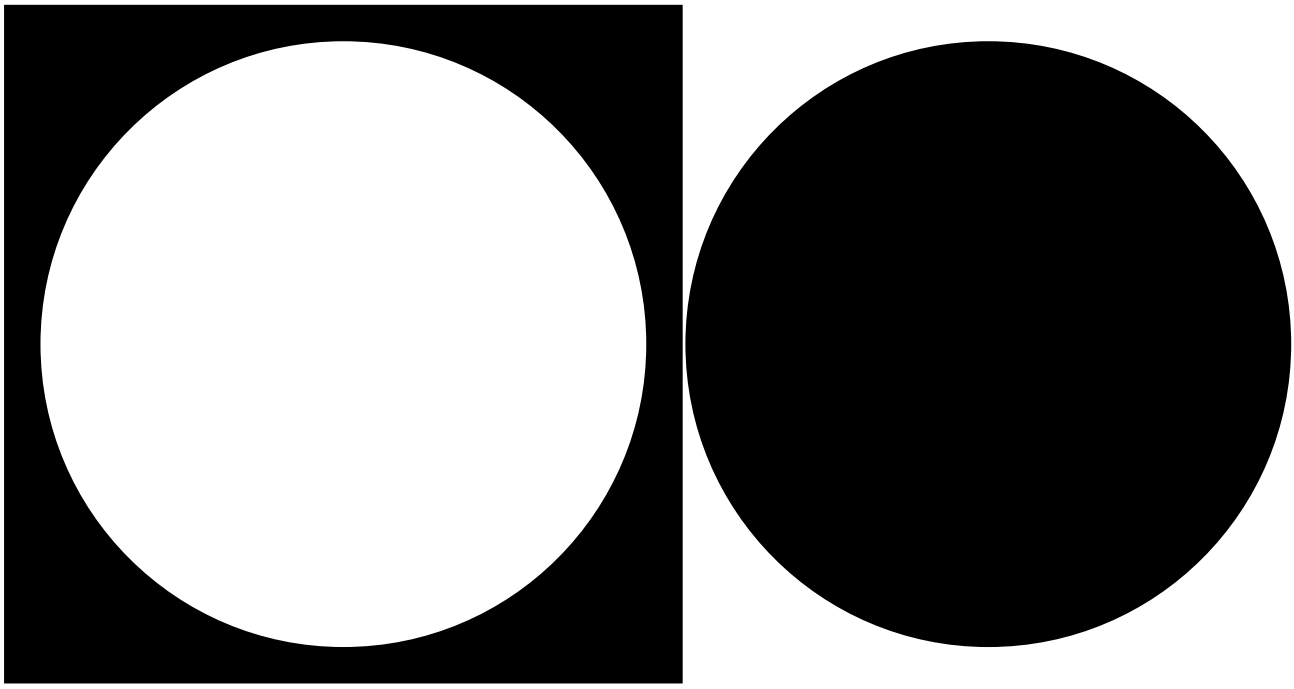


GLOBAL OVERVIEW

HARM REDUCTION INTERNATIONAL

TABLE 1 COUNTRIES OR TERRITORIES EMPLOYING A HARM REDUCTION APPROACH IN POLICY OR PRACTICE

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
ASIA										
Bangladesh	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bhutan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Brunei Darussalam	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cambodia	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
China	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Hong Kong	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
India	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Indonesia	✓	✓	✓	✗	✗	✗	✓	✗	✗	✓
Japan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Laos	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Macau	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Malaysia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Maldives	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Mongolia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Myanmar	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Nepal	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
North Korea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Philippines	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Singapore	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
South Korea	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sri Lanka	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Taiwan	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Thailand	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Vietnam	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
EASTERN AND SOUTHERN AFRICA										
Angola	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Botswana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Comoros	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Eritrea	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Eswatini	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ethiopia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kenya	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Lesotho	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Madagascar	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Malawi	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Mauritius	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Mozambique	✗	✓	✓	✗	✓	✗	✗	✗	✗	✗
Namibia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Rwanda	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Seychelles	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
South Africa	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
South Sudan	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Uganda	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
United Republic of Tanzania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Zambia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Zimbabwe	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
EURASIA										
Albania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Armenia	✓	✓	✓	✗	✗	✗	✗	✗	✓	✓
Azerbaijan	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗
Belarus	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bosnia and Herzegovina	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Bulgaria	✓	✗	✓	✗	✗	✗	✗	✗	✗	✓
Croatia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Czechia	✓	✓	✓	✗	✓	✗	✓	✓	✗	✓
Estonia	✓	✓	✓	✗	✓	✗	✓	✗	✗	✓
Georgia	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Hungary	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kazakhstan	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Kosovo	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Kyrgyzstan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Latvia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Lithuania	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Moldova	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓
Montenegro	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
North Macedonia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Poland	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Romania	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Russia	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Serbia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Slovakia	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗

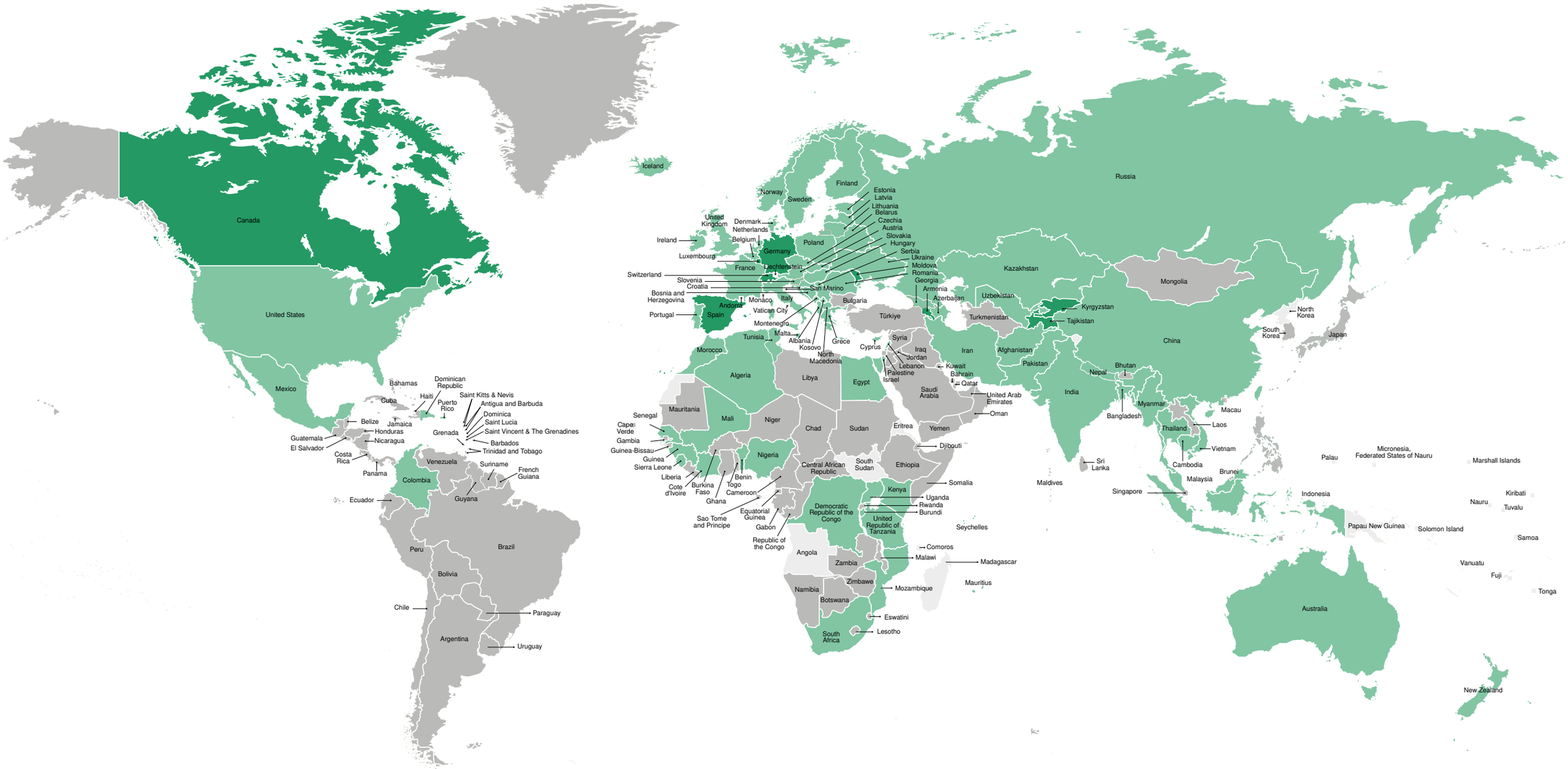
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Slovenia	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Tajikistan	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Turkmenistan	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ukraine	✓	✓	✓	✗	✓	✗	✗	✗	✗	✓
Uzbekistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
LATIN AMERICA AND THE CARIBBEAN										
Antigua and Barbuda	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Argentina	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Bahamas	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Barbados	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Belize	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Bolivia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Brazil	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗
Chile	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Colombia	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Costa Rica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cuba	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Dominican Republic	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Dominica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ecuador	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
El Salvador	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Grenada	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guatemala	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guyana	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Haiti	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Honduras	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Jamaica	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Mexico	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗
Nicaragua	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Panama	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Paraguay	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Peru	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Puerto Rico	✓	✓	✓	✗	✓	✓	✗	✗	✗	✗
Saint Kitts and Nevis	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saint Lucia	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Saint Vincent and the Grenadines	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Suriname	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Trinidad and Tobago	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Uruguay	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Venezuela	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
MIDDLE EAST AND NORTH AFRICA										
Afghanistan	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Algeria	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Bahrain	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Djibouti	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Egypt	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Iran	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Iraq	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Israel	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Jordan	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kuwait	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Lebanon	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Libya	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Morocco	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Oman	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Pakistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Palestine	✓	✗	✓	✗	✗	✗	✗	✗	✗	✓
Qatar	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saudi Arabia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Somalia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sudan	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Syria	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tunisia	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
United Arab Emirates	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Yemen	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
NORTH AMERICA										
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United States of America	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓

Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
OCEANIA										
Aotearoa-New Zealand	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Australia	✓	✓	✓	✓	✓	✓	✗	✗	✗	✓
Federated States of Micronesia	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Fiji	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Kiribati	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Marshall Islands	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Nauru	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Palau	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Papua New Guinea	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Samoa	✓	nd	✗	✗	nd	nd	nd	nd	nd	nd
Solomon Islands	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Timor Leste	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tonga	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Tuvalu	✗	nd	✗	✗	nd	nd	nd	nd	nd	nd
Vanuatu	✓	nd	✗	✗	nd	nd	nd	nd	nd	nd
WEST AND CENTRAL AFRICA										
Benin	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Burkina Faso	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Burundi	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Cameroon	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cape Verde	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Central African Republic	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Chad	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Congo	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cote d'Ivoire	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Democratic Republic of the Congo	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Equatorial Guinea	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Gabon	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Gambia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ghana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guinea	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Guinea-Bissau	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Liberia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗

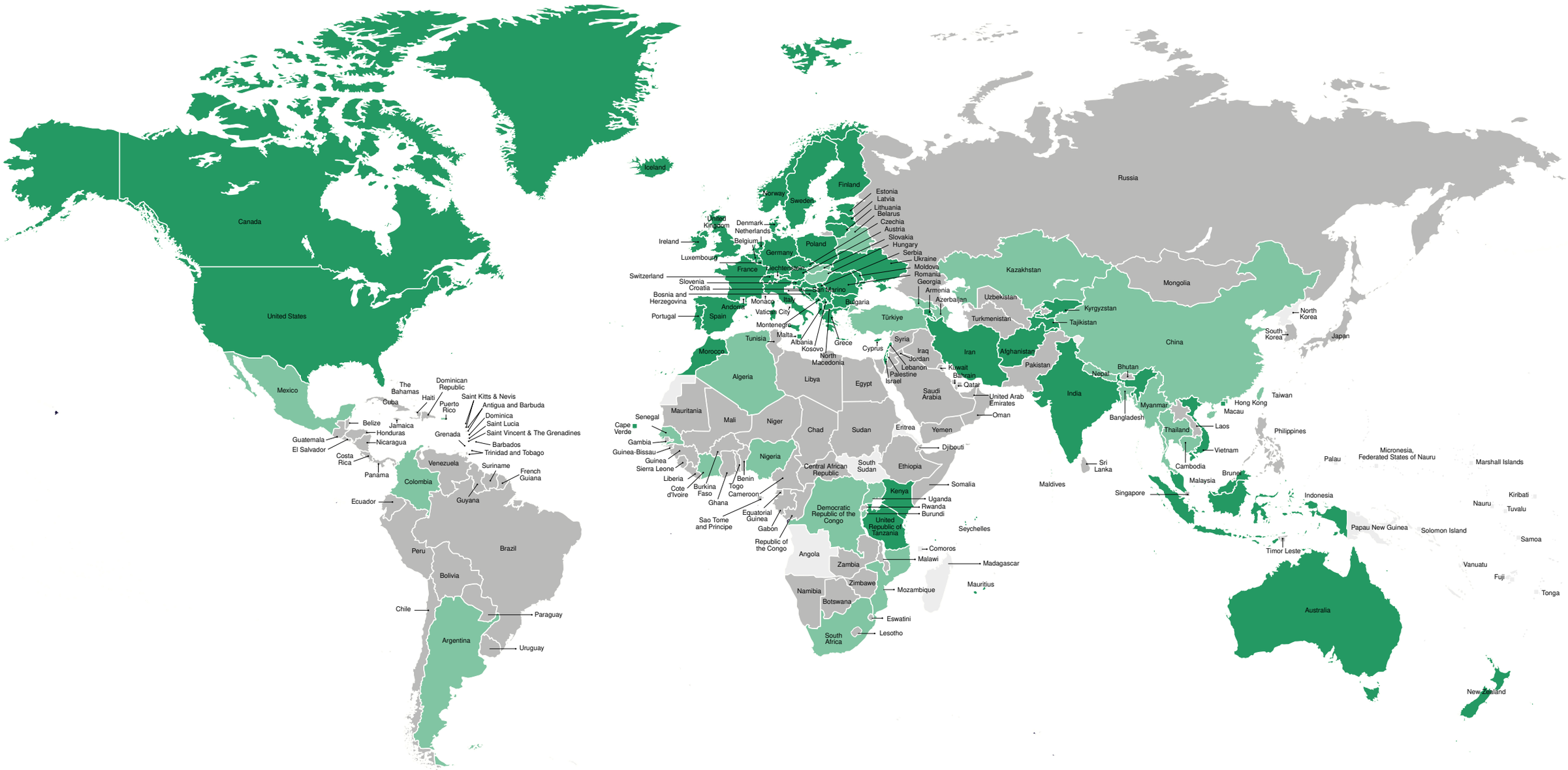
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take home naloxone available	At least one naloxone peer distribution programme operational	At least one safer smoking kit distribution programme	Stimulant prescription available	NSP in at least one prison	OAT in at least one prison
Mali	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Mauritania	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Niger	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Nigeria	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Sao Tome and Principe	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Senegal	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Sierra Leone	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Togo	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
WESTERN EUROPE										
Andorra	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Austria	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Belgium	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Cyprus	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Denmark	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Finland	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
France	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓
Germany	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Greece	✓	✓	✓	✓	✗	✗	nd	✗	✗	✓
Iceland	✓	✓	✓	✓	✗	✗	nd	✗	✗	✓
Ireland	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Italy	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Liechtenstein	nd	nd	nd	✗	nd	nd	nd	nd	nd	nd
Luxembourg	✓	✓	✓	✓	✗	✗	nd	✗	✓	✓
Malta	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Norway	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Portugal	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓
Sweden	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Switzerland	✓	✓	✓	✓	✗	✗	✓	✗	✓	✓
Türkiye	✗	✗	✓	✗	✗	✗	nd	✗	✗	✗
United Kingdom	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
GLOBAL TOTAL	**105**	**92**	**87**	**16**	**35**	**21**	**19**	**2**	**9**	**59**

M1.1 GLOBAL AVAILABILITY OF NEEDLE AND SYRINGE PROGRAMMES (NSPs) IN THE COMMUNITY AND IN PRISONS



- NSP available in the community
- NSP available in the community and prison
- NSP not available

M1.2 GLOBAL AVAILABILITY OF OPIOID AGONIST THERAPY (OAT) IN THE COMMUNITY AND IN PRISONS

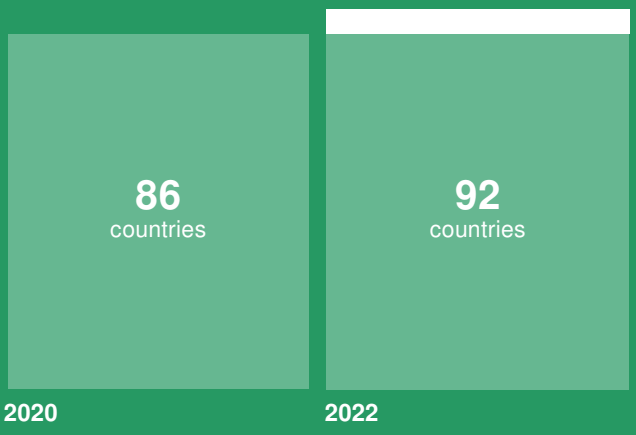


- OAT available in the community
- OAT available in the community and prison
- OAT not available

HARM REDUCTION INTERVENTIONS FROM 2020 TO 2022

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

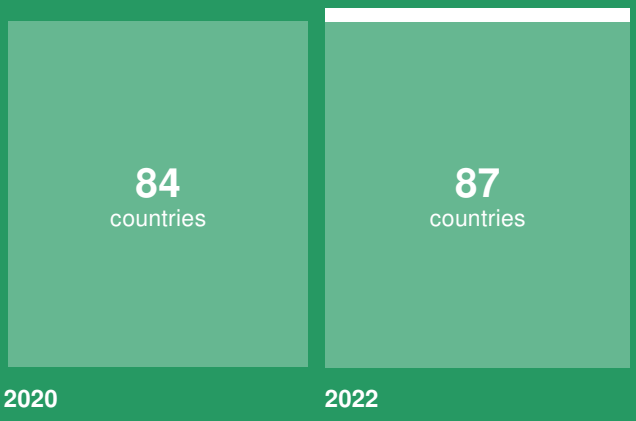
92 countries with at least one NSP in 2022



*Additionally, in Seychelles NSP has been available since 2016, but this was unreported in previous editions of the *Global State of Harm Reduction.*

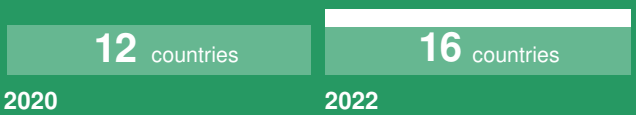
OPIOID AGONIST THERAPY (OAT)

87 countries with at least one OAT programme in 2022



DRUG CONSUMPTION ROOMS (DCRs)

16 countries with legal and operational DCRs in 2022



HARM REDUCTION IS STRONGER THAN IN 2020

The period from 2020 to 2022 has seen increased uptake of harm reduction interventions. For the first time since 2014, the *Global State of Harm Reduction* has found an increase in the number of countries implementing key harm reduction services.

