov Foundation.

LESSONS FROM HISTORY:
Advocating for harm reduction in challenging environments

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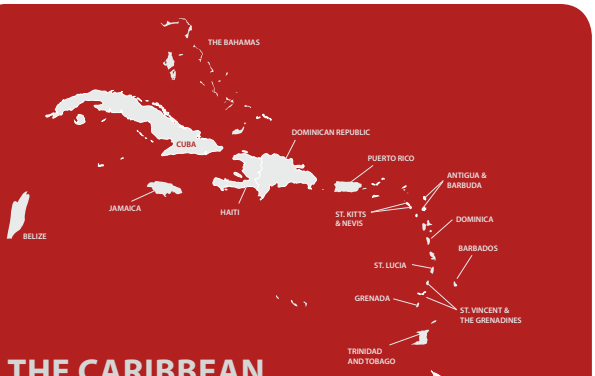
INTRODUCTION

The reasons for starting and scaling-up harm reduction services are multifaceted, compelling and well established. If policy-making were a purely scientific, objective and methodical process, harm reduction would already be the global norm. However, this is not the case. Section 1 lists 158 countries that report injecting drug use (IDU), of which 94 support harm reduction in policy and/or practice to help individuals stay safe, manage or end their drug use and avoid blood-borne viruses (BBV). The other 64 countries still do not support and/or implement harm reduction. What accounts for these variations in response? What makes one country adopt harm reduction in policy and practice, while a neighbour continues to ignore the evidence?

This chapter highlights four examples from around the world where harm reduction has been endorsed to varying degrees: from early adoption and nationwide scale-up in Switzerland and Macedonia, to opening the harm reduction debate in Malaysia and overcoming strong ideological resistance in the Caribbean. Each case study explores how harm reduction came to be accepted and documents the events and actions that were key to this process. It is hoped that this chapter will inform ongoing advocacy efforts for harm reduction elsewhere in the world and provide encouragement to those who are working to promote change in their own countries — including those in both governmental and nongovernmental positions. At the same time, it should be equally relevant for countries that are seeing their existing services come under threat (see Chapter 3.6 for a more in-depth discussion of this).



THE CARIBBEAN

Injecting drug use is reported to be rare in the Caribbean region, with the notable exception of Puerto Rico. The harm reduction response in the region remains very limited, with needle and syringe exchange and opioid substitution therapy only available in Puerto Rico. The response in the rest of the region is predominantly characterised by abstinence-based, high-threshold services. The use of illicit drugs is highly criminalised, with harsh sentencing resulting in large numbers of people who use drugs in Caribbean prisons. This case study illustrates the emergence of harm reduction advocacy in the region and describes the various efforts which have contributed to its wider acceptance.

Drug policy in the Caribbean has always been heavily influenced by the USA, and its historical antipathy toward harm reduction approaches as 'capitulation' to drug use. In the 1990s, any mention of the term 'harm reduction' would lead to the loss of US State Department funding for drug demand reduction programmes. In 1997, the European Commission contracted a situational assessment of drug treatment in the Caribbean, which remains an influential work to this day.[1] The following year, Deutsche Orden Hospitaller (DOH) International received a grant from the European Commission to expand low-threshold programmes for street-engaged people who use drugs.

In the absence of prevalent drug injecting, harm reduction in the Caribbean often refers to services that treat people who use drugs with respect and dignity: providing food, clothes, showers, referrals and a supportive, listening ear. However, when the first drop-in centres began implementing this approach, service providers were forced to label them as 'public health approaches' to address HIV among the homeless, rather than harm reduction for people who use drugs. The first drop-in centre in the Caribbean was opened in Castries (Saint Lucia) in 2000, followed by centres in Santo Domingo (Dominican Republic) in 2001, Kingston (Jamaica) in 2002 and Port of Spain (Trinidad) in 2003.

Meanwhile, work was being done by leading activists in the halls of the Caribbean Community (CARICOM) Secretariat to place harm reduction on the agendas of various Councils of Ministers. In particular, as a result of the work and advocacy efforts of a handful of researchers and service providers, there was a growing acceptance by the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), the UNAIDS Regional Office and others of an overlap between non-injecting crack cocaine use and HIV infection, with five to 10 times the national prevalence among this population.[2] This countered the common argument that 'Caribbean people do not inject, so there is no link with HIV'.

