HARM REDUCTION INTERNATIONAL | Reports

The Case for a Harm Reduction Decade:

Progress, potential and paradigm shifts

MARCH 2016

Catherine Cook, Maria Phelan, Gen Sander, Katie Stone, Fionnuala Murphy

20 YEARS HARM REDUCTION INTERNATIONAL

10% BY 2020

THE GLOBAL STATE OF HARM REDUCTION

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ISBN 978-0-9935434-2-5

Copy-edited by The Write Effect, Oxford
Designed by Samantha Owen
Published by
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Harm Reduction International is a leading non-governmental organisation (NGO) working to promote and expand support for harm reduction. We work to reduce the negative health, social and human rights impacts of drug use and drug policy - such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs - by promoting evidence-based public health policies and practices, and human rights-based approaches to drug policy. We are an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues. The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

Acknowledgements:

The authors would like to acknowledge Rick Lines, Tom Henderson and Olga Szubert for their assistance in the development of this report. Harm Reduction International would like to thank David Wilson at the Burnet Institute, with support from Sherrie Kelly and Ines Yap, for mathematically modelling the impact of various harm reduction funding scenarios on the HIV epidemic among people who inject drugs. Thanks to David Wilson, Daniel Wolfe (Open Society Foundations) and Damon Barrett for providing their feedback and reviewing the report. We would also like to thank Pascal Tanguay and Andy Guise for their review and input on the situations in Thailand and Kenya respectively.

This report was made possible by financial contributions from the Open Society Foundations, the Robert Carr Networks Fund, Community Action on Harm Reduction (CAHR) and the MAC AIDS Fund.

Thanks also to UNAIDS and the Ministry of Health of the Government of Switzerland for their financial support of this project.

This report is based on the collective priorities of the harm reduction sector ahead of the UN General Assembly Special Session on Drugs in 2016. We would like to thank the harm reduction working group for their support in developing this concept:

Asian Network of People who Use Drugs (ANPUD)
Caribbean Harm Reduction Coalition (CHRC)
Correlation
Drug Policy Alliance
Espolea
Eurasian Harm Reduction Network (EHRN)
Harm Reduction Coalition (HRC)
Harm Reduction International (HRI)
Intercambios
International Drug Policy Consortium (IDPC)
International Network of People Who Use Drugs (INPUD)
NZ Drug Foundation
Open Society Foundation (OSF)
Canadian Drug Policy Coalition
The Kenya Network of People who Use Drugs (KeNPUD)
The Australian Injecting & Illicit Drug Users League (AIVL)
The Canadian HIV/AIDS Legal Network
The International HIV/AIDS Alliance
The Middle East and North Africa Harm Reduction Association (MENAHRA)
The Transnational Institute (TNI)
Transform Drug Policy Foundation
Youth RISE

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Executive summary

Published biennially since 2008, the *Global State of Harm Reduction* is the leading independent resource monitoring the international harm reduction response.

The April 2016 UN General Assembly Special Session on the World Drug Problem coincides with the tenth anniversary of the start of the *Global State of Harm Reduction* project, and offers a significant opportunity to reflect on the past decade of harm reduction evidence, and project forward into the next decade.

What we know about the last ten years of harm reduction.

Global progress:

Harm reduction programmes are now operating at some level in more than half of the 158 countries in the world where injecting drug use has been documented.

Of these 158 countries:

- 91 provide for harm reduction in national policy documents;
- 90 have at least one needle and syringe programme; and
- 80 provide opioid substitution therapy.

At an operational level, harm reduction is now the majority response in the international community, with more than half of the countries with injecting drug use, across every region of the globe, supporting or tolerating harm reduction programmes to some extent.

Global crisis:

Despite the growth in acceptance of harm reduction around the world, the response on the ground falls far short of what is needed to end the injecting-related HIV and viral hepatitis epidemics, overdose and other avoidable health harms.

Although harm reduction programmes are now available to some extent in a majority of countries with injecting drug use, in many places these programmes remain small-scale and NGO-driven, and under threat from underfunding and a lack of strong political support.

The chronic underfunding of harm reduction, particularly in middle-income countries where the majority of injecting-related harms are documented, severely undermines the global response. At last count, investment in harm reduction in low- and middle-income countries totalled USD 160 million, only 7% of the estimated USD 2.3 billion required. Worryingly, with shifting international donor priorities, many existing programmes are now at risk of closure.

Shaping the next ten years of harm reduction

Global solution:

New modelling projections prepared for this report demonstrate how just a tiny shift in global priorities in drug control funding could end injecting-related HIV infections by 2030.

It has been estimated that USD 100 billion is spent annually on global drug enforcement and control. As detailed in the modelling projections in this report, a shift of as little as 2.5% of this money away from current drug enforcement spending into harm reduction programmes has the potential to achieve a 78% reduction in new HIV infections among people who inject drugs by 2030, alongside a 65% drop in HIV-related deaths. The global health impact of redirecting investment by 7.5% would be even more staggering, enabling us to cut new HIV infections among people who inject drugs by 94% and reduce HIV-related deaths by similar proportions.

What we need to create a Harm Reduction Decade.

Global action:

The evidence over the past ten years shows the steady progress of harm reduction around the globe, yet also shows how fragile this progress is due to a lack of firm political support and financial investment. Now is the time for governments and international agencies to end the harm reduction crisis by committing to '10 by 20', a redirection of funding from the war on drugs into health and human rights-based programmes, including harm reduction, by the year 2020. As detailed in the modelling projections in this report, such a redirection would have the effect of nearly ending injecting drug-related health harms and mortality by 2030.

Around the world, civil society organisations and networks of people who use drugs are the driving force of harm reduction implementation and advocacy, and that consolidated action is now a mainstay of the harm reduction movement. Together, the global harm reduction community calls on governments to support '10 by 20', and demonstrate the political and financial commitment to a health and human rights-based response to drug use.

Harm reduction programmes save lives, save money and help respect, protect and fulfil the human rights of people who use drugs. Since the last UN General Assembly Special Session on drugs in 1998, harm reduction is the only global drug policy response that can claim these outcomes, and back them up with evidence.

Now is the time to consolidate and secure that success and commit to making the next ten years The Harm Reduction Decade.

Introduction

The harm reduction approach

Harm reduction aims to reduce the health, social and economic harms associated with drug use, without requiring people to stop using drugs.[1] Within the current global drug policy framework, with its focus on prohibition and zero tolerance, harm reduction stands alone in its attempt to address the realities of drug-related harms experienced by individuals and their families. It also stands alone as an approach that has worked, where so many interventions have proven fruitless or even damaging.

The success of harm reduction is rooted in the fact that it goes beyond a set of highly effective interventions. It is an approach that is underpinned by the principles of pragmatism, dignity, human rights and public health, and one within which people who use drugs are firmly at the centre. This approach, often implemented in the face of resistance, has saved countless lives and helped people to stay healthy. It has reduced overdose and HIV and hepatitis C infections among people who inject drugs. It has reduced the strain on financial and human resources caused by drug-related health harms. It has paved the way towards new models of policing in relation to drugs and new policy frameworks at the municipal, national and even global levels.

It is, however, the untenable goal of reaching a drug-free society that remains the dominant call within global drug policy fora today.[2] This is despite the catalogue of negative consequences associated with the zero-tolerance approach and the impossibility of the target. It is time for the failed policies of the past to give way to an approach that has actually worked. Harm reduction deserves international political recognition for the lives it has saved, the lives it has improved and the health costs it has reduced.

The progress and potential of harm reduction

Harm Reduction International began documenting the global response to drug-related health harms in 2006. Since then, harm reduction has been adopted in many new countries around the world at a slow yet steady pace. Today, we have reached the point where the majority of the 158 countries in the world that report injecting drug use have adopted harm reduction measures to some degree in domestic policy and practice: 90 have at least one needle and syringe programme (NSP), and 80 provide opioid substitution therapy (OST). Yet the existence of harm reduction does not necessarily equate with access, and in many places these programmes remain small-scale and NGO-driven, and not supported to the degree necessary to meet national need.