This growth has been driven by new needle and syringe programmes (NSPs) opening in five African countries as well as four new countries having officially sanctioned drug consumption rooms (DCRs).[a] This includes a site in Mexico that had been operating without formal approval since 2018 but now has approval from local authorities. Three countries have introduced opioid agonist therapy (OAT) for the first time.

No country has stopped the implementation of NSP, OAT or DCRs since 2020.

In 2022, we identified:

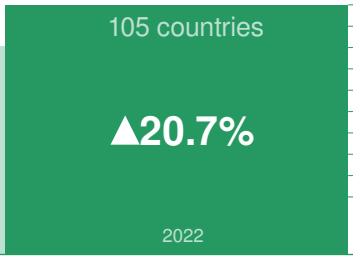
- 92 countries implementing at least one NSP (up from 86 in 2020)
- 87 countries with at least one OAT programme (up from 84 in 2020)
- 16 countries with legal and operational DCRs (up from 12 in 2020).

The number of countries providing naloxone on a take-home basis and through peer-distribution models has also increased. Changes in definitions and research strategies make year-on-year comparisons difficult, but the *Global State of Harm Reduction 2022* finds there are 35 countries where take-home naloxone is available, and 21 countries operating peer-distribution naloxone programmes. However, these programmes are often on a very small scale and highly vulnerable to regulatory or funding changes, especially those in low- and middle-income countries such as Iran, Kenya and South Africa.

An unprecedented 105 countries are now reported to include supportive references to harm reduction in national policy documents, compared with 87 in 2020.

The overall increase in the commitment to and implementation of harm reduction is a testament to the dedication, resilience and strength of community, civil society and international organisations, which have successfully advocated for a health and human rights-based approach to drug use despite extremely limited resources.

Supportive references to harm reduction in national policy documents



EASTERN AND SOUTHERN AFRICA	9
WESTERN AND CENTRAL AFRICA	11
ASIA	13
EURASIA	26
LATIN AMERICA AND THE CARIBBEAN	5
MIDDLE EAST AND NORTH AFRICA	15
NORTH AMERICA	2
OCEANIA	4
WESTERN EUROPE	20
Total	**105**

a The legal status of DCRs varies globally. The *Global State of Harm Reduction* includes in its count those facilities that have official backing from state authorities at either the national, sub-national or city level.

"The overall increase in the commitment to and implementation of harm reduction is a testament to the dedication, resilience and strength of community, civil society and international organisations, which have successfully advocated for a health and human rights-based approach to drug use despite extremely limited resources."

UNEQUAL RESOURCES, UNEQUAL PROGRESS

Nevertheless, the harm reduction movement cannot be complacent. The coverage and scale of harm reduction is still limited, and great inequalities remain within and between regions and countries in terms of access.

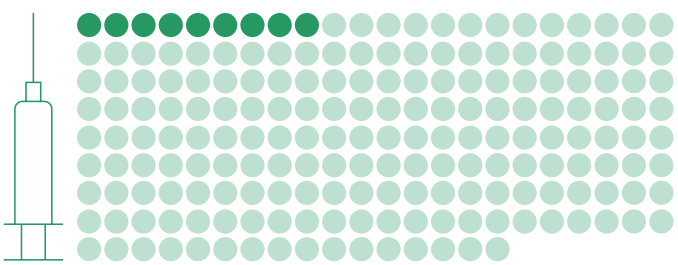
While the vast majority of countries in Eurasia, North America and Western Europe implement both NSP and OAT, these programmes are more absent than they are present in all regions of Africa, Latin America and the Caribbean, and the Middle East. Only North America, Oceania, Western Europe, and Mexico have officially sanctioned DCRs, and even in these countries support may be from local or state government rather than at the national level.

Even in countries where harm reduction programmes are implemented, availability, accessibility and quality remain significant issues. Services are unevenly distributed in most countries. People living in rural areas or outside capital cities, for example, are often poorly served.

Around the world, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services. Certain populations experience these barriers particularly acutely; most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, all of whom face a lack of services tailored to their needs.

"Around the world, people who use drugs continue to face criminalisation, stigma and discrimination that prevents access to services. Certain populations experience these barriers particularly acutely; most notably, women, LGBTQI+ people, people who are migrants or refugees, young people, and Black, Brown, and Indigenous people, all of whom face a lack of services tailored to their needs."

Needle and syringe programmes (NSPs) in prisons



EURASIA Kyrgyzstan, Moldova, Armenia, Tajikistan	4
NORTH AMERICA Canada	1
WESTERN EUROPE Germany, Luxembourg, Spain and Switzerland	4
Total	**9**

b In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP never been meaningfully implemented in the country.

Harm reduction in prisons has seen little expansion since 2020. Still, only 9 countries operate NSPs in prisons: Armenia, Canada, Germany, Kyrgyzstan, Luxembourg, Moldova, Spain, Switzerland and Tajikistan.[b] Canada has the world's only prison based DCR. The number of countries providing OAT in prisons is unchanged at 59. While OAT programmes are now operating in prisons in Kosovo, Macau, and Tanzania, this is balanced by new data indicating that prisons in Georgia, Hungary and Jordan only offer opioid agonists for detoxification.