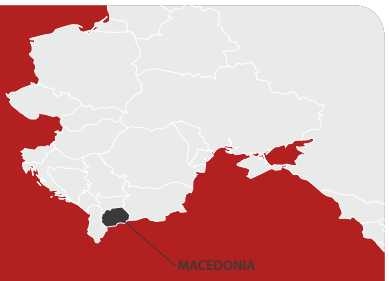
In 2001, the Foreign and Commonwealth Office commissioned an evaluation of demand reduction programmes in the Caribbean, which confirmed the link between crack smoking and unsafe sexual behaviours, leading to increased HIV infections.[3] In the Nassau Declaration on Health 2001, Caribbean Heads of Government committed to Phase II of the Caribbean Cooperation in Health Initiative, which explicitly

classified substance use as a mental health and public health issue.[4,5] A steady stream of US-funded interventions continued to undermine harm reduction by focusing solely on drug use prevention and high-threshold abstinence-based services. However, harm reduction programmes remained successful in reaching and supporting 'hidden' populations in the region.

Several events led to 2001 being a pivotal year for civil society advocacy. A number of Caribbean treatment professionals attended the International Harm Reduction Conference in Delhi, India, and the US Harm Reduction Conference in Miami later that year. At the latter event, the Caribbean Harm Reduction Coalition (CHRC) was formed during a special satellite meeting. CHRC set out to promote the emerging experiences in the region and support research to increase the evidence base for interventions. The Caribbean Drug and Alcohol Research Institute was then formed to work alongside CHRC and provide the necessary evidence to support advocacy efforts. In 2004, the Caribbean Vulnerable Communities Coalition was formed, of which CHRC was a founding member, and allowed for the expansion of harm reduction to other vulnerable groups such as sex workers and men who have sex with men.

Despite the weight of US drug policy in the region, contributions from a range of international donors and partners have proven invaluable for the success of harm reduction efforts. The original European Commission funding got the ball rolling, while support from the Open Society Foundations and the UK Department for International Development (via Harm Reduction International) enabled the exchange of information, ideas and experiences across the region and internationally. In 2008, the Caribbean Vulnerable Communities Coalition began work on a successful multi-country proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria.[6] Although injecting and opioid use is less common in the Caribbean than in many parts of the world, non-injecting crack cocaine users were included as a target population, and programmes began in 2011. As a result of a rapid assessment conducted by CHRC that documented heroin injecting, efforts are also underway to provide sterile injecting equipment and to advocate for the adoption of opioid substitution therapy (OST) interventions by Caribbean governments.

Overall, the HIV crisis in the region facilitated the emergence of harm reduction as a proven public health response. Governments were presented with a harsh economic reality: they would experience a significant drop in Gross National Product if the HIV epidemic were left unaddressed. With the establishment of the Caribbean Vulnerable Communities Coalition, CHRC became part of a Caribbean-wide movement advocating for the adoption of a human rights-based agenda to augment the public health arguments previously espoused. Although the HIV epidemic remains, responses to HIV are presently more practical and evidence-informed. Agencies that previously were resistant to adopting harm reduction strategies a decade ago began to embrace and implement variations of harm reduction adapted to the contextual realities they experienced. Trinidad adopted harm reduction as part of its national drug policy, supporting the continuation of the drop-in centre started with European Development Fund (EDF) funding in 2003. Jamaica carried this one step further when the National Council for Drug Abuse received support from the Ministry of Health to operate a mobile outreach project targeting homeless street-engaged crack smokers. As this report shows, three of the countries in the region now embrace harm reduction in policy and/or practice (see Section 1: Global Overview). Advocacy efforts are ongoing, but the Caribbean example shows how harm reduction can be promoted even under the shadow of a major global detractor such as the USA.



MACEDONIA

The timely introduction of harm reduction interventions is credited for averting an HIV epidemic among PWID in Macedonia. This case study outlines the antecedent factors which contributed to the adoption of a harm reduction approach in the country, including well-timed research and well-placed civil society actors funded to take forward research recommendations. In addition to this, international technical assistance and the continued engagement of decision-makers, civil society groups and people who use drugs have been critical factors in developing the national harm reduction response.