The harm reduction successes witnessed in varied settings around the world illustrate the potential of this approach when given the legal and policy space to innovate and the resources to flourish. This can be seen in those countries that are considered early harm reduction pioneers, as well as those that have adopted harm reduction more recently. In Ukraine, for example, the past decade of harm reduction implementation has had a dramatic impact on the HIV epidemic among people who inject drugs - stabilising the number of new HIV infections and reducing HIV prevalence.[3]

However, the potential of harm reduction in many countries has been limited by weak state support and underfunding. As government reports to UNAIDS indicate, most countries still do not implement harm reduction to recommended levels. The world has missed the UN target of halving HIV among people who inject drugs by 2015 by a staggering 80%, and continuing the status quo will result in a failure to meet the ambitious goal of ending AIDS by 2030. Globally, HIV prevalence among people who inject drugs is estimated to be 28 times higher than among the rest of the adult population,[4] and if implementation continues at current levels only a minimal reduction will be seen.

This report uses mathematical modelling to show, for the first time, what could be achieved on a global scale if harm reduction were supported by adequate financing. If even a relatively small amount of additional funding were directed into harm reduction programmes, the course currently plotted could completely change. As this report shows, a redirection of just 2.5% of the USD 100 billion spent each year on drug control could secure a 78% reduction in new HIV infections among people who inject drugs by 2030. Taking investment to 7.5% of drug control spend has even greater potential, enabling us to cut new HIV infections among people who inject drugs by 94%.

The Kuala Lumpur Declaration: A Global Call for a Harm Reduction Decade

The achievements of harm reduction should no longer be side-lined or underfunded. In October 2015, at the International Harm Reduction Conference, the harm reduction sector released the Kuala Lumpur Declaration, calling for an alternative response to drug use that is rooted in evidence, public health, human rights and dignity. The Declaration urges governments and international organisations to adopt harm reduction as a key principle of drug policy throughout the next decade, and to end punitive drug laws, human rights abuses and the mass incarceration of people who use drugs. It also proposes a global target: to redirect 10% of funding from ineffective punitive drug control activities into harm reduction.

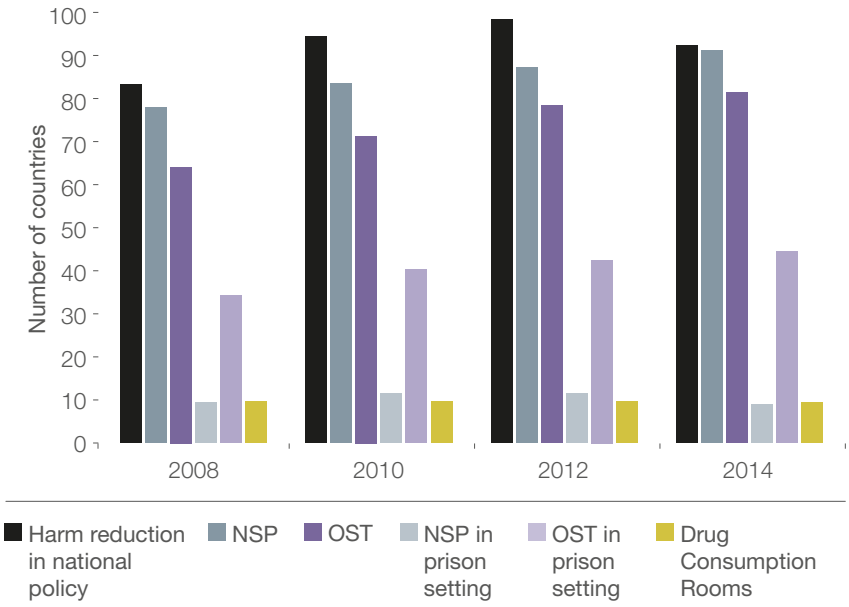
Over 1,000 organisations and individuals have now added their names to the Kuala Lumpur Declaration, with signatories including Sir Richard Branson, UNAIDS Asia-Pacific, Kofi Annan Foundation and Ruth Dreifuss, the former president of Switzerland as well as additional members of the Global Commission on Drug Policy. As the 2016 UN General Assembly Special Session on the World Drug Problem approaches, these organisations and individuals are sending the message that the provision of harm reduction services can no longer be seen as a policy option at the discretion of governments, but must instead be understood as a core obligation of States to meet their international legal obligations under the right to health.

The Declaration lays the foundation for the paradigm shift needed to make real progress in relation to drug-related harms. While the focus of this report is on specific aspects of harm reduction, a harm reduction approach is capable of achieving so much more, across drug types, methods of consumption and drug-using environments. Harm reduction has been proven to save lives, promote health and enhance the human rights and dignity of people who use drugs. Over the past 50 years, the punitive and zero-tolerance status quo has achieved little other than significant health and social damage.[5] A Harm Reduction Decade would do more for health, social care and cost savings than drug control has in the past half-century. It is time for a change. It is time for the international community to embrace this success and ensure that the next ten years are the Harm Reduction Decade.

'Why I value harm reduction' statements from delegates at the 2015 International Harm Reduction Conference in Kuala Lumpur

I: A decade of progress: Ten years of tracking the global state of harm reduction

Figure 1: Harm reduction policy and practice around the world 2008-2014



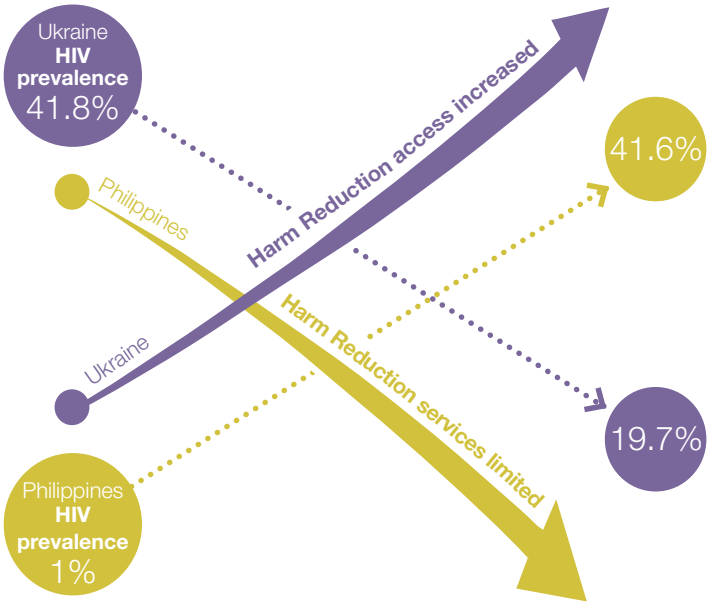
I: A decade of progress: Ten years of tracking the global state of harm reduction

Harm Reduction International began documenting the global harm reduction response to drug-related health harms in 2006. The first Global State of Harm Reduction report in 2008 illustrated that harm reduction approaches had been adopted on every continent, with programmes being successfully implemented in varied political, cultural and economic contexts.[6] Since then, more countries have adopted harm reduction at a slow but steady pace. Today, 91 countries provide for harm reduction in national policy documents, and 90 have at least one NSP - a higher number than ever before. Some 80 countries provide OST today - an increase of 17 since this monitoring began.[7] In contrast, progress on harm reduction within prison settings has been especially slow, and in fact the number of countries with NSPs available in prison has decreased over the past decade.

Where harm reduction programmes have been scaled up, countless lives have been saved. Early harm reduction implementers such as Switzerland, the UK and Australia lowered new HIV infections among people who inject drugs to practically zero.[8] In Nepal, an early implementer in Asia, HIV prevalence among people who inject drugs was found to be 68% in 2002 and then 6.3% in 2011, following the scale-up of harm reduction.[9] In Xichang City, China, the number of new HIV cases among people who inject drugs dropped by 75% following the implementation of harm reduction programmes.[10] In Ukraine, a decade of harm reduction implementation has had a dramatic impact on the HIV epidemic among people who inject drugs - stabilising the number of new HIV infections and reducing HIV prevalence.[3] Since the publication of the first Global State of Harm Reduction report in 2008, estimates of national HIV prevalence among people who inject drugs in Ukraine have more than halved from 41.8% to 19.7% as access to harm reduction has increased. In contrast, during the same period in the Philippines, where harm reduction is very limited, reported national HIV prevalence among people who inject drugs has soared from 1% to 41.6%.

In addition to preventing HIV and hepatitis C, harm reduction programmes also seek to address the high rates of opioid overdose among people who use drugs, with the highly effective medication naloxone now joining methadone and buprenorphine on the World Health Organization list of essential medicines. More countries are heeding UN advice to make Naloxone available for peer distribution so that people who use drugs can use it to save lives within their communities. In the USA, more people died from drug overdose than from car accidents in 2014, leading to an unprecedented commitment from the White House of USD 1.1 billion to address drug overdose, including with the roll out of naloxone.[11] In the Sichuan and Yunnan provinces of China, the distribution of 4,000 naloxone kits to people who inject drugs during 2013 and 2014 led to 119 lives being saved at very minimal cost.[12] Harm reduction interventions that focus on reducing harms other than HIV - including drug consumption rooms and heroin prescription - have also gained in traction and in evidence base, but are found only in high-income countries.