HARM REDUCTION IN TIMES OF CRISIS

Since 2020, the world has experienced several acute crises which have tested the resilience of harm reduction services. The COVID-19 pandemic has continued to have a dramatic impact on harm reduction and public health. Many services were forced to close or reduce their operations during the worst of the pandemic, while lockdown orders and emergency powers resulted in the securitisation and militarisation of public health, which had a heavy impact on people who use drugs.[1,2] Nevertheless, harm reduction services, particularly those led by the community of people who use drugs and civil society, adapted to ensure they could still operate throughout the COVID-19 pandemic, for example, by increasing access to take-home OAT and naloxone (see the COVID-19 chapter, page 33). It is essential that community and civil society – which in many cases were the frontline of the COVID-19 response – are included in international conversations and decision making about pandemic preparedness, notably the proposed Pandemic Treaty.[3]

Economic, political, humanitarian, and environmental crises have also put harm reduction at risk. In Afghanistan, the Taliban retook control of the country in August 2021, which has had a significant impact on harm reduction service provision (see Spotlight: Afghanistan, page 105). Russia's invasion of Ukraine in February 2022 has caused Europe's largest movement of refugees since the Second World War[4] and put harm reduction services in Ukraine and neighbouring countries under immense pressure. Community and civil society organisations have continued to provide harm reduction services during this economic and humanitarian crisis (see Spotlight: Ukraine, page 80). In Lebanon, the COVID-19 pandemic and a major explosion in the port of Beirut led to an economic crisis and shortages of essential OAT medications in 2021. A coalition of national, regional and global civil society and community-led organisations reached an agreement with pharmaceuticals company Ethypharm and the Lebanese government to import a donation of buprenorphine to mitigate the impact of the shortage (see Spotlight: Lebanon's OAT Shortage, page 103).[5] In Sri Lanka, economic and political crises resulted in shortages of essential medicines and limited the operations of essential health services, including harm reduction.[6] Climate crisis and extreme weather, including flooding, wildfires, droughts and heatwaves, have created acute public health disasters across the globe which have affected vulnerable populations, including people who use drugs, people in prison and detention and people experiencing homelessness.[7,8,9,10]

Since May 2022, the world faced another public health challenge in the form of an ongoing outbreak of monkeypox. The outbreak has particularly affected gay men and other men who have sex with men. Within days of the outbreak being confirmed, the harm reduction movement and LGBTQI+ communities were already responding with advice on harm reduction and avoiding infection.[11,12]

The community and civil society organisations that make up the harm reduction movement have met all of these crises with compassion, dedication and resilience. With or without the support of the state, civil society and peer support groups have mobilised to ensure that as many people as possible continue to access lifesaving and life-enhancing harm reduction services.

"The community and civil society organisations that make up the harm reduction movement have met all of these crises with compassion, dedication and resilience. With or without the support of the state, civil society and peer support groups have mobilised to ensure that as many people as possible continue to access lifesaving and life-enhancing harm reduction services."

DECOLONISING DRUG POLICY AND BUILDING AN ANTI-RACIST HARM REDUCTION MOVEMENT

In the *Global State of Harm Reduction 2020* we reported on the wave of reflection on racism and colonialism that followed the murder of George Floyd by a police officer in Minneapolis, United States. These shifts have continued to influence thinking about drug policy and harm reduction globally.[13,14,15,16,17]

In November 2021, a group of advocates and academics published a paper detailing the ways in which drug policy has been used to uphold colonial and racist power structures around the world.[15] Over recent years, this has been a theme of advocacy and research carried out by many organisations in different countries, including Bolivia, Brazil, Indonesia, South Africa and the United States.[13,14,18,19,20,21,22]

The implementation of harm reduction continues to be affected by racism and colonial structures. Black, Brown and Indigenous people who use drugs have less access to harm reduction services.[15] Direct and structural racism makes it harder for Black, Brown and Indigenous people to access services, it results in Black, Brown and Indigenous communities being targeted by drug law enforcement agencies and disproportionately detained or imprisoned, and means the needs of these communities are often deprioritised or ignored.[23] People who are migrants or refugees face particular challenges, to the extent that experiencing migration can be a major detriment to a person's health.[24]

There are strong examples of harm reduction organisations leading the way on providing actively anti-racist services. For example, the Canberra Alliance for Harm Minimisation and Advocacy in Australia provides harm reduction services specifically tailored to the needs and practices of Indigenous communities.[25]

REACHING UNDERSERVED COMMUNITIES

The movement to build an anti-racist harm reduction movement is just one example of the efforts documented in this report to reach people who have historically been underserved by harm reduction.

For the first time, the *Global State of Harm Reduction 2022* has collected country-by-country data on the provision of safer smoking kits and pharmacotherapy for people who smoke drugs and use stimulants. Our research has found that safer smoking kits are distributed in 19 countries around the world[f], and 2 countries (Canada and Czechia) have nascent stimulant pharmacotherapy programmes.

The needs of women who use drugs remain gravely under-addressed in most contexts. As reported in every regional chapter of this report, community and civil society actors observe that women who use drugs face consistently higher

c These are Austria, Belgium, Brazil, Canada, Czechia, Estonia, France, Germany, Italy, Indonesia, Moldova, the Netherlands, Portugal, Slovakia, Slovenia, Spain, Switzerland, the United Kingdom and the United States.

barriers to harm reduction services than men, and that there is a lack of services specifically tailored to women's needs. Pregnant and parenting people face particularly acute stigma and discrimination when accessing harm reduction services, despite all evidence indicating that parental substance use is best addressed by harm reduction.[26,27] People engaged in sex work, despite being formally prioritised as a key population in global policy documents, face criminalisation which hinders access to health and harm reduction practices and services.[28] The efforts of global networks, such as the Women and Harm Reduction International Network and Women4GlobalFund, have been important in raising awareness of these inequities.

"Women who use drugs face consistently higher barriers to harm reduction services than men, and there is a lack of services specifically tailored to women's needs. Pregnant and parenting people face particularly acute stigma and discrimination when accessing harm reduction services, despite all evidence indicating that parental substance use is best addressed by harm reduction"

FAILURE TO FUND: THE CONTINUED CRISIS FOR HARM REDUCTION

Harm Reduction International has been monitoring investment in harm reduction for more than a decade[d]. Findings have been consistently dire, and this remains the case in the latest research. Still, only a few international donors fund harm reduction, and their investment appears to be shrinking. In low- and middle-income countries, funding for harm reduction is only 5% of the level needed to meet the estimated service needs for people who inject drugs by 2025. Sadly, the gap between the funding that is required and the funding that is available has only grown wider in recent years.[29]

In September 2022, the seventh replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) took place. The replenishment raised USD 14.25 billion, falling short of the target of USD 18 billion.[30] Nineteen donors[e] increased their pledge by 30%, including the European Union and Germany – a testament to sustained civil society advocacy. There was outstanding leadership from 13 African governments,[f] which together pledged more than USD 50 million. With 60% of harm reduction funding in low- and middle-income countries coming from the Global Fund, it is essential that harm reduction funding is protected from the shortfall in the replenishment.[31]