In Macedonia, harm reduction began with the provision of OST to a very small group of people from the early 1980s, growing into an organised state-run programme from 1990 onwards. In addition, however, two key milestones stand out in the development of broader harm reduction policies and programmes.

The first of which was the research of Jean-Paul Grund and Dusan Nolimal in 1995 entitled *The Heroin Epidemics in Macedonia*.[7] This report for the Open Society Foundations was perfectly timed — HIV had not become established in Macedonia, but research indicated that widespread high-risk injecting behaviours such as syringe sharing could drive the emergence of an HIV epidemic among people who inject drugs (PWID). One of the report's recommendations was to open needle and syringe exchange programmes (NSPs). As

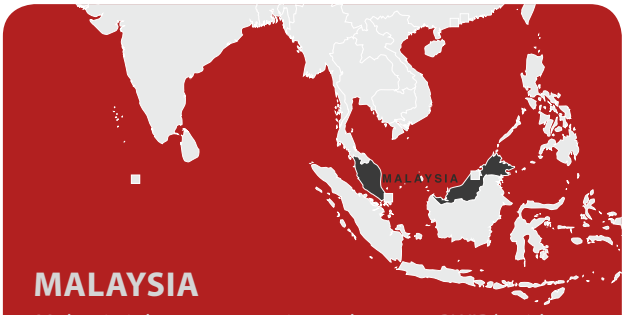
a result, the first service opened in 1996 via the Macedonian Association for Socio-Culture Activities (MASKA). This move was initiated by people who use drugs and supported by the Open Society Institute in Macedonia.

The second key milestone was the founding in 1997 of the Healthy Options Project Skopje (HOPS), a nongovernmental organisation (NGO) that continued the work undertaken by MASKA. Since then, HOPS has developed or supported all 16 harm reduction programmes in 13 towns across Macedonia. Because of this work, harm reduction programmes can be seen even in towns with populations of just 20,000 people. Harm reduction programmes have also been developed for the Roma suburbs, as well as for sex workers who inject drugs.

HOPS has played a key role in promoting harm reduction in Macedonia through these services, by promoting and respecting the meaningful involvement of people who use drugs in all programmes and insisting on a wide spectrum of services being made available (beyond just needles, syringes and condoms). At present, the majority of harm reduction programmes also provide medical, social and psychiatric services, and legal aid and court representation in cases of human rights violations. Experience has shown that only this comprehensive approach can achieve the coverage and results that are needed. Annually, these programmes serve more than 3,000 PWID — approximately one-third of the estimated number of people in need.[8]

The feared HIV epidemic in the country has been avoided. This has been largely attributed to the immediate implementation of harm reduction programmes, according to the latest available evidence. Only 10 of the 142 registered HIV cases are among PWID, and there have been just two cases of HIV among PWID in the last eight years.[9] Intolerance of drug use and harm reduction programmes was overcome by engaging and bringing together decision-makers, authorities, civil society groups and people who use drugs.

A key strategy used to achieve a shift in initially hostile attitudes was the inclusion of state and local government bodies in joint project activities financed by the Global Fund and the Open Society Foundations. Cooperation with the international community was also important. Experts and agencies such as UNAIDS, WHO, UNICEF and the European Union were all involved in advocating for changes to state policies on HIV and drugs. Macedonia's EU candidacy also played a role in pushing the finalisation of the National Drugs Strategy 2006–2012 and its reflection of international guidance on harm reduction.[10] With this collective support, harm reduction was first mentioned in official government documents as part of the National Strategy on HIV/AIDS in 2003 and, subsequently, as part of the National Drugs Strategy in 2006. In 2011, for the first time, small quantities of the needles, syringes, condoms and lubricants needed for harm reduction programmes were purchased through the state budget. Another important element has been the inclusion of state and local government bodies such as the Ministry of Health, Ministry of Social Policy, the National Drug Coordinator and the Departments for Social and Health Protection in activities within local municipalities, which has helped to shift the initial attitudes to drug use and harm reduction. Local municipalities are also supportive of harm reduction approaches, including through the provision of local funding for such programmes. Slowly but surely, harm reduction is becoming ingrained within national health and social care systems.