Figure 2. Harm reduction prevents HIV infection



Box 1: Harm reduction works: progress and potential in Kenya

Reliable information on injecting drug use in sub-Saharan Africa is limited, but estimates suggest there are over 1 million people who inject drugs in the region.[13] In 2005, of the 82,369 new cases of HIV in Kenya, 4.8% were attributed to injecting drug use.[14] Despite HIV infection rates of 18% among the population of people who inject drugs, compared to 5.6% in the general population,[15] Kenya has had no access to OST or NSP service provision until recent years. This was in part due to legal and policy barriers, and to a political focus on drug supply reduction and law enforcement rather than public health. That changed with the introduction of ten needle and syringe programme sites in 2014.[16]

Although coverage remains far below UN recommended levels, the introduction of NSP is a positive step forward, and a leading example of the importance of harm reduction implementation in the region. Civil society initiatives, through local community-based organisations, pioneered the harm reduction response in Kenya. The implementation of the CAHR programme in 2011, the establishment of the Kenya Network of People who Use Drugs (KeNPUD) in 2012, the Eastern African Harm Reduction Network[16, 17] ReachOut, Teen Watch and Omaria all served to strengthen advocacy and support for harm reduction services. Slowly but surely harm reduction is now receiving government backing in the country. Although yet to be made available, mathematical modelling has shown the potential of OST in Kenya. With just 10% OST coverage, HIV incidence would reduce by 5-10% among people who inject drugs, and with 40% coverage, new HIV infections among this group would be reduced by 20%.[18]

The cost-effectiveness of implementing harm reduction

Over the past decade the body of research into the cost-effectiveness of harm reduction has also grown. It is now indisputable that harm reduction works, is cost-effective and can be implemented successfully in a variety of settings. In Australia, for example, it was estimated that every dollar invested in NSPs returned four dollars in healthcare savings.[19] In eight countries in Eastern Europe and Central Asia, NSPs were found to be extremely cost-effective when considering prevention of both hepatitis C and HIV infections, with a return on investment of between 1.6 and 2.7 times the original investment.[20] The National Institute on Drug Abuse in the United States concluded that methadone treatment is 'among the most cost-effective treatments, yielding savings of $3 to $4 for every dollar spent'.[21] Similarly, studies from China concluded that investment in OST provision would yield substantial savings for the government through averted HIV infections and decreased HIV treatment costs.[22] Research suggests that the combined implementation of harm reduction interventions and HIV anti-retroviral therapy for people who inject drugs offers the highest return on investment. This has been demonstrated by modelling the potential impact of scaled-up NSPs, OST and HIV testing and treatment in Kenya, Pakistan, Thailand and Ukraine from 2011 to 2015.[23] Researchers have also found that the peer distribution of naloxone to people who inject drugs is among the most cost-effective of all lifesaving interventions.[24]

Human rights and harm reduction

Over the last decade, international endorsement for harm reduction has grown significantly, with an emerging consensus among multilateral agencies that harm reduction must be central to national responses to HIV, hepatitis C and drug use.[25] Importantly, the human rights case for harm reduction has also been strengthened. Prior to 2007, very few UN human rights mechanisms engaged in debates around drug policy or harm reduction. Today multiple UN human rights bodies have called on governments to implement harm reduction programmes as part of fulfilling the right to the highest attainable standard of physical and mental health, the right to benefit from scientific progress and its applications, and, in places of detention, to freedom from cruel, inhuman or degrading treatment or punishment. These include every holder of the mandate of the UN Special Rapporteur on the Right to Health, the current and former Special Rapporteurs on Torture, the UN Committee on Economic, Social and Cultural Rights and the UN Committee on the Rights of the Child.

> "… a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV "

In 2009, the then UN High Commissioner for Human Rights recognised 'the longstanding evidence that a harm reduction approach is the most effective way of protecting rights, limiting personal suffering, and reducing the incidence of HIV', stressing that 'this is particularly the case for those in detention, who are already vulnerable to many forms of human rights violations'.[26] In 2015, the current High Commissioner supported this view, stating that 'Criminalization of possession and use of drugs causes significant obstacles to the right to health' and that 'virtually all States urgently need far greater availability [of harm reduction services] in prisons'.[27] Both the Special Rapporteur on Torture and, more recently, the UN Human Rights Committee have deemed that the denial of harm reduction services can amount to cruel and degrading treatment, while the former UN Special Rapporteur on the Right to Health, Anand Grover, has stressed that States must 'ensure that all harm reduction measures and drug dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations'.[28]

Most recently, the current UN Special Rapporteur on the Right to Health, Dainius Pūras, has called on States to commit the maximum available resources to scale up investment for harm reduction. He emphasised the need for 'proactive and results-oriented discussion of harm reduction at the UNGASS and targets to be set on harm reduction scale up, both within and outside prisons and including access to naloxone to prevent opioid overdose'.[37]

Leadership from civil society and people who use drugs

Around the world, civil society organisations and networks of people who use drugs are a driving force of harm reduction implementation and advocacy. New national, regional and global networks have formed and are advocating for harm reduction and the rights of people who use drugs in more countries than ever before. Drug-user organising has increased in every region of the world. Major grants from the Global Fund to fight AIDS, Tuberculosis and Malaria with an exclusive focus on harm reduction are held by civil society organisations such as Alliance Ukraine, the Middle East and North Africa Harm Reduction Association (MENAHRA) and, most recently, the Eurasian Harm Reduction Network (EHRN). The involvement of harm reduction civil society and drug-user representatives on UN strategic advisory groups has increased, as has civil society involvement in the UN Commission on Narcotic Drugs. Over 25 non-governmental organisations were represented at the 2015 meeting of the Commission, and at least four national delegations included civil society representation.[29] In both 2011 and 2014, harm reduction was a focus at UNAIDS Programme Committee Board meetings, with people who use drugs and regional harm reduction organisations represented as civil society members and observers.

Coordinated regional and global advocacy is becoming a mainstay of the harm reduction movement. In Europe, networks of people who use drugs are working together to demand access to new and more effective hepatitis C treatment, while the 'Support. Don't Punish' day of action, which focuses on the decriminalisation of people who use drugs, saw campaign activities in over 160 cities in 2015. The '10 by 20' campaign, initiated by Harm Reduction International, is calling on governments to redirect 10% of the resources currently spent on drug enforcement to harm reduction. It is time to ensure that international commitments translate into national realities with commitments for funding to make harm reduction possible.

II. Potential: HIV and harm reduction projections for the coming decade

II. Potential: HIV and harm reduction projections for the coming decade

The scientific evidence … the public health rationale, and the human rights imperatives are all in accord: we can and must do better for PWID [people who inject drugs]. The available tools are evidence based, rights affirming, and cost effective. What is required now is political will and a global consensus that this critical component of global HIV can no longer be ignored and under-resourced. World Bank, 2013 [23]

Meeting international commitments

Although 91 countries include harm reduction in national policy documents, this often does not translate into wide-reaching programmes. Government reports to UNAIDS indicate that at present most countries do not even implement harm reduction to 'low' levels as defined in UN guidance.[25, 30] If scale-up of harm reduction continues at the current pace, it will be 2026 before every country in need has even one or two programmes operating.

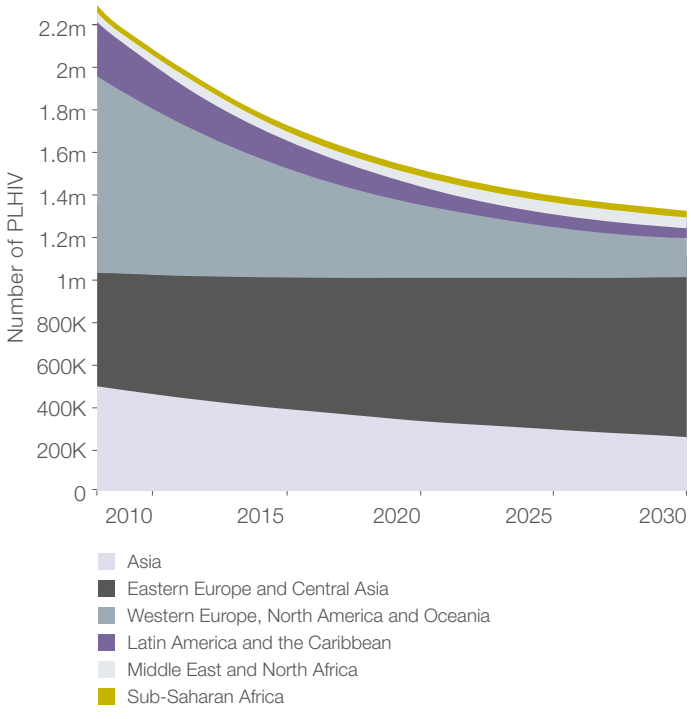
> "If scale up of harm reduction in new countries continues at the current pace, it will be 2026 before every country in need has even one or two programmes operating, or has endorsed harm reduction within national policy."