The funding gap for harm reduction in low- and middle-income countries is widening

Funding for harm reduction is only 5% of the level required in low- and middle-income countries

d For more information on funding for harm reduction, see Harm Reduction International's 2021 funding report, *Failure to Fund: The continued crisis for harm reduction in low- and middle-income countries,* available at www.hri.global/failure-to-fund.

e These were Belgium, Burkina Faso, Cote d'Ivoire, European Commission, Germany, Ireland, Kenya, South Korea, Kuwait, Portugal, Rwanda, Saudi Arabia, South Africa, Spain, Togo, Uganda, CIFF (Children Investment Fund Foundation), Rotary Australia World Community Service and Rotarians Against Malaria.

f These were Burkina Faso, Central African Republic, Côte d'Ivoire, Malawi, Zimbabwe, Tanzania, Uganda, Nigeria, Eswatini, South Africa, Togo, Rwanda and Kenya.

Research by Harm Reduction International in 2016 found that fully funding an effective harm reduction response would be achievable by redirecting just 7.5% of the funds spent on drug law enforcement towards harm reduction.[32,33] Six years later, funding for drug law enforcement still dwarfs investment in harm reduction. Globally, USD 100 billion is spent on drug law enforcement, and just USD 131 million is spent on harm reduction.[29,32]

Of particular concern is the shrinking investment in advocacy for harm reduction. Community-led advocacy is particularly underfunded. Opportunities for funding of harm reduction advocacy via multi-country grants from the Global Fund have significantly reduced, despite their positive impact.[34] Without advocacy for national investment in harm reduction, services in low- and middle-income countries will continue to be reliant on a shrinking pool of international funding. Adding to this, Open Society Foundations, a key funder of drug policy reform and harm reduction advocacy, has undergone structural and organisational changes which could have implications for its funding in this area.

Some donors have slightly increased their funding for harm reduction. These include the Elton John AIDS Foundation, the Robert Carr Fund and ViiV Healthcare Positive Action.[35,36]

HUMAN RIGHTS AND HARM REDUCTION

Harm reduction is a human right. It is recognised as a vital component of the right to the highest attainable standard of health for people who use drugs.[37] Denial of access to harm reduction, including in detention settings, violates the prohibition of torture and other cruel, inhuman and degrading treatment.[38,39]

In her May 2022 report on human rights and HIV, the United Nations High Commissioner for Human Rights, Michelle Bachelet, noted the barriers to harm reduction access created by the criminalisation, stigmatisation and marginalisation of people who use drugs.[40] The report highlights the human rights violations faced by women and trans people who use drugs; notably physical and sexual violence, which exacerbate both groups' vulnerability to HIV. This theme was also addressed by 18 human rights and harm reduction organisations in a joint statement to the 50th Session of the Human Rights Council (2022), which highlighted the disproportionate impact of the COVID-19 pandemic and government responses on the rights of marginalised and criminalised populations, including people who use drugs, people who sell sex and LGBTQI+ people.[41]

In June 2022, UN human rights experts[g] called for an end to the 'war on drugs', stating: 'Data and experience accumulated by UN experts have shown that the "war on drugs" undermines health and social wellbeing and wastes public resources while failing to eradicate the demand for illegal drugs and the illegal drug market.' The statement also emphasised the responsibility of the UN system, the international community and individual UN member states to reverse the devastation.[42]

Human rights violations continue to be committed worldwide in the name of drug control. These include, among many others, the denial of access to harm reduction services, including through the criminalisation of drug paraphernalia (such as syringes and pipes), the prohibition of OAT (for example, in Russia), and discrimination against people who use drugs in the provision of HIV and viral hepatitis care.[43]

g The statement was issued jointly by the Working Group on Arbitrary Detention, the Working Group on discrimination against women and girls, the Special Rapporteur on the Right to Health, the Special Rapporteur on the right to adequate housing, the Working Group of Experts on People of African Descent, the Special Rapporteur on the rights to freedom of peaceful assembly and of association, the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, the Independent Expert on the enjoyment of all human rights by older persons, the Special Rapporteur on contemporary forms of slavery including its causes and consequences, the Special Rapporteur on the situation of human rights in the Islamic Republic of Iran, the Special Rapporteur on trafficking in persons, especially women and children, the Special Rapporteur on extrajudicial, summary or arbitrary executions, and the Special Rapporteur on violence against women.

As of 2021, 35 countries retained the death penalty for drug offences. At least 131 people were executed for drug offences in 2021. Due to a lack of transparency, and even censorship, this figure is likely to represent only a fraction of all drug-related executions. There was an 11% increase in known death sentences for drug offences from 2020 to 2021, with at least 237 death sentences handed down in 16 countries. Roughly 10% of all drug-related death sentences confirmed in 2021 were handed to foreign nationals, raising significant fair trial and human rights concerns.[44] Despite the progress towards abolishing the death penalty for drug offences that some countries have made (such as in Malaysia),[45] it remains a tool of drug control in many others. Indeed, in some countries, there are ongoing national-level discussions to reinstate or introduce the death penalty for drug offences (such as in the Philippines and Tonga).[44,46,47]

POLITICS AND POLICY

Since 2020, there have been significant policy and political developments at the national and international level that may have implications for harm reduction implementation.

At the national level, elections in Colombia and the United States saw the inauguration of presidents who have made commitments in favour of a health-based approach to drug use. In the Philippines, Rodrigo Duterte was ineligible to stand for election due to the country's single-term limit, thus ending a presidency that had waged a drug war responsible for up to 30,000 extrajudicial killings.[48] However, human rights abuses against people who use drugs and people involved in the drug trade continue in the country.[49]

THE GLOBAL DRUG POLICY INDEX (GDPI)

In 2021, a consortium of harm reduction organisations launched the Global Drug Policy Index (GDPI).[h] The GDPI is the world's first accountability and evaluation mechanism to assess national drug policies. Its aim is to promote and measure countries' alignment with United Nations' recommendations on health, human rights and development.

The 2021 index evaluated 30 countries around the world. It is composed of 75 indicators across five dimensions: (1) absence of extreme responses, (2) proportionality and criminal justice, (3) harm reduction, (4) access to medicines, (5) development. Of the 30 countries, Norway, New Zealand and Portugal received the highest average scores across all dimensions, while Indonesia, Uganda and Brazil received the lowest scores of the 30 countries included in the index.