MALAYSIA

Malaysia is home to an estimated 170,000 PWID[4], with the latest reported HIV prevalence among them being 8.7%.[4] Hepatitis C prevalence among PWID remains high at 67.1%.[11] In recent years, Malaysia has refocused efforts into scaling up harm reduction services and is now reported to have 'medium' NSP coverage and increasing OST coverage.[12] This case study catalogues developments leading to the policy shift towards harm reduction, including strong civil society advocacy, and the important approval of a harm reduction approach by Islamic scholars. Also described is the recent movement towards evidence-based treatment options in favour of drug detention centres.

For many decades, Malaysia has employed a punitive and prohibitionist drug policy, characterised by a statutory presumption of trafficking when possessing more than a certain quantity of drugs (such as 200g of cannabis and 15g of heroin), mandatory death sentences, incarceration for personal drug use offences and a vision of a drug-free nation by 2015.[13] However, since the turn of the century, there has been a policy shift toward harm reduction.[14] This was a response to HIV epidemics among PWID. At the height of the epidemic, Malaysia recorded approximately 7000 new infections in 2002, 75% of which were due to injecting.[15] The shift in approach was certainly facilitated by international and internal pressure to achieve all eight Millennium Development Goals (MDGs), the prerequisites for being categorised as a developed nation.[16] Malaysia has achieved seven of these goals, the exception being the goal related to HIV.

Although the policy decisions were made by the federal government, they were clearly influenced by strong voices from patient groups and NGOs such as the Malaysian AIDS Council (MAC). In 2002, a grant was obtained from the US National Institutes of Health for exploratory research and a rapid situational analysis on HIV and drug use.[17]

A Harm Reduction Working Group was then formed, hosted by MAC, which used the data and findings to advocate to the relevant government agencies. The Working Group also worked with Islamic scholars to obtain their buy-in, and the Institute for Islamic Understanding of Malaysia pronounced harm reduction to be a public health issue which did not violate *shariah* law.[18]

At around the same time that the MDG results were released, the case for NSPs and OST was presented to the Prime Minister, Deputy Prime Minister and a governmental committee on drugs. Approval was given for methadone treatment and later, from the Minister of Health, for needle and syringe distribution. Free antiretroviral treatment (ART) was introduced in 2004, methadone pilot projects began in 2005 (and have since been expanded nationwide to include community and prison programmes, as well as a pilot clinic within a mosque setting), and NSPs began in 2006. Between 2006 and 2010, Malaysia saw a decline in the annual number of recorded HIV cases,[19] although this cannot be solely attributed to the introduction of the harm reduction programmes. Additional factors that may have contributed to the overall decline in HIV prevalence include the decreasing purity of heroin, which has led some PWID to switch to inhaling or to consuming methamphetamine tablets or buprenorphine, the increasing influx of amphetamine-type substances from East Asia,[20] and improved coverage of awareness and prevention programmes for other key populations at higher risk of HIV.[21]

In recent years, dialogue around Malaysian drug policy has begun to move away from HIV as the sole reason for reform. Arguments are increasingly being made based on an understanding that policies focusing on incarceration and corporal or capital punishment do not work. Malaysia has seen increased cooperation between NGOs and police and anti-drug agencies, which has helped to promote the humanitarian and health perspectives of drug use and dependency. While 'hard-line' perspectives and rhetoric still obviously exist, they are being broken down over time. Even among senior members of the police force there is a growing realisation that the 'war on drugs' has failed, and an openness to discuss alternatives such as police referrals into health services. Although HIV remains a concern, it has now become easier to argue for harm reduction on the basis of the dignity, health and productivity of the individual person who uses drugs.

These approaches contributed to the introduction of state-run 'Cure and Care' clinics in early 2010 by the National Anti-Drugs Agency. These facilities are voluntary clinics which provide integrated healthcare for PWID, including methadone treatment and counselling. This represents a significant paradigm shift for an agency that has traditionally focused on compulsory detention centres (or 'Pusat Serenti'). These centres still exist across Malaysia, but the number of people held in them is in decline.