Many countries do not collect strategic information regarding drug use, HIV and other health-related harms. Of the 158 countries and territories where injecting drug use occurs, 45% have no estimate of the number of people who inject drugs, and only around a third have figures that have been updated since 2012. The story is similar for data relating to HIV and hepatitis C among people who inject drugs. This lack of quality data impedes strategic national responses to epidemics among people who inject drugs and means that limited resources are not strategically allocated. It also means that progress towards national and international targets on HIV and viral hepatitis cannot be measured, and governments remain unaccountable for lives lost to these preventable infections.

In 2014, UNAIDS launched its Fast Track Strategy to end the AIDS epidemic by 2030. A year later, world leaders adopted the Sustainable Development Goals (SDGs), including a target to end AIDS by 2030 and a pledge to leave no one behind.

Currently, HIV prevalence among people who inject drugs is 28 times higher than among the rest of the adult population.[4] Estimates suggest that between 8.9 and 22.4 million people inject drugs worldwide, and between 0.9 and 4.8 million of them are living with HIV.[4] As mentioned above, the world has already missed the UN target of halving HIV among people who inject drugs by 2015 by a staggering 80%. The ambitious goal of ending AIDS by 2030 cannot be achieved without a significant increase in funding for and provision of harm reduction services. Indeed, if implementation continues at current levels, the impact on annual new HIV infections among people who inject drugs will be minimal. As figure 3 shows, only a slight reduction in HIV prevalence among people who inject drugs will be seen by 2030.

Figure 3. HIV among people who inject drugs with harm reduction coverage at current levels until 2030[a]



[a] Modelling calculations for this report were conducted by David Wilson and colleagues at the Burnet Institute, Australia.

The funding crisis for harm reduction

While the scenario above shows what would happen if services continue at current levels, harm reduction funding is in decline. In low- and middle-income countries, efforts to prevent HIV among people who inject drugs are predominantly reliant on international donor funds. At last count, investment totalled USD 160 million - only 7% of the USD 2.3 billion needed. An updated estimate of global harm reduction investment is required. Worryingly, with donor priorities changing, even these existing programmes are at risk of closure.

Increasingly, donors are targeting HIV spending at low- or lower-middle-income countries with a high disease burden. Yet almost three quarters of people who inject drugs live in middle-income countries. Often, epidemics concentrated among people who inject drugs in such countries are deemed to be the problem of the national governments. The Global Fund to fight AIDS, Tuberculosis and Malaria, the largest donor for harm reduction, has since 2013 implemented a New Funding Model (NFM) which has left 24 of the 58 countries with previous harm reduction grants either ineligible for further funding or not able to receive any new resources until 2017. Other significant donors have similarly shifted investment away from middle-income countries. The UK Department for International Development was the second largest funder of harm reduction programmes in 2007 but no longer invests bilaterally in harm reduction.[31] The Australian Government supported harm reduction programmes across Asia but has now also retreated from many of these countries. The United States is reducing investment in harm reduction delivery, prioritising funds for technical support. Among the major bilateral aid investors, only the Dutch Ministry of Financial Affairs retains significant support for harm reduction programmes, regardless of countries' income status.[31]

Box 2. The future of harm reduction in Ukraine

	2008	2010	2012	2014
No. of people who inject drugs	325,000 - 435,000	291,000	296,000	310,000
HIV prevalence among people who inject drugs	41.8%	32.4%	21.5%	19.7%
Hep C prevalence among people who inject drugs	70–90%	Unknown	67%	27.1%
No. of NSP sites	362	985-1323	1667	1667
No. of OST sites	Unknown	Unknown	Unknown	169

* Data sourced from Global State of Harm Reduction reports 2008, 2010, 2012 and 2014

The impact of harm reduction investment and scale-up in Ukraine over the past decade has been one of the most marked in the world. OST was introduced in 2004,[6] and by 2008, when the first Global State of Harm Reduction report was published, there were 362 NSP sites operating. Global Fund support led to harm reduction services rapidly expanding over the coming years, with 212,807 people who inject drugs reached by harm reduction services in 2015, and over 19 million syringes distributed. Reported national HIV and hepatitis C prevalence rates have reduced dramatically during this time (see table above). NSP and OST services in the country have also been shown to be highly cost-effective, with the cost-effectiveness ratio per infection averted calculated to be USD 487.4 in NSP provision and USD 1,145.9 in OST provision.[33]

However, harm reduction in Ukraine faces an uncertain future. As of 2017, harm reduction services in Ukraine will no longer have the support of the Global Fund, and at present there is no government funding available to sustain these essential services for people who use drugs.[32]

Donors reducing aid to middle-income countries argue that these countries can afford to provide health services without international assistance. Problematically, although national governments are investing more in their HIV responses than ever before, their expenditure rarely focuses on people who inject drugs, even where this population accounts for the majority of new HIV infections. The Thai government, for example, has committed to fully funding the national HIV response but will not support harm reduction programmes. In Vietnam, donor funding is reducing even though the national government is not able to sustain harm reduction services at current levels. National governments must be persuaded to increase investment in harm reduction, but for this a paradigm shift is required. In the meantime, we must find ways to sustain international funding. If we fail to, the gains made over decades of investment will be lost. In contrast, if we can direct even a relatively small amount of additional funding into harm reduction programmes, the course currently plotted could completely change.

> "In other words, by making small shifts in how we spend existing resources, the world could virtually eliminate HIV among people who inject drugs by 2030."

Realising the potential of harm reduction

Underinvestment in harm reduction is not always a question of lack of resources, but often is a lack of appropriate allocation of resources. Harm Reduction International's '10 by 20' campaign calls for a redirection of funding from the war on drugs, arguing that just 10% of the estimated USD 100 billion spent annually on drug control would more than meet the global need for harm reduction. Indeed, as the modelling below shows, even as little as 2.5% could bring harm reduction coverage levels to those defined as mid-level by UN guidance,[25] with the potential to secure a 78% reduction in new HIV infections among people who inject drugs by 2030, alongside a 65% drop in HIV-related deaths. Taking investment to 7.5% of drug control spending (USD 7.66 billion) has even greater potential, securing high levels of coverage in all countries. By 2030 the results of this would be staggering, enabling us to cut new HIV infections among people who inject drugs by 94% and reduce HIV-related deaths by similar proportions. In other words, by making small shifts in how we spend existing resources, the world could virtually eliminate HIV among people who inject drugs by 2030.

See Methodology section, page 26, for more information on the mathematical modelling conducted for this report.