In the harm reduction dimension, Norway, Portugal and the United Kingdom scored highest, and Brazil, Ghana and Uganda scored lowest, among the 30 countries.

h This consortium consisted of the Eurasian Harm Reduction Association, the Eurasian Network of People who Use Drugs, the European Network of People who Use Drugs, the Global Drug Policy Observatory, Harm Reduction International, the International Drug Policy Consortium, the Middle East and North Africa Harm Reduction Association, the West African Drug Policy Network, the Women and Harm Reduction International Network and Youth Rise. The consortium was funded by the Robert Carr Fund.

The Russian government has continued to be an obstacle to evidence-based, rights-based drug policy at the international level, most notably at the United Nations Commission on Narcotic Drugs (CND), the governing body of the United Nations Office on Drugs and Crime (UNODC). Following the Russian invasion of Ukraine, Latvia challenged Russia's nomination to represent the Eastern European Group in the working group responsible for overseeing UNODC's finances and governance ('FINGOV'). The Latvian Ambassador stated: "I believe that a representative of a country that is being more and more isolated because of its aggression against Ukraine would not be the best adviser on implementation of regional and global programmes." In response, the Russian delegation forced a vote on the issue. This represented an extraordinary break with the longstanding consensus that has governed the CND's procedures and caused unprecedented friction between member states' delegations, which may have long-term implications on the governance of drug policy at CND.[50] Russia has also continued to block harm reduction civil society organisations from gaining Special Consultative Status with the Economic and Social Council of the United Nations.[36]

Elsewhere at the United Nations, in 2021, the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the *Global AIDS Strategy 2021-2026: End Inequalities. End AIDS.* The strategy focuses on closing gaps in the accessibility of HIV prevention, treatment and care, drawing attention to the needs of key populations (including people who use drugs) and regions where resources and political will are inadequate for an effective response to HIV.[51] In addition, to mark International Drug Users' Day in November 2021, UNAIDS issued a statement reaffirming its commitment to the decriminalisation of people who use drugs and the promotion of community-led services.[52]

At the World Health Organization (WHO), the 2022 session of the World Health Assembly (WHA) passed a resolution to ensure the WHO Director General continues to report to the WHA every two years on how the WHO is addressing the public health dimensions of drug use.[53] The WHO also launched the new *Global Health Sector Strategies (2022-2030)* on HIV, viral hepatitis and sexually transmitted infections, which include commitments to harm reduction for people who use or inject drugs and tailored interventions for people who use stimulants.[54]

In 2022, the Global Fund also launched a new strategy for 2023 to 2028. Notably, the strategy explicitly commits the Global Fund to the engagement and leadership of key populations to broaden and improve service provision.[55] However, the Global Fund Advocates Network has criticised the strategy as it does not include a goal for funding services that fit this commitment.[56]