Since the introduction of harm reduction programmes, Malaysia has seen a positive shift toward evidence-based prevention and treatment for people who use drugs. These programmes have continued to expand nationwide, and have led to increased collaboration between health workers and law enforcers. Today, MAC and numerous partner organisations continue to work toward reducing HIV infections among PWID and raise awareness about harm reduction, safe sex and the destigmatisation of people living with HIV. However despite these major advances, challenges still remain amidst a legal and policy environment that continues to heavily criminalise drug use.

SWITZERLAND

There are an estimated 31,653 PWID in Switzerland.[22] The early introduction of harm reduction measures had a dramatic impact on the HIV epidemic among PWID, which in 1990, was the most severe in Europe. Switzerland now maintains a low HIV prevalence among this group at 1.4%.[23] This case study describes the factors which culminated in the development of a pioneering and committed harm reduction response, including advocacy from professionals in the health and social sectors and Swiss professionals taking opportunities to learn from international experiences.

In the 1980s, Switzerland experienced a steady rise in the number of people using drugs, the amount of seized drugs, drug-related crimes (including organised crime leading to higher drug prices, delinquency and prostitution) and deaths related to overdose.[24] By 1990, the HIV infection rate in Switzerland was the highest in Europe.[25] Despite the alarming trends, prominent psychiatrists and officials remained opposed to harm reduction.[26] This led to protests from health professionals, social workers, some politicians and the media, all of whom accused officials of exacerbating the problem. In 1985, for example, a heated debate broke out when the Chief Medical Officer in Zürich prohibited NSPs and threatened severe sanctions against any organisation that offered them. Around 300 physicians signed a declaration challenging this stance.[27] A parliamentary investigative committee also reproached the Chief General Attorney for remaining passive while crime rates and organised crime increased.[28] That same year, the Swiss AIDS Federation was founded to advocate strongly for key services,[29] and numerous attempts were made

by activists to try to improve the health and social situation of people who use drugs.

Crucially, the Federal Subcommittee on Drug Questions (EKDF) published a report in 1989 proposing various measures to reduce harm, including widespread OST.[30] The Federal Office of Public Health (FOPH) sent this report to the major stakeholders for consultation.[31] In 1990, several Swiss professionals attended the first international harm reduction conference in Liverpool, and an FOPH delegation to England, the Netherlands and Sweden further supported the roll-out of harm reduction. The well-documented harm reduction work being done in Australia was also a major inspiration.

As a result of this work, at a national drug conference in October 1991,[32] 'survival assistance/harm reduction' was confirmed as one of the four pillars of the new Swiss drug policy (alongside 'repression', prevention and treatment).[33,34] This decision was particularly informed by the measurement of various drug-related indicators to compare the efficacy of different measures.[35] During this process, EKDF helped to bridge the gap between activists, professionals and the government. Its report proposed viable solutions later adopted by the government and implemented by the FOPH, while an Advocacy Coalition Framework helped to make the decision possible.[36]

During the last two decades, harm reduction in Switzerland has been held up as an example of best practice in the field. All levels of government have entrusted public services and civil society to provide comprehensive support for people who use drugs. The first authorised drug consumption room (DCR) opened in 1986 in Berne, and similar facilities soon opened in Zürich and Basel, providing contact points, food and basic medical care.[37,38] Low-threshold OST became widely available in most of the country, and methadone prescriptions rose steadily from a few hundred in 1975 to 10,000 in 1991, and then stabilised at around 17,000 per year.[39] The various cantons (districts) offer DCRs, NSPs[40] (including in pharmacies) and night services.[41] Heroin assisted treatment is also provided (and is considered as treatment rather than harm reduction) despite initial opposition from the International Narcotics Control Board[42] and the WHO. This intervention now reaches around 1000 of the estimated 30,000 people who use heroin. The FOPH also supported the creation of projects, including safer night-life programmes, and cities and cantons have assured sustainability by integrating activities into their budgets.[43]

The results of this approach are clear, not least in the downward trend in HIV transmission – an estimated 1.4% of PWID are currently living with HIV.[44] Just 4% of new HIV infections were associated with IDU in 2007, compared with the late 1980s and early 1990s when this was the primary mode of transmission.[45] Illegal drug use in public spaces is now less of an issue, and the number of deaths from overdose has declined markedly over the last 20 years.[46,47] Whereas public health and public order arguments were the most prominent in the early stages of the Swiss debates, ethical considerations and human rights were also a key part of the discussion. Harm reduction is considered a means to save lives and support people to survive their drug use, and this overcame the convictions that drug consumption violated other fundamental values of Swiss society.[48]

More than 25 years after opening its first DCR, Switzerland has firmly embedded harm reduction within its drug policy. The actions of activists, advocates and professionals helped to mainstream this approach, while the concrete evidence and data provided by researchers empowered the public and politicians to agree on pragmatic steps. Harm reduction in Switzerland no longer faces opposition from international organisations such as the WHO, and numerous referenda and popular initiatives have confirmed continuing support from the Swiss public (the most recent being in 2008). Although many aspects of this example may be considered 'typically Swiss', there remain numerous lessons that can be applied by other countries.[49]

CONCLUSION

This chapter highlights the successes achieved in advocating for harm reduction in the Caribbean, Macedonia, Malaysia and Switzerland. There are numerous other countries that could have also been featured, but the highlighted examples successfully draw out several key themes. Across all these case studies, it is clear that scientific research and the collection and communication of data are essential to make strong and evidence-based arguments to policymakers. The role of dedicated civil society groups is also clearly pivotal. Organisations such as CHRC, HOPS and MAC have all helped to engage and convince governments and religious leaders through innovative service delivery, organising or attending key meetings and events (including the International Harm Reduction Conferences) and generating and communicating sound evidence.

In all four examples, high rates of HIV transmission among people who use drugs was a key factor in the early conversations around harm reduction, and this remains the case in many countries around the world. While some countries such as Malaysia needed to react in order to control and reverse existing epidemics, others such as Macedonia were able to generate action to avert potential crises. This latter approach may be particularly important now for sub-Saharan Africa, where injecting-driven epidemics are beginning to emerge. Crucially, dialogue around HIV vulnerability, prevention and treatment has also helped to open doors to broader conversations around human rights, the overall health and well-being of PWID and the development of supportive policy environments.

These four case studies also demonstrate the need to carefully tailor approaches to the local situation. For example, whereas Switzerland embraced heated public debates to negotiate the issue in the 1980s, a more subtle approach was taken in the Caribbean to allow services to be delivered under the watchful gaze of the USA. Effective advocacy has to reflect the local context and should ideally be driven by local groups who best understand this context (meaning that these groups should be appropriately funded and empowered to perform this role). The relevant groups, whether governmental or nongovernmental, must acknowledge and understand the factors that guide policy decisions. Interestingly, these examples also allude to a diversity in the motivations of policy makers in adopting harm reduction, including ensuring national productivity, improving public health and order, and achieving MDGs and consequent 'developing country' status. Crucially, advocates must also decide and focus on which factors they can realistically influence or control. Although the ultimate 'tipping point' may come from factors beyond their control (such as changes in political leadership), their work will lay the foundations for policy shifts for change. Finally, the four examples highlighted here also demonstrate the need for patience. In the Caribbean, Macedonia, Malaysia and Switzerland, there will undoubtedly have been times when it seemed like fighting a losing battle. The policy shifts described here happened over a prolonged period and as the result of tireless and dedicated activism and advocacy.

Factors Influencing Successful Local Advocacy for Harm Reduction

- Carefully tailor responses to local contexts
- Involvement of strong, local civil society organisations
- Innovative services opened (with or without official support or permission)
- Commissioning or conducting research
- Evidence made accessible for policymakers and the public
- Clear articulation of costs, benefits, and risks of inaction
- Empowerment and meaningful engagement of people who use drugs
- Key groups united for discussions and debate: policymakers, academics, civil society, religious groups, the media and people who use drugs
- Conferences, events and exchanges (international, regional and national)
- Support from international or regional donors and organisations
- Emphasis of international goals, commitments and targets (for public health, human rights and other issues)
- Alliances built with other fields and groups

REFERENCES

1. Kohler U & Moore D (1997) *Drug Treatment and Rehabilitation Needs: Report for the European Commission of the Assessment Mission for Drug Treatment and Rehabilitation Needs in the Caribbean*. Barbados: European Commission.
2. Klein A, Day M & Harriott A (Eds) (2004) Caribbean Drugs: From Criminalization to Harm Reduction. London: Zed Books.
3. Ibid.
4. Caribbean Community (CARICOM) Secretariat (2001) Nassau Declaration on Health 2001: The Health of the Region is the Wealth of the Region. Nassau: CARICOM.
5. Caribbean Community (CARICOM) Secretariat. Caribbean Cooperation in Health Initiative. Nassau: CARICOM.
6. Pan Caribbean Partnership against HIV/AIDS (PANCAP) (2009) *Global Fund Grant Proposal Form: Round 9*. Nassau: PANCAP.
7. Grund J-PC & Nolimal D (1995) *A Heroin Epidemic in Macedonia: Report to the Open Society Institute, New York and the Open Society Institute Macedonia*. New York: The Lindesmith Center.
8. Mikic V & Kuzmanovska G (2010) *Report from the Bio Behavioural Survey among Injecting Drug Users and Assessment of Population Size of Injecting Drug Users in Macedonia*. Skopje: UNAIDS/Institute for Public Health.
9. Zarko Karadzovski, Macedonia Institute for Public Health. Press conference, Skopje, 30 November 2011.
10. Ministry of Health of the Republic of Macedonia (2006) National Drugs Strategy of the Republic of Macedonia 2006–2012.Skopje: Ministry of Health.
11. 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
12. 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.
13. Rusdi AR, Noor Zuraini MHR, Muhammad MAZ & Mohamad HH (2008) A Fifty-Year Challenge in Managing Drug Addiction in Malaysia, *Journal of the University of Malaya Medical Centre*, 11(1):3–6.
14. Kamarulzaman A (2009) Impact of HIV Prevention Programs on Drug Users in Malaysia, *Journal of Acquired Immune Deficiency Syndromes*, 52(Supplement 1):S17–19.
15. Kamarulzaman A (2005) Taking Stock of Two Decades of the HIV/AIDS Epidemic in Malaysia, *Medical Journal of Malaysia*, 60(1):1–4.
16. Reid G, Kamarulzaman A & Sran SK (2007) Malaysia and Harm Reduction: The Challenges and Responses, International Journal of Drug Policy, 18(2):136–140.
17. Reid G, Kamarulzaman A & Sran SK (2004) *Rapid Situation Assessment of Malaysia*. Kuala Lumpur: University of Malaya.
18. Kamarulzaman A & Saifuddeen SM (2010) Islam and Harm Reduction, *International Journal of Drug Policy*, 21(2):115–118.
19. Malaysian AIDS Council 'HIV Statistics', http://www.mac.org.my/v3/?page_id=792 (last accessed 8 June 2012).
20. Personal e-mail communication with Fifa Rahman, Malaysian AIDS Council, Malaysia, 7 June, 2012.
21. Personal e-mail communication with Dr Adeeba Kamarulzaman, University of Malaya, Malaysia, 2 June, 2012.
22. 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.
23. European Monitoring Centre for Drugs and Drug Addiction. Statistical Bulletin 2011. Table INF-1. Prevalence of HIV infection among injecting drug users in the EU countries, Croatia, Turkey and Norway, 2009 or most recent year available — Summary table by country, http://www.emcdda.europa.eu/stats11/inftab1.
24. Herzig M (2007) 'Der Überlebenskampf der Überlebenden'. Presented at the Forum für Sucht und Drogen in Zürich, Switzerland, 27 November 2007.
25. Heller A & Binzegger L (1992) Drogenpolitik auf Irrwegen: Chronik eines verlorenen Kampfes, *Neue Zürcher Zeitung*, NZZ Folio 04/92.
26. Subkommission Drogenfragen der Eidgenössischen Betäubungsmittelkommission (Ed.) (1989) *Aspekte der Drogensituation und Drogenpolitik in der Schweiz.* Bern: Bundesamt für Gesundheit.
27. Kraushaar B & Lieberherr E (1996) Drogenland in Mafiahand. Entwicklung, Kommentar und Materialien zur Drogensituation in der Schweiz. Zürich: Werd-Verlag.
28. Bundesblatt (1995). Die Drogensituation in der Schweiz und im internationalen Umfeld. Bern: Bundeskanzlei.
29. AIDS Hilfe Schweiz '20 Jahre AIDS Arbeit an der Basis', http://www.aids.ch/d/20_Jahre/aidshilfen.html (last accessed 8 June 2012).
30. Subkommission Drogenfragen der Eidgenössischen Betäubungsmittelkommission (Ed.) (1989) *Aspekte der Drogensituation und Drogenpolitik in der Schweiz.* Bern: Bundesamt für Gesundheit.
31. Bundesamt für Gesundheit (1990) *Ergebnisse der Vernehmlassung zum Bericht der Subkommission Drogen der Eidgenössischen Betäubungsmittelkommission*. Bern: BAG.
32. Bundesamt für Gesundheit (2006) *Die Drogenpolitik der Schweiz: Drittes Massnahmenpaket des Bundes zur Verminderung der Drogenprobleme (MaPaDro III) 2006–2011*. Bern: BAG.
33. Schweizerische Eidgenossenschaft (1991) *Beschluss des Bundesrates vom 20. Februar 1991: Massnahmenpaket zur Verminderung der Drogenprobleme*. Bern: Bundeskanzlei.
34. Lehmann P (1997) The Principle Aims of Drug Policy in the Swiss Confederation, in FOPH (Ed.) The Medical Prescription of Narcotics. Bern: Hogrefe & Huber.
35. Gervasoni GP, Dubois-Arber F, Benninghoff F, Spencer B, Devois Th & Paccaud F (1996) *Evaluation of the Federal Measures to reduce the problems related to drug use. Second Synthesis Report 1990–1996*. Lausanne: Institut de médecine sociale et preventive.
36. Kübler D (2001) Understanding policy change with the Advocacy Coalition Framework: an application to Swiss drug policy, *Journal of European Public Policy*, 8(4):623–641.
37. Bundesamt für Gesundheit (1991) *Massnahmenpakete Drogen*. Bern: BAG.
38. Dolan K, Kimber J, Fry C, Fitzgerald J, Mcdonald D & Trautman F (2000) Drug consumption facilities in Europe and the establishment of supervised injection centers in Australia, *Drug and Alcohol Review,* 19(3):337–346.
39. Csete J (2010) *From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland*. New York: Open Society Foundations.
40. Lehmann P (1997) The Principle Aims of Drug Policy in the Swiss Confederation, in FOPH (Ed.) The Medical Prescription of Narcotics. Bern: Hogrefe & Huber.
41. Hardegger S, Hasenhoeller A, Scheuber M, Stucki S & Rihs-Middel M (2009) *Behandlungszugang für Substanzkonsumenten: Literaturübersicht in Bezug auf die «niedrigschwellige» und «intermediäre» Betreuung von Personen, die von illegalen Drogen und Alkohol abhängig sind*. Fribourg: FERARIHS.
42. International Narcotic Control Board (1997) *Annual Report*. Vienna: INCB. UN Doc No. E/INCB/1997/1.
43. Reuter P & Schnoz D (2009) *Assessing Drug Problems and Policies in Switzerland, 1998–2007.* Bern: Bundesamt für Gesundheit.
44. Mathers B, Degenhardt L, Phillips B et al. (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, *Lancet*, 372: 1733–1745.
45. Swiss Aids Federation 'HIV/Aids Statistics', www.aids.ch/e/fragen/zahlen.php (last accessed 8 June 2012).
46. Schweizerische Bundesanwaltschaft (1990) *Schweizerische Betäubungsmittelstatistik*. Bern: Schweizerische Bundesanwaltschaft.
47. Gervasoni GP, Balthassar H, Huissoud T, Jeannin A & Dubois-Arber F (2011) A high proportion of users of low threshold facilities with needle exchange programs in Switzerland are currently on methadone treatment: Implications for new approaches in harm reduction and care, *International Journal of Drug Policy,* 23(1):33–6.
48. Rust A (1997) Ethical Considerations, in Swiss Federal Office of Public Health (Ed.) The Medical Prescription of Narcotics. Bern: Hogrefe & Huber, pp104–109.
49. Csete J (2010) *From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland*. New York: Open Society Foundations.