Table 1. Harm reduction investment scenarios

	Current	Scenario 1	Scenario 2
Harm reduction coverage	Low	Mid	High
Additional resources as a percentage of resources spent on punitive responses	0%	2.5%	7.5 - 10%
Total resources on harm reduction per year (USD billion)	0.16	2.66	7.66

Figure 4. The impact of shifting investment on HIV incidence rates

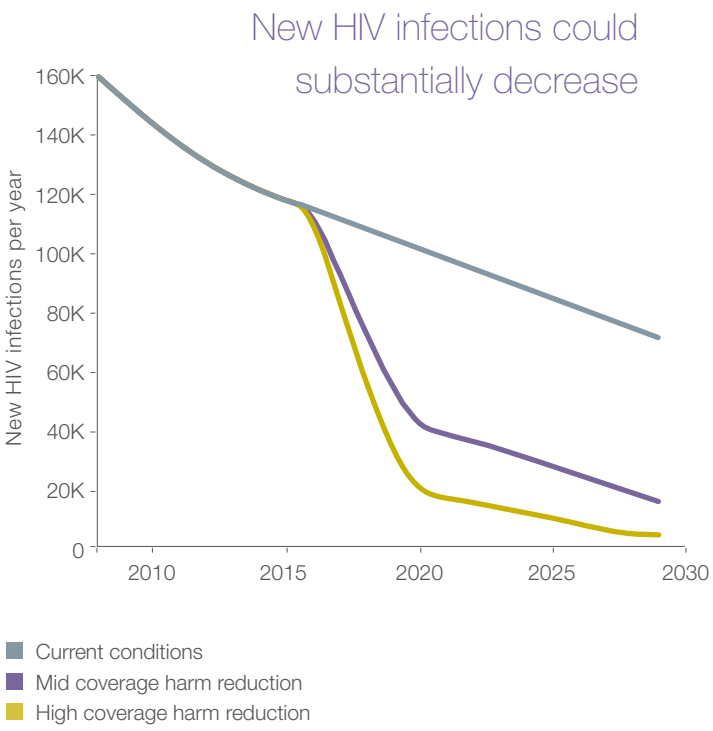
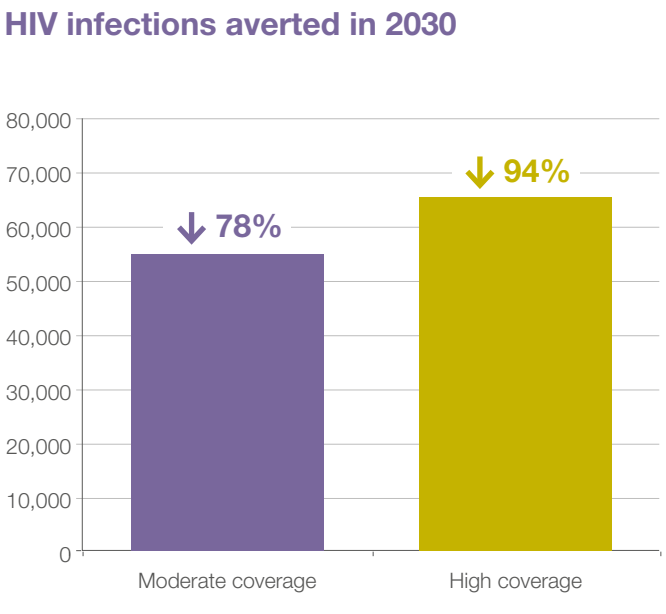


Figure 5. HIV infections and deaths averted in 2030 with moderate and high coverage of harm reduction programmes



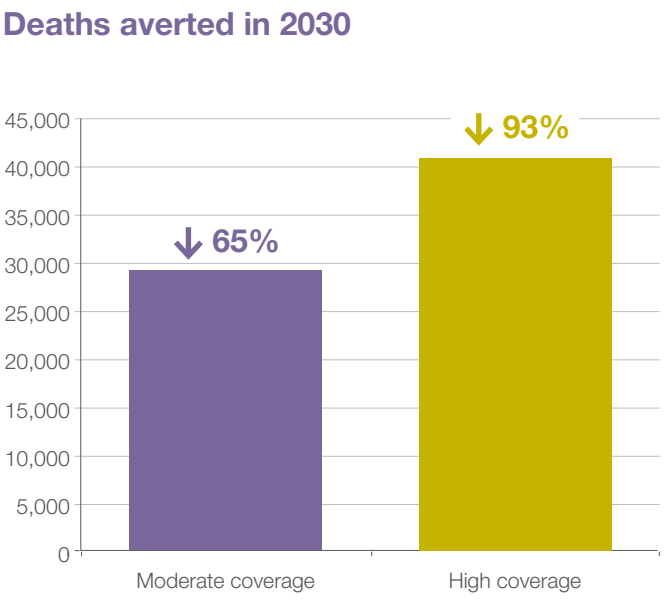


Figure 6. Impact of resource shift to fund **MEDIUM** harm reduction coverage levels

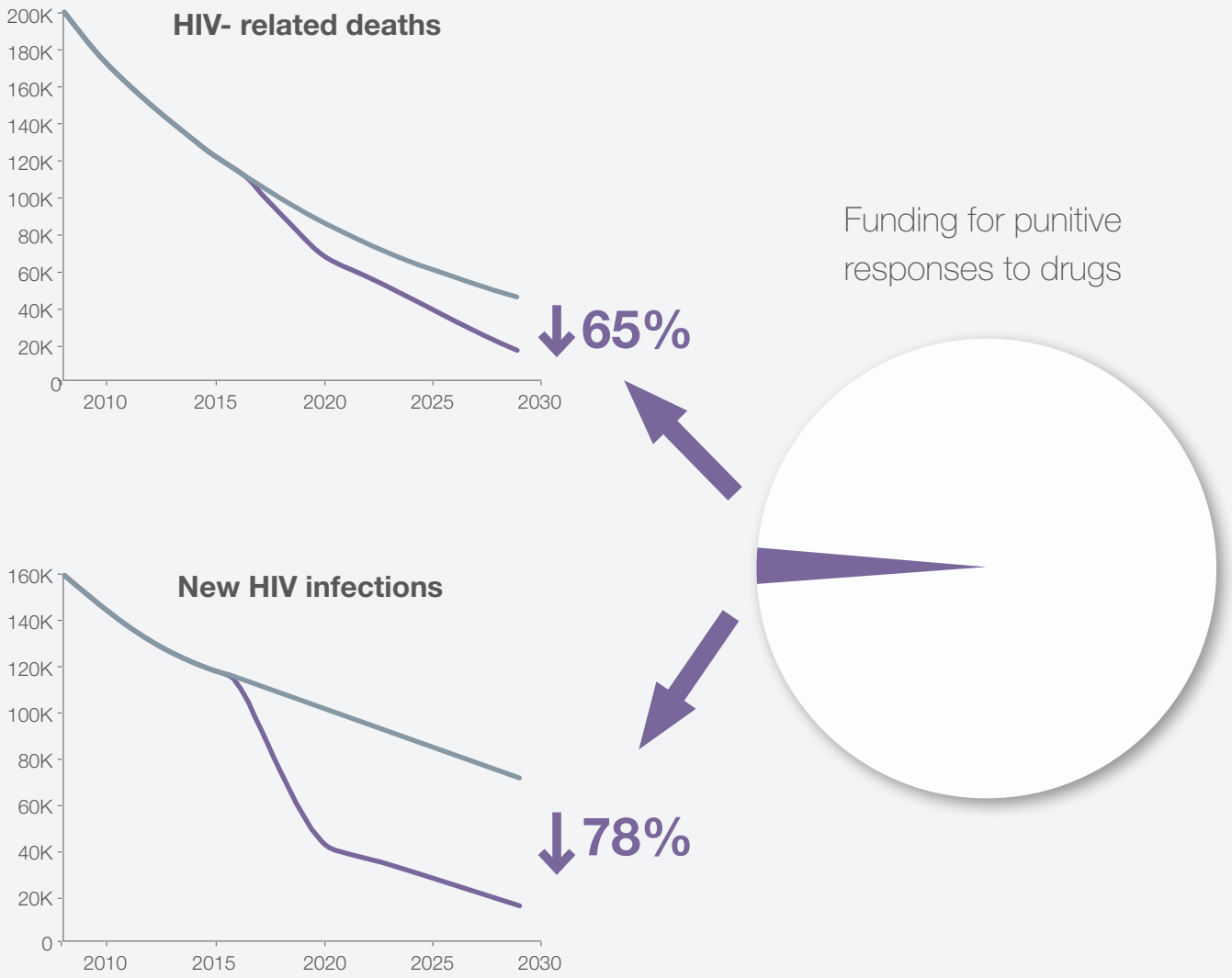
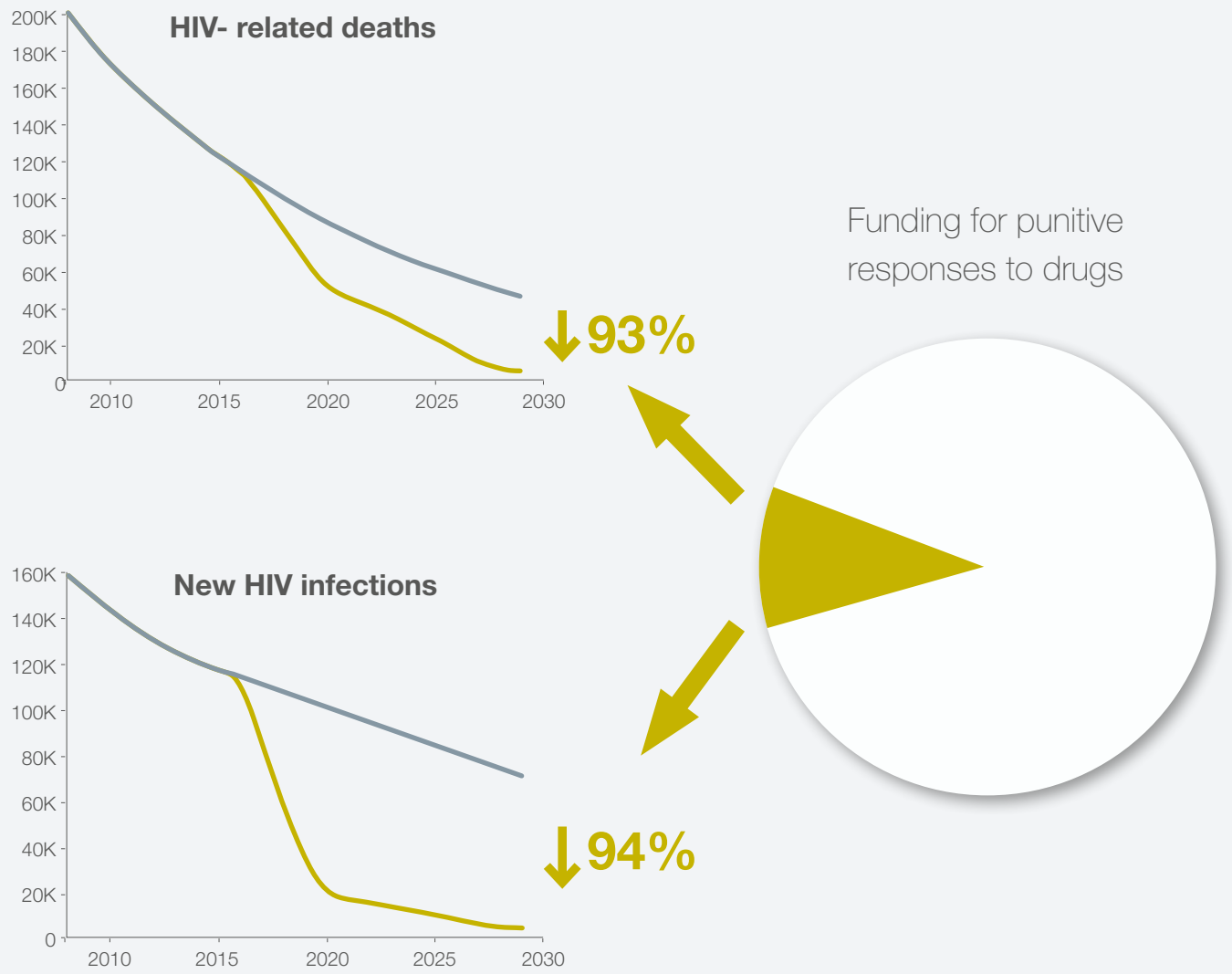