1 Asia Centre, Harm Reduction International (2021), *The Securitisation of COVID-19 Health Protocols: Policing the Vulnerable, Infringing Their Rights.*
2 Harm Reduction International, Larasati A, Girelli G (2021), *Caught in the Crossfire: Health and human rights impacts of COVID-19 measures on people who use drugs in Indonesia and the Philippines.*
3 Harm Reduction International, Burke-Shyne N (9 March, 2022), 'Letter to HC OHCHR: HRI, Community and Civil Society seek OHCHR engagement in Pandemic Treaty process' [internet]. Available from www.hri.global/contents/2180.
4 UNHCR, 'Operational Data Portal: Ukraine Refugee Situation' [internet].
5 Daniels C (2022), personal communication.
6 ACAPS (2022), *Sri Lanka: Update on the socioeconomic crisis.*
7 Tseregounis IE, Delcher C, Stewart SL, Gasper JJ, Shev AB, Crawford A, et al. (2022), 'The impact of California wildfires on patient access to prescription opioids', *Journal of the American Pharmacists Association.* Available from www.sciencedirect.com/science/article/pii/S1544319122001509.
8 Erens B, Williams L, Exley J, Ettelt S, Manacorda T, Hajat S, et al. (2021), 'Public attitudes to, and behaviours taken during, hot weather by vulnerable groups: results from a national survey in England', *BMC Public Health,* 21(1):1631.
9 Sarkar S (2022), 'Pakistan floods pose serious health challenges', *BMJ*, 378:o2141.
10 Cusack L, de Crespigny C, Athanasos P (2011), 'Heatwaves and their impact on people with alcohol, drug and mental health conditions: a discussion paper on clinical practice considerations', *Journal of Advanced Nursing,* 67(4):915–22.
11 Gay Men's Sexual Health Alliance, (20 May, 2022), 'Monkeypox: What We Know' [internet, cited 22 August, 2022]. Available from https://gmsh.ca/monkeypox/.
12 European Centre for Disease Prevention and Control, The Love Tank, MPACT (2022), *Navigating monkeypox: Considerations for gay and bisexual men and other men who have sex with men.*
13 International Drug Policy Consortium, Fordham A (26 June, 2020),' The war on drugs is built on racism. It's time to decolonise drug policies', [internet, cited 22 August, 2022]. Available from https://idpc.net/blog/2020/06/the-war-on-drugs-is-built-on-racism-it-s-time-to-decolonise-drug-policies.
14 Shelly S, Howell S, (2019), 'Perpetuating apartheid: South African Drug Policy', in Koram K [ed],*The War on Drugs and the Global Colour Line.* Available from www.jstor.org/stable/j.ctvdmwxn7.11.
15 Daniels C, Aluso A, Burke-Shyne N, Koram K, Rajagopalan S, Robinson I, et al. (2021), 'Decolonizing drug policy', *Harm Reduction Journal*, 18(1):120.
16 Filter Magazine, Hoque U (3 June, 2021),'To Decolonize Drugs, Start With Prohibition's Settler Origins' [internet, cited21 September, 2022]. Available from https://filtermag.org/decolonize-drugs-prohibition-panel/.
17 Lasco G (2022), 'Decolonizing harm reduction', *Harm Reduction Journal*, 19(1):8.
18 Duarte EP, Freitas F da S (2019), 'Racism and drug policy: criminal control and the management of Black bodies by the Brazilian state', in Koram K [ed] *The War on Drugs and the Global Colour Line.* Available from www.jstor.org/stable/j.ctvdmwxn7.7.
19 Fransiska A (2019), 'Racism and social injustice in War on Drugs narratives in Indonesia', in Koram K [ed] *The War on Drugs and the Global Colour Line.* Available from www.jstor.org/stable/j.ctvdmwxn7.12.
20 Rede Nacional de Feministas Antiproibicionistas (2022), 'Manifesto RENFA - Nosso Partido é o Feminismo Negro Decolonial' [internet, cited 22 August, 2022]. Available from https://renfa.org/manifesto2022.
21 Drug Policy Alliance, 'Race and the Drug War' [internet, cited 22 August, 2022]. Available from https://drugpolicy.org/issues/race-and-drug-war.
22 Dejusticia, Drug Policy Alliance, Harm Reduction International, International Drug Policy Consortium, Release, Transnational Institute, et al. (2021) 'Descolonizar las políticas de drogas: La guerra contra las drogas y la negación de los derechos indígenas' [internet, cited 22 August, 2022]. Available from https://idpc.net/es/events/2021/08/descolonizar-las-politicas-de-drogas-la-guerra-contra-las-drogas-y-la-negacion-de-los-derechos-indigenas.
23 Harm Reduction International, Release (2022), Submission to OHCHR on the "*Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officersthrough transformative change forracial justice and equality", pursuant to Human Rights Council resolution 47/21.*
24 WHO (2022), *World report on the health of refugees and migrants.*
25 Harm Reduction International (2021), *Integrated and Person-Centred Harm Reduction Services.*
26 Shirley-Beavan S, Roig A, Burke-Shyne N, Daniels C, Csak R. (202), 'Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain', *Harm Reduction Journal,* 17(1):78.
27 National Advocates for Pregnant Women (2022), *Prenatal Drug and Alcohol Exposure: Science Refutes Media Hype and Enduring Myths.*
28 Platt L, Grenfell P, Meiksin R, Elmes J, Sherman SG, Sanders T, et al. (2018), 'Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies', *PLOS Medicine*, 15(12):e1002680.
29 Harm Reduction International, Serebryakova L, Cook C, Davies C (2021), *Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries.*
30 Devex, Saldinger A, Mohammed O (22 September, 2022),'Global Fund falls short of $18B target as UK, Italy delay pledges', [internet, cited 23 September, 2022]. Available from www.devex.com/news/sponsored/global-fund-falls-short-of-18b-target-as-uk-italy-delay-pledges-104046.
31 Harm Reduction International, International Network of People who Use Drugs, Eurasian Harm Reduction Association (2022), *Key harm reduction messages for the replenishment conference, implementation of new Global Fund Strategy and NFM4.* Available from https://www.hri.global/contents/2226.
32 Harm Reduction International (2021), *Redirection.*
33 Harm Reduction International, Cook C, Phelan M, Sander G, Stone K, Murphy F. (2016), *The Case for a Harm Reduction Decade.* Available from https://www.hri.global/files/2016/03/10/Report_The_Case_for_a_Harm_Reduction_Decade.pdf
34 Harm Reduction International, Schonning S (2020), *The impact of a multi-country harm reduction advocacy grant in South-East Asia.*
35 Wolfe D (2022), 'Global State of Harm Reduction 2022 reviewer response'.
36 Bridge J (2022), 'Global State of Harm Reduction 2022 reviewer response'.
37 UN General Assembly, Grover A (2010), *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, A/HRC/14/20.* Available from https://documents-dds-ny.un.org/doc/UNDOC/GEN/N10/477/91/PDF/N1047791.pdf?OpenElement.
38 UN General Assembly, van Boven T (2003), *Report of the Special Rapporteur on Torture, and Other Cruel, Inhuman, and Degrading treatment and Punishment, E/CN.4/2004/56.* Available from https://documents-dds-ny.un.org/doc/UNDOC/GEN/G03/173/27/PDF/G0317327.pdf?OpenElement.
39 UN General Assembly, Nowak M (2009), *Report of the Special Rapporteur on Torture, and Other Cruel, Inhuman, and Degrading treatment and Punishment, A/HRC/10/44.* G. Available from https://undocs.org/A/HRC/10/44
40 Harm Reduction International (2022), *50th Session of the Human Rights Council: Drug Policy Highlights.*
41 Harm Reduction International et al. (2022), '50th Session of the Human Rights Council: Joint oral statement on states' responses to pandemics' [internet, cited 22 August, 2022]. Available from https://www.hri.global/contents/2214.
42 OHCHR, United Nations Media Centre (24 June, 2022), 'End 'war on drugs' and promote policies rooted in human rights: UN experts' [internet, cited 21 September, 2022]. Available from https://www.ohchr.org/en/statements/2022/06/end-war-drugs-and-promote-policies-rooted-human-rights-un-experts.
43 Harm Reduction International et al. (2022), '50th Session of the Human Rights Council: joint oral statement on the right to health' [internet, cited 22 August, 2022]. Available from https://www.hri.global/contents/2215.
44 Harm Reduction International, Girelli G, Larasati A (2022), *The Death Penalty for Drug Offences: Global Overview 2021.*
45 Office of the High Commissioner for Human Rights (20 June, 2022), 'Malaysia: UN experts welcome announcement to abolish mandatory death penalty', [internet, cited 22 August, 2022]. Available from www.ohchr.org/en/press-releases/2022/06/malaysia-un-experts-welcome-announcement-abolish-mandatory-death-penalty.
46 Legislative Assembly of Tonga (1 September, 2021), 'Parliament passes the Illicit Drugs Control Bill 2021 but did not endorse the death penalty' [internet, cited 1 September, 2022]. Available from www.parliament.gov.to/media-centre/latest-news/latest-news-in-english/842-parliament-passes-the-illicit-drugs-control-bill-2021-but-did-not-endorse-the-death-penalty.
47 World Coalition against the Death Penalty, O'Connor GK (3 April, 2021), 'Adoption of Bill Allowing the Imposition of the Death Penalty for a New Crime' [internet, cited 1 September, 2022]. Available from https://worldcoalition.org/2021/04/30/adoption-of-bill-allowing-the-imposition-of-the-death-penalty-for-a-new-crime/.
48 Human Rights Watch (2022), *World Report 2022: Events of 2021.*
49 United Nations High Commissioner for Human Rights (2022), *Implementation of Human Rights Council Resolution 45/33 and on the progress and results of technical cooperation and capacity building for the promotion and protