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Global State of **Harm Reduction 2010**

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Introduction

Injecting drug use is reported in at least 158 countries and territories around the world.[1] An estimated 15.9 million people inject drugs globally. In 120 countries, there are reports of HIV infection among people who inject drugs. In some countries prevalence among this group reaches 40% or more. Worldwide, an estimated 3 million people who inject drugs are living with HIV. [2] Extremely high proportions of people who inject drugs are also affected by viral hepatitis, often with HIV co-infection. They are also at greater risk of tuberculosis, a leading cause of death among people who inject drugs, particularly those living with HIV. In countries with injection-driven HIV epidemics, such as Russia and Ukraine, overdose is a leading cause of death among people living with HIV.

Methodology

IHRA's Public Health Programme monitors the adoption and implementation of harm reduction policies and practice worldwide. IHRA collaborates with representatives of harm reduction networks, drug user organisations and UN agencies around the world to gather information for the 'Global State of Harm Reduction' reports. Data gathering in 2009 and 2010 focused on the major developments in the following areas:

> implementation, including opening/closure of services and barriers to accessing services
> national HIV or drug policies that relate to harm reduction
> civil society achievements, such as successful advocacy campaigns, at a regional or international level
> multilateral activity on harm reduction (including UNODC, UNAIDS, UNDP, UNESCO, WHO, UNICEF)
> the availability of funding for harm reduction activities

This information was used to draft regional updates. In addition, experts from civil society and UN agencies contributed chapters on the following key areas for harm reduction: overdose and overdose prevention, viral hepatitis, tuberculosis, injection-related bacterial infections, harm reduction responses to amphetamines, harm reduction in prisons and resourcing for harm reduction. Contributions were reviewed by experts in the relevant area of harm reduction and IHRA staff. The report was externally edited.

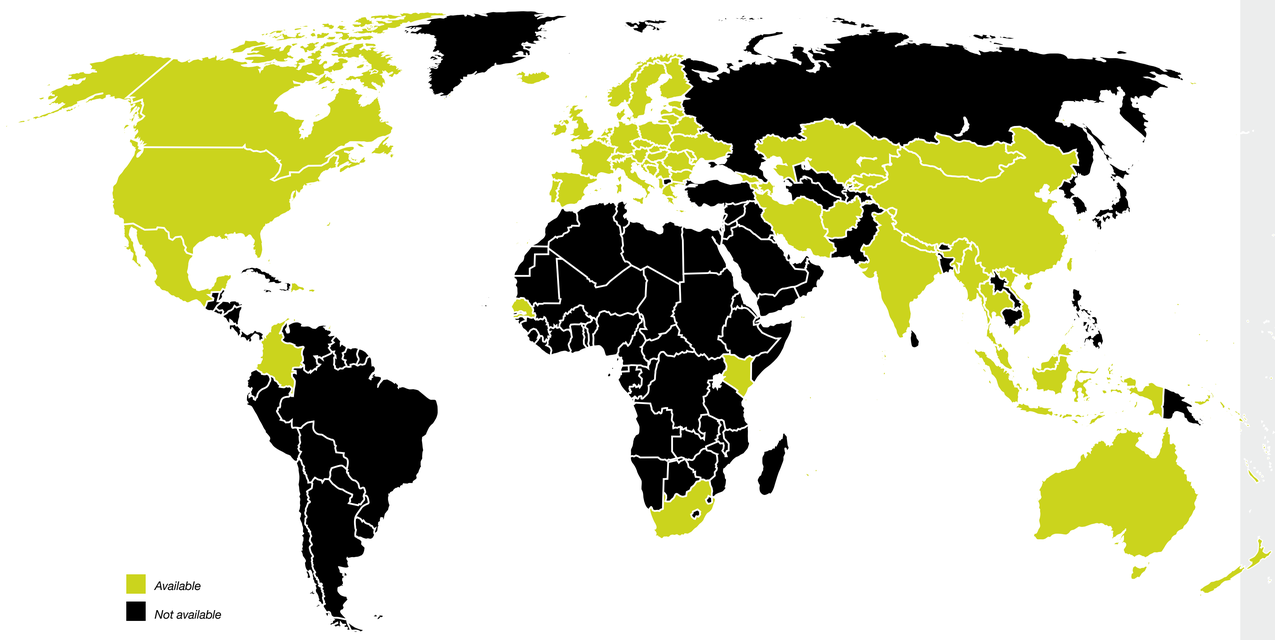
KEY FINDINGS:

Harm reduction policies or programmes have been adopted in more than half of the 158 countries and territories where injecting drug use has been reported.

> **93 support harm reduction in policy or practice**
> **79 have an explicit supportive reference to harm reduction in national policy documents**
> **82 have needle and syringe exchange**
> **10 have needle and syringe exchange in prisons**
> **72 have opioid substitution therapy[3]**
> **39 have opioid substitution therapy in prisons**
> **8 have drug consumption rooms**

Key harm reduction interventions such as needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST) are available in an increasing number of countries. However, the coverage of services remains limited, particularly in low and middle income countries. Recent estimates indicate that many countries are distributing less than one needle per person who injects drugs per year. Similarly, in many Central Asian, Latin American and Sub-Saharan African countries, opioid substitution therapy (OST) coverage is low - equating to less than one OST recipient for every 100 people who inject drugs. Of the countries with reported injecting drug use, seventy-six have no needle and syringe exchange services and eighty-eight have no OST provision.

Global availability of opioid substitution therapy



Sixty cities around the world have drug consumption rooms, which allow people to use drugs with the supervision of trained staff and without fear of arrest. These are mostly in Western Europe, with the exception of one in Sydney, Australia and one in Vancouver, Canada.

The availability of harm reduction services within prisons and other places of detention remains poor. Many countries that have adopted harm reduction outside prisons have failed to do so in prisons and other places of detention. To date, only ten countries have NSPs operating in at least one prison and less than forty countries have some form of OST available in at least one prison. Many of these interventions reach very small numbers.

The extent to which harm reduction interventions other than NSP and OST are reaching people who inject drugs around the world is largely unknown on a global scale. It is difficult to determine, for example, the numbers who are in need of or have received treatment for hepatitis B or C, or for tuberculosis (TB). These interventions are included within the WHO, UNAIDS and UNODC comprehensive package of interventions recommended for people who inject drugs. However, available information suggests that while these affect vast numbers of people who inject drugs, very few have access to treatment, particularly in low and middle income countries.

Similarly, while overdose is a leading cause of death among people who use drugs, particularly those who inject, the numbers in receipt of overdose prevention information or life-saving naloxone remain very low.

Global availability of needle and syringe programmes

THREE CENTS A DAY IS NOT ENOUGH

In calling for increased access to services, it is important to assess the finances that are currently available for the harm reduction response. IHRA estimates that US$160 million was spent on HIV-related harm reduction in low and middle income countries in 2007.[4] This works out at less than three US cents per day per person injecting drugs in these countries, which is clearly insufficient. The biggest investors in harm reduction are people who inject drugs themselves. Expenditure on harm reduction supplies (e.g. needles and syringes) and on drug treatment mainly comes from the out-of-pocket expenses of people who use drugs, rather than from harm reduction services.

Conclusion

Increasing numbers of countries and territories are employing a harm reduction approach (an increase of 11 since 2008). However, the extent to which people who inject drugs have access to key harm reduction interventions remains limited, particularly in low and middle income countries.

Interventions must be scaled up in order to have an impact on HIV epidemics, but this will only be possible with substantially increased investment from governments and international donors. A severe lack of resources, government apathy and distrust of harm reduction, the criminalisation of drug users and harm reduction activities and poor engagement of people most affected by drugs and drug policy in the decision-making fora all act as barriers to harm reduction around the world. The work of harm reduction networks and wider civil society to advocate for harm reduction approaches, sometimes in very hostile policy and legal environments, is essential to the sustainability and scale up of this life-saving approach.

GUIDE TO READING THE TABLE

This table lists the countries and territories around the world that support harm reduction in policy or practice.[5] Please note that inclusion in this table does not indicate the scope, quality or coverage of services. It is also important to recognise that the explicit supportive reference to harm reduction in national policy may not necessarily equate to the existence of quality and high coverage services. Furthermore, in many countries harm reduction services, NSP in particular, are NGO-driven and may be operating without government support.

Explicit supportive reference to harm reduction in national policy documents:
Countries and territories which have an explicit reference to harm reduction in national health or drug-related policy.

Needle and syringe exchange programmes (NSP) operational:
Countries and territories which have one or more operational NSP sites.

Opioid substitution therapy programmes operational:
Countries and territories which have one or more sites which provide opioid substitution therapy as maintenance (not for detoxification only).

Drug consumption rooms:
Countries and territories which have one or more operational drug consumption rooms (or safer injecting facilities)

Needle exchange in prisons:
Countries and territories which have one or more prisons with operational NSP.

Opioid substitution therapy in prisons:
Countries and territories which have one or more prisons with opioid substitution therapy as maintenance (not for detoxification only)

Country or territory	Explicit supportive reference to harm reduction in national policy documents	Needle and syringe exchange programmes operational	Opioid substitution therapy programmes operational	Drug consumption rooms	Needle exchange in prisons	Opioid substitution therapy in prisons
ASIA						
Afghanistan	✓	✓	✓			
Bangladesh	✓	✓				
Cambodia	✓	✓				
China	✓	✓	✓			
Hong Kong	✓		✓			
India	✓	✓	✓			✓
Indonesia	✓	✓	✓			✓
PDR Laos	✓					
Malaysia	✓	✓	✓			✓
Maldives			✓			
Mongolia		✓				
Myanmar	✓	✓	✓			
Nepal	✓	✓	✓			
Pakistan	✓	✓				
Philippines	✓	✓				
Taiwan	✓	✓	✓			
Thailand	✓	✓	✓			
Vietnam	✓	✓	✓			
CARIBBEAN						
Puerto Rico	nk	✓	✓			✓
Trinidad and Tobago	✓					
CENTRAL AND EASTERN EUROPE AND CENTRAL ASIA						
Albania	✓	✓	✓			✓
Armenia	✓	✓	✓		✓	
Azerbaijan		✓	✓			
Belarus	✓	✓	✓		✓	
Bosnia and Herzegovina	✓	✓	✓			
Bulgaria	✓	✓	✓			
Croatia	✓	✓	✓			✓
Czech Republic	✓	✓	✓			✓
Estonia	✓	✓	✓			
Georgia	✓	✓	✓			✓
Hungary	✓	✓	✓			✓
Kazakhstan	✓	✓	✓			
Kosovo		✓				
Kyrgyzstan	✓	✓	✓		✓	
Latvia	✓	✓	✓			
Lithuania	✓	✓	✓			
Macedonia FYR	✓	✓	✓			✓
Moldova	✓	✓	✓		✓	✓
Montenegro	✓	✓	✓			✓
Poland	✓	✓	✓			✓
Romania	✓	✓	✓		✓	✓
Russia		✓				
Serbia	✓	✓	✓			✓
Slovakia	✓	✓	✓			
Slovenia	✓	✓	✓			✓
Tajikistan	✓	✓	✓			
Turkmenistan		✓				
Ukraine	✓	✓	✓			
Uzbekistan	✓	✓				
LATIN AMERICA						
Argentina	✓	✓				
Brazil	✓	✓				
Colombia	✓		✓			
Mexico	✓	✓	✓			
Paraguay	✓	✓				
Uruguay	✓	✓				
MIDDLE EAST and NORTH AFRICA						
Egypt		✓				
Iran	✓	✓	✓		✓	✓
Israel	✓	✓	✓			
Lebanon	✓	✓	✓			
Morocco	✓	✓	✓			
Oman		✓				
Palestine		✓				
Tunisia		✓				
NORTH AMERICA						
Canada	✓	✓	✓	✓		✓
United States	✓	✓	✓			✓
OCEANIA						
Australia	✓	✓	✓	✓		✓
New Zealand	✓	✓	✓			✓
SUB-SAHARAN AFRICA						
Kenya	✓		✓			
Mauritius	✓	✓	✓			✓
Senegal			✓			
Seychelles						
South Africa			✓			
Tanzania	✓					
Zanzibar	✓					
WESTERN EUROPE						
Austria	✓	✓	✓			✓
Belgium	✓	✓	✓			✓
Cyprus	✓	✓	✓			
Denmark	✓	✓	✓			✓
Finland	✓	✓	✓			✓
France	✓	✓	✓			✓
Germany	✓	✓	✓	✓	✓	✓
Greece	✓	✓	✓			
Iceland			✓			
Ireland	✓	✓	✓			✓
Italy	✓	✓	✓			✓
Luxembourg	✓	✓	✓	✓	✓	✓
Malta	✓	✓	✓			✓
Netherlands	✓	✓	✓	✓		✓
Norway	✓	✓	✓	✓		✓
Portugal	✓	✓	✓		✓	✓
Spain	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓			✓
Switzerland	✓	✓	✓	✓	✓	✓
United Kingdom	✓	✓	✓			✓

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Footnotes: (Endnotes)

1 Cook C & Kanaef N (2008) Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics. International Harm Reduction Association, London, UK

2 Mathers B et al (2008) for the 2007 Reference Group to the UN on HIV and Injecting Drug Use. Global epidemiology of injecting drug use and HIV among people who inject drugs: A systematic review. Lancet 372(9651):1733-45.

3 This figure includes Morocco and Tajikistan where pilot methadone maintenance programmes have recently been initiated.

4 Stimson GV et al (2010) Three Cents a Day is Not Enough. Resourcing HIV-related harm reduction on a global basis. International Harm Reduction Association, London, UK.

5 The data are largely drawn from Cook C (ed) (2010) Global State of Harm Reduction 2010: Key issues for broadening the response (International Harm Reduction Association, UK). The table also reflects the start up of pilot OST programmes in Morocco and Tajikistan as of June 2010.