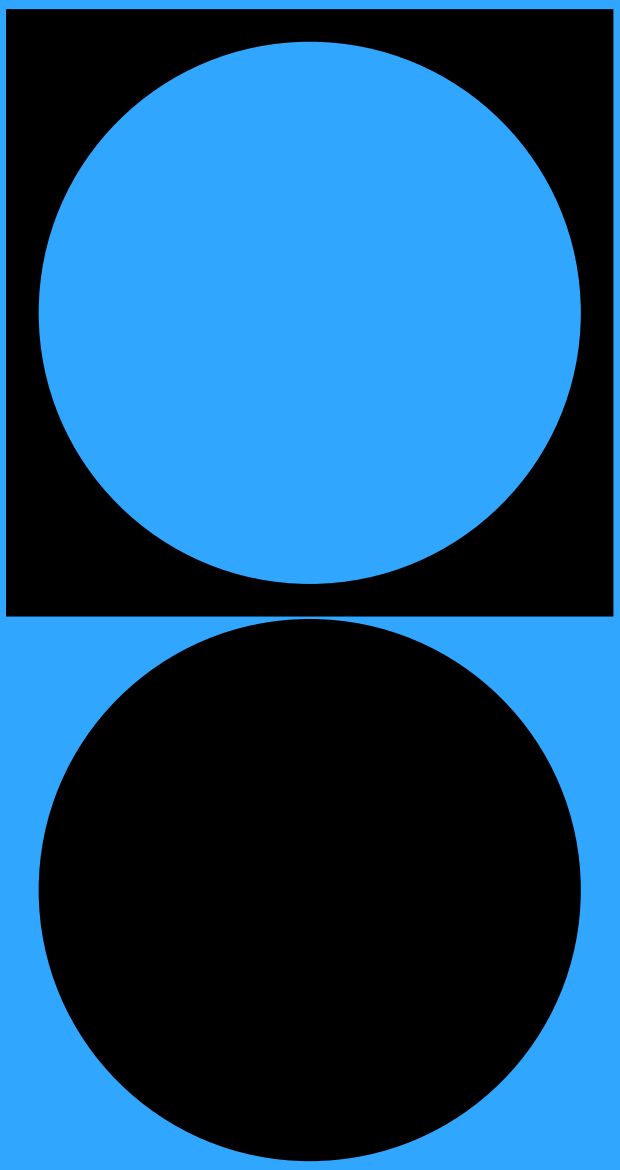
REGIONAL OVERVIEW: LATIN AMERICA AND THE CARIBBEAN



THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

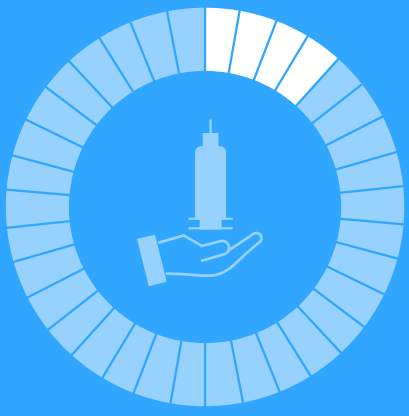
TABLE 5 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN LATIN AMERICA AND THE CARIBBEAN

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

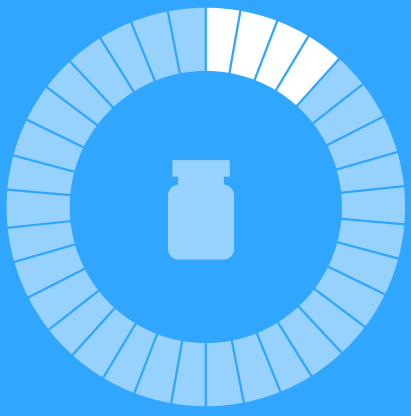
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)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


Bañamas
Cuba
Dominican Republic
Mexico
Belize
Jamaica
Haiti
Puerto Rico
Antigua and Barbuda
Saint Kitts & Nevis
Dominica
Saint Lucia
Saint Vincent & The Grenadines
Barbados
Honduras
Guatemala
El Salvador
Nicaragua
Grenada
Trinidad and Tobago
Costa Rica
Venezuela
Guyana
Suriname
French Guiana
Panama
Colombia
Ecuador
Peru
Brazil
Bolivia
Chile
Paraguay
Argentina
Uruguay
Both NSP and OAT available
OAT only
NSP only
Neither available
Not known
Peer-distribution of naloxone
DCR available

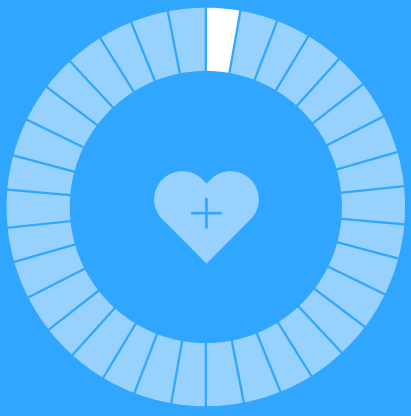
NSPs, OAT AND DCRs SINCE 2020



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



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



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

HARM REDUCTION IN PRISONS

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

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

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

REGIONAL OVERVIEW

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

INTRODUCTION

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

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

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

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

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

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

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

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

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

OPIOID AGONIST THERAPY (OAT) AND ACCESS TO NALOXONE

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

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

STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

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

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

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

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

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

DRUG CONSUMPTION ROOMS (DCR)

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

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

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

CHEMSEX

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

VIRAL HEPATITIS, HIV AND ANTIRETROVIRAL THERAPY (ART)

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

HARM REDUCTION IN PRISONS

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

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

POLICY DEVELOPMENTS FOR HARM REDUCTION

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

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

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

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

FUNDING DEVELOPMENTS

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

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

SPOTLIGHT

COVID-19, SMOKABLE COCAINE AND SOCIAL VULNERABILITY

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

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

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

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

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

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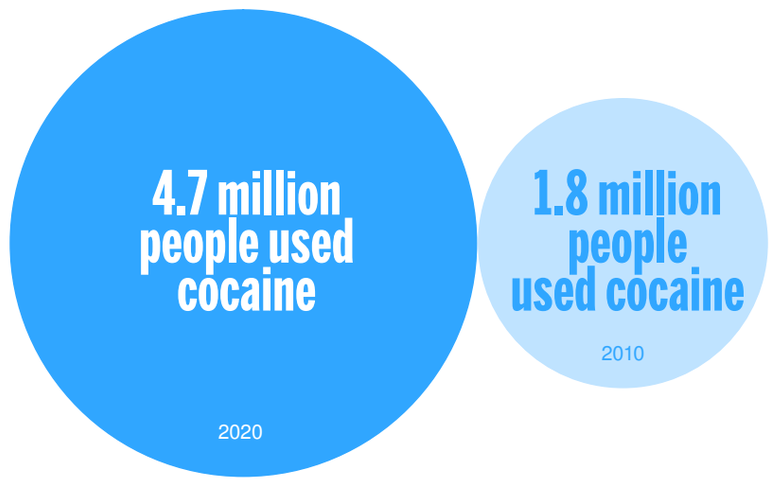

SPOTLIGHT

TOWARDS REGULATED MARKETS FOR CANNABIS AND COCAINE

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

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

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

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

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

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