Figure 7. Impact of resource shift to fund **HIGH** harm reduction coverage levels



Not only could a small reallocation away from punitive responses to drugs secure close to the elimination of HIV among people who inject drugs, but it would also cover hepatitis C prevention, pay for enough naloxone to save thousands of lives from opiate overdose and strengthen networks of people who use drugs to provide peer services and campaign for their rights. Yet for all of this potential to be achieved, a paradigm shift is required.

III. Paradigm shift: Time for a Harm Reduction Decade

III. Paradigm shift: Time for a Harm Reduction Decade

The current system for international drug control rests on three conventions that were established with the principal objective of preventing the non-scientific and non-medical production, supply, use and possession of drugs.[34] States are urged to 'do everything in their power to combat the spread of the illicit use of drugs',[35] which is characterised as 'evil' and 'dangerous'.[36] The 'war on drugs' and the political and societal attitudes born from it have seen governments spend vast amounts of resources on drug law enforcement, while overlooking and sometimes actively opposing the provision of harm reduction services.

> "'harm reduction' has yet to be included in a consensus document of a UN drug control forum."

At the international level, the emphasis on the suppression of drug use and production means that a pragmatic approach which accepts that people use drugs is the subject of contention in drug policy fora. Although harm reduction was agreed as a goal by all Members States participating in the 2001 HIV/AIDS UN General Assembly Special Session, and reaffirmed in subsequent UN meetings on HIV, the term 'harm reduction' has yet to be included in a consensus document of a UN drug control forum.

For the new SDG targets to be met by 2030, this imbalance must be redressed, and rapidly. This is why, in the year that a UN General Assembly will review the global approach to drug policy, Harm Reduction International and over 1,000 of our partners and allies have called for a Harm Reduction Decade.

In the decade ahead of us, we want to see an alternative response to drug use that is rooted in evidence, public health, human rights and dignity. We want harm reduction to be a driving principle of national and international approaches to drug use, one that focuses on protecting and improving the health and well-being of people who use drugs, and that rejects the human rights abuses, criminalisation and mass incarceration which for too long have characterised the global response to drugs.

The call for a Harm Reduction Decade builds on the existing evidence of what harm reduction has delivered in saving lives and in responding to HIV and viral hepatitis epidemics. The modelling in this report illustrates what could be achieved if harm reduction were adequately funded through a small reallocation of funds currently being squandered on punitive policies and practices.

The Harm Reduction Decade rests not only on the principles of harm reduction but on a number of essential components:

Accountability for human rights abuses in the context of drug control

Despite their overarching concern for the 'health and welfare of mankind', the international drug conventions have generated an overwhelmingly punitive approach to drug control, one which favours criminalisation and punishment over health and welfare, and which has guided national drug laws around the world. Moreover, some States have chosen to interpret the treaties in excessively punitive ways,[37] resulting in large-scale human rights abuses for which there has been very little, if any, accountability. Abusive law enforcement practices are widespread; excessive criminal penalties, including executions, for non-violent offences are common; and abuses in the name of drug dependence treatment are well documented. Lifesaving NSPs are lacking, especially in prisons, and access to essential medicines such as OST is restricted. As the UN Special Rapporteur on the Right to Health recently noted, 'Repressive responses to…drug use…pose unnecessary risks to public health and create significant barriers to the full and effective realisation of the right to health, with a particularly devastating impact on…people who use drugs'.[38] Accessing harm reduction in these punitive environments is itself risky, exposing individuals to stigma and discrimination, police harassment, arbitrary arrest and imprisonment. These are human rights abuses in themselves, but they also limit the extent to which harm reduction can affect epidemics and improve people's lives. Unless human rights become fully incorporated into all drug control processes, policies and programmes, these violations will continue to be ignored.

Ending the criminalisation of people who use drugs

Punitive approaches to drug use have also resulted in criminal law forming the lead strategy for addressing drug use in our societies. This has produced enormous health, social and economic harms. Criminal records are handed down in almost every country for possession offences. Although often seen as a minor penalty, a criminal record damages not only one person's life chances but often their children's too. They limit the ability of people to enter the workforce and contribute to society.

Many countries impose custodial sentences for possession. The resulting mass incarceration of people who use drugs is both a human rights and public health crisis. People who inject drugs make up one third to one half of prison populations, and levels of injecting drug use in prisons are high.[39] Yet as of 2015, only seven countries or territories implement NSPs, and just 44 implement OST in prison.[40] As needles and syringes are scarce in prison, people who inject drugs are often forced to make or share injecting equipment, and sometimes up to 20 individuals inject with the same equipment,[39] fuelling HIV and hepatitis C infection.[41]

HIV, hepatitis C and tuberculosis (TB) have emerged as especially severe problems in prison systems worldwide. TB is one of the leading causes of mortality in prisons in many countries,[42] with rates up to 81 times higher in prisons that in the broader community.[43] Global HIV prevalence, for example, is up to 50 times higher among the prison population than in the general public,[44] while one in four detainees worldwide is living with hepatitis C,[45] in comparison to, for example, one in 50 people in the broader community in Europe.[46] These figures reflect the urgent need for a rethink of the current global approach to drugs, orienting goals and investments away from prohibition and towards health and human rights.

The harm reduction approach does not include the criminalisation and imprisonment of people who use drugs, some of whom are in need of health or social support. Decriminalising personal possession of drugs and ending the mass incarceration of people who use drugs are a priority for a Harm Reduction Decade. Supportive legal and policy environments are necessary for the full potential of harm reduction to be realised.

Reframing harm reduction workers as human rights defenders

Repressive drug control measures affect not only people who use drugs but the extent to which harm reduction programmes can be effectively delivered. Harm reduction workers - comprising a diversity of individuals, groups and organisations, including peer workers, outreach workers, service providers and advocates - work to reduce the harms associated with drug use and drug laws and policies. They

Figure 8. TB, HIV and HCV in places of detention

Higher TB rates in places of detention

Higher prevalence of HIV in places of detention

One in four detainees is living with HCV

are human rights defenders because they work tirelessly, day in and day out, to promote and protect the rights of people who use drugs, including their rights to life, health, humane treatment and non-discrimination.[47, 48] Like many other defenders, harm reduction workers sometimes carry out their activities in hostile environments and may be subjected to human rights abuses in the course of their work. They report arbitrary arrest, detention and prosecution, as well as harassment, intimidation and slander. Many harm reduction organisations have seen their funding cut or limited, making it extremely difficult to carry out their work. In line with the UN Declaration on Human Rights Defenders, a Harm Reduction Decade would include increased efforts, and international assistance, to protect harm reduction workers and peer workers from arbitrary threats, violence and discrimination, and suitable political, legislative and financial support to enable them to deliver safe and high-quality services.[48]

A harm reduction approach to measuring success

The UN drug control and human rights regimes have developed in what have been described as 'parallel universes',[49] with human rights considerations historically absent from the monitoring and evaluation of drug policy. Current measures of success, focused on the suppression of drug use, supply and production, include such indicators as number of arrests, number of prosecutions secured, amount of illicit crops destroyed, quantity of drugs seized, and levels of funding spent on counter-narcotic equipment and personnel.[50] The current approach does not include any health or human rights impact evaluations, and success is not measured on the basis of changes in health, welfare, respect for human rights, political stability, development or security. Not only that, the current monitoring focus has generated very negative and harmful impacts, while diverting focus and resources towards costly and ultimately ineffective enforcement-led approaches. This, in turn, has created significant obstacles to pursuing alternative cost-effective and evidence-based approaches dedicated to promoting and protecting health and human rights, such as harm reduction approaches.

Box 3. Harm reduction workers under attack - Ozone's experience in Thailand

Ozone is a Thai NGO which delivers around 75% of the country's harm reduction services, reaching over 5,000 people who inject drugs in 12 provinces.

With drug use highly stigmatised and criminalised, delivering harm reduction services in Thailand is challenging. Peer outreach workers are frequently arrested, with arrests averaging 3 to 4 per month and reaching a high of 12 in one month. Physical, sexual and psychological abuse has been documented at the hands of law enforcement officials, and bribery, drug planting, sexual and psychological abuse are routine, with little accountability. Up to a third of female peer outreach workers and clients at a focus group discussion in Bangkok in May 2012 reported being pressured into sex by law enforcement officials in exchange for release.

Since initiation of the Global Fund's New Funding Model in January 2015, funding for HIV prevention among people who inject drugs has decreased by more than 50%, and there is currently no funding to continue the national harm reduction response beyond 1 January 2017. The Thai government has never funded harm reduction beyond inadequate methadone maintenance treatment programmes, and there are no indications that it will make funding available. Already this transition has had crippling effects, with the number of sites reduced and no plans to ensure support to clients. Stocks of needles and syringes have been depleted, and, as of November 2015, procurement has ceased. Fewer civil society organisations are involved in the national harm reduction response, and tensions between these has significantly increased; the number of harm reduction workers has been reduced, while workloads and targets have increased; all workforce support has been eliminated; distribution of needles via pharmacies has been terminated; collaboration activities with law enforcement have been discontinued; research and documentation have been curtailed; and data collection in the field is restricted. Furthermore, advocacy activities have been centralised and are now conducted via one agency responsible for advocacy for HIV and TB across all populations. As a consequence, the national harm reduction policy was not renewed in October 2015 because not enough was done to maintain pressure on government agencies.

"success is not measured on the basis of changes in health, welfare, respect for human rights, political stability, development or security."

The ultimate objective of drug policy should be to reduce drug-related harms, while ensuring respect for human rights. To realign global drug policy with these priorities, public health, human rights and harm reduction principles and standards need to guide the policymaking process. They must be incorporated into policies, strategies and programme design delivery, monitoring and evaluation, as well as accountability mechanisms. Central to this entire process is the identification of suitable alternative indicators that are firmly grounded in harm reduction, public health and human rights to monitor and evaluate the appropriateness and effectiveness of these interventions, as well as their impact on people's health, well-being, safety, development and human rights.

> "as it stands, the 'official' evaluation of global drug control, is therefore telling less than half the story"
>
> Global Commission on Drug Policy

Calling for a Harm Reduction Decade

The world needs alternatives to the current failed and counterproductive policies. In April 2016, political leaders will meet in New York at a UN General Assembly Special Session on drugs, an event that offers the opportunity to learn from the policies of the past and build an alternative response to drug use that is rooted in evidence, public health, human rights and dignity. It offers the opportunity to make harm reduction a driving principle of national and international approaches to drug use, one that focuses on protecting and improving the health and well-being of people who use drugs, rather than maintaining a focus on punishment and prohibition in the name of drug suppression.

In October 2015, at the International Harm Reduction Conference the harm reduction sector released the Kuala Lumpur Declaration, **calling on governments and international organisations to:**

- endorse and adopt harm reduction as a key principle of drug policy throughout the next decade of the global response to drug use;
- redirect just a small portion of funding from ineffective punitive drug control activities into health, human rights and harm reduction responses, and deliver a global target of a 10% shift in such funding by 2020 at the upcoming UN General Assembly Special Session; and
- end the criminalisation of people who use drugs and the punitive legal frameworks that fuel HIV transmission, overdose, mass incarceration and human rights violations.

Since Kuala Lumpur, over 1,000 organisations and individuals have added their names to the Declaration, with signatories including Sir Richard Branson, UNAIDS Asia-Pacific, Kofi Annan Foundation and Ruth Dreifuss, the former president of Switzerland. As the UN General Assembly Special Session approaches, these signatories are sending the message that the provision of harm reduction services can no longer be seen as a policy option at the discretion of governments but must instead be understood as a core obligation of States to meet their international legal obligations under the right to health. Achieving the UN drug control regime's own stated objective of promoting the health and welfare of humankind also necessitates increased commitment to the core principles of harm reduction.

Harm reduction has been proven to save lives, promote health and increase the human rights and dignity of people who use drugs. It is time for the international community to embrace this success and ensure that the next ten years are the Harm Reduction Decade.

www.harmreductiondecade.org

Methodology

Mathematical modelling for this report was conducted using the Optima HIV model (JAIDS, Vol 69, 3, Pages 365-376). Optima is an HIV epidemiological and economic model that uses an integrated analysis of epidemic, programme, and cost data to determine an optimal distribution of investment at different funding levels to better serve the needs of HIV and health decision-makers and planners. Separate HIV epidemiological models were developed in the Optima framework to be calibrated to the HIV incidence and prevalence among people who inject drugs by world region: Asia; Eastern Europe and Central Asia; Western Europe, North America and Oceania; Latin America and the Caribbean; Middle East and North Africa; Sub-Saharan Africa. For each region, data on the number of people who inject drugs in each country and the prevalence of HIV among people who inject drugs in each country were used in a weighted average to obtain regional epidemiological estimates (data were sourced from UNODC World Drug Report 2014; Mathers et al, HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage, Lancet, 2010 Mar 20;375(9719):1014-28; Global AIDS Progress Reporting 2014 and the UNAIDS GAP Report 2014).

The interventions included within the modelling calculations were NSP, OST and ART. The coverage of different harm reduction intervention components differed by world region and were assumed based on available data within each region. For the estimated costs of scaling up harm reduction to mid- and high-coverage levels in each region, see Wilson DP et al (2015) The cost-effectiveness of harm reduction, International Journal of Drug Policy, Vol 26, S1, Pages S5–S11. The six regional models were then aggregated to produce a global model of HIV among people who inject drugs. The regional models and aggregate model were projected into the future according to scenarios of continuation of current funding and associated constant levels of intervention coverage levels and also according to shifts in intervention coverage related to changes in assumed funding available for harm reduction.

References

1. Harm Reduction International (2009) *What is harm reduction?* London: Harm Reduction International. Available from: http://www.ihra.net/what-is-harm-reduction [Accessed 23 February 2016].
2. UNGASS (2016) Draft outcome document UNGASS 2016 (revised 9 February 2016): *Our joint commitment in effectively addressing and countering the world drug problem.* New York: UNGASS.
3. WHO (2014) *Good practice in Europe. HIV prevention for people who inject drugs implemented by the International HIV/AIDS Alliance in Ukraine.* Geneva: WHO.
4. UNAIDS (2014) *The Gap Report.* Geneva: UNAIDS.
5. Commission on Narcotic Drugs (2008) *"Making drug control 'fit for purpose': Building on the UNGASS decade" Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly.* [E/CN.7/2008/1]. Vienna.
6. Cook, C & Kanaef, N (2008) *The Global State of Harm Reduction 2008: Mapping the response to drug-related HIV and hepatitis C epidemics.* London: International Harm Reduction Association.
7. Stone, K (2014) *The Global State of Harm Reduction 2014. London:* Harm Reduction International.
8. Cook, C, Bridge, J & Stimson, G (2010) *The diffusion of harm reduction in Europe and beyond.* Lisbon: EMCDDA.
9. UNAIDS (2013) *HIV in Asia and the Pacific.* Geneva: UNAIDS.
10. Ruan, Y, Liang, S, Zhu, J, Li, X, Pan, S, Liu, Q et al. (2013) Evaluation of harm reduction programs on seroincidence of HIV, hepatitis B and C, and syphilis among intravenous drug users in southwest China. *Sexually Transmitted Diseases* 40(4):323–8.
11. The White House (2016) *Fact Sheet: President Obama Proposes $1.1 billion in new funding to address the prescription opioid abuse and heroin use epidemic.* Washington, DC: The White House. Available from: https://www.whitehouse.gov/the-press-office/2016/02/02/president-obama-proposes-11-billion-new-funding-address-prescription [Accessed 23 Febraury 2016].
12. Shaw, G (2014) *Independent Evaluation: Community Action on Harm Reduction (CAHR).* Brighton: International HIV/AIDS Alliance.
13. UNODC (2014) *World Drug Report 2014.* Vienna: UNODC.
14. Deveau, C, Levine, B & Beckerleg, S (2011) Heroin use in Kenya and findings from a community based outreach programme to reduce the spead of HIV/AIDS. *African Journal of Drug and Alcohol Studies* 5(2).
15. UNAIDS (2014) *Global AIDS Response Progress Reporting: Kenya.* Geneva: UNAIDS.
16. Ayon, S (2014) GSHR 2014 survey response, 30 June 2014. Nairobi: Kenya AIDS NGOs Consortium.
17. Rose, N (2014) GSHR 2014 survey response. Port Louis, Mauritius: Collectif Urgence Toxida.
18. Rhodes, T, Guise, A, Ndimbii, J, Strathdee, S, Ngugi, E, Platt, L et al. (2015) Is the promise of methadone Kenya's solution to managing HIV and addiction? A mixed-method mathematical modelling and qualitative study. BMJ Open 5(3):e007198.

19. Australian Government Department of Health and Ageing (2009) *Return on investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia.* Canberra: Department of Health and Ageing.

20. Wilson, D, Kwon, A, Anderson, J et al. (2009) *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia.* Sydney: National Centre in HIV Epidemiology and Clinical Research, University of New South Wales.

21. Centre for Substance Abuse Treatment (2005) *Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP).* Rockville, MD: Substance Abuse and Mental Health Services Administration.

22. Ni, M, Fu, L, Chen, X, Hu, X & Wheeler, K (2012) Net financial benefits of averting HIV infections among people who inject drugs in Urumqi, Xinjiang, Peoples Republic of China (2005-2010). *BMC Public Health* 12:572.

23. Dutta, A et al. (2012) *The global HIV epidemics among people who inject drugs.* Washington, DC: World Bank.

24. Coffin, P & Sullivan, S (2013) Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal in Russian cities. *Journal of Medical Economics* 16(8):1051–60.

25. 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.

26. OHCHR (2009) *United Nations High Commissioner calls for focus on human rights and harm reduction in international drug policy.* Geneva: OHCHR.

27. OHCHR (2015) *Statement by by Mr. Zeid Ra'ad Al Hussein, United Nations High Commissioner for Human Rights, at the high-level panel on public health and human rights approaches to the world drug problem.* Geneva: OHCHR. Available from: http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16628&LangID=E [Accessed 23 Febraury 2016].

28. UN General Assembly (2010) *Report of the Special Rapporteur on the Right to Health, Anand Grover.* New York: United Nations.

29. ECOSOC (2015) Commission on Narcotic Drugs Reconvened fifty-eigth Session. List of participants [E/CN.7/2015/INF/3/Rev.1]. Vienna: ECOSOC.

30. UNAIDS (2015) *The Gap Report.* Geneva: UNAIDS.

31. Cook, C, Bridge, J, McLean, S et al. (2014) *The funding crisis for harm reduction: Donor retreat, government neglect and the way forward.* London: Harm Reduction International.

32. Skala, P (2016) *The Comprehensive Harm Reduction Package in Ukraine.* New Approaches on Harm Reduction with a look at UNGASS 2016. 15-18 February. Berlin.

33. Kim, S, Pulkki-Brannstrom, A & Skordis-Worrall, J (2014) Comparing the cost effectiveness of harm reduction strategies: a case study of the Ukraine. *Cost Effectiveness and Resource Allocation* 12:25.

34. Bewley-Taylor, D (2012) *International Drug Control: Consensus Fractured.* Cambridge: Cambridge University Press.

35. ECOSOC (1981) *Resolution III. Social conditions and protection aginst drug addiction. Adopted by the United Nations Conference to Consider Amendments to the Single Convention on Narcotic Drugs.* Geneva: ECOSOC.

36. Single Convention on Narcotic Drugs 1961 (Preamble): United Nations.

37. Barrett, D et al. (2008) *Recalibrating the Regime: the Need for a Human Rights Based Approach to International Drug Policy.* Oxford: Beckley Foundation Drug Policy Programme and London: International Harm Reduction Association.

38. OHCHR (2015) *Open letter by the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Daniel Puras, in the context of the preparations for the UNGASS 2015.* Geneva: OHCHR. Available from: http://www.ohchr.org/Documents/Issues/Health/SRLetterUNGASS7Dec2015.pdf [Accessed 16 February 2016].

39. Dolan, K, Moazen, B, Noori, A, Rahimzadeh, S, Farzadfar, F & Hariga, F (2015) People who inject drugs in prison: HIV prevalence, transmission and prevention. International Journal of Drug Policy 26, Supplement 1:S12–S5.

40. Sander, G (2016) *HIV, HCV, TB and Harm Reduction in Prisons: Human Rights, Minimum Standards and Monitoring at the European and International Levels.* London: Harm Reduction International.

41. International Federation of Red Cross and Red Crescent Societies (2010) *Out of Harm's Way: Injecting Drug Users and Harm Reduction.* Geneva: IFRC.

42. Lines, R (2008) The right to health of prisoners in international human rights law. International Journal of Prisoner Health 4(1):3–53.

43. WHO (2014) *Prisons and Health - WHO Guide.* Geneva: WHO.

44. Mariner, J & Schleifer, R (2013) The Right to Health in Prisons. In: Zuniga, J et al. (eds) *Advancing the Human Right to Health.* Oxford: Oxford University Press.

45. Larney, S, Kopinski, H, Beckwith, C, Zaller, N, Jarlais, D, Hagan, H et al. (2013) Incidence and prevalence of hepatitis C in prisons and other closed settings: results of a systematic review and meta-analysis. *Hepatology* 58(4):1215–24.

46. WHO (2015) *Hepatitis C in the WHO European Region: Fact Sheet.* Geneva: WHO.

47. OHCHR (2011) Human Rights Defenders: Protecting the Right to Defend Human Rights. *Fact Sheet* No. 29. Geneva: OHCHR.

48. UN Special Rapporteur on the Situation of Human Rights Defenders (2011) *Commentary to the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms.* Geneva: OHCHR.

49. Hunt, P (ed.) (2008) *Human Rights, Health and Harm Reduction: States' amnesia and parallel universes.* Address given at the 19th International Harm Reduction Conference in Barcelona, 11 May 2008.

50. Barrett, D & Nowak, M (2009) 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 K Kalliopi.* Leiden: Brill/Nijhoff.

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights based approaches to drug policy through an integrated programme of research, analysis, advocacy and civil society strengthening. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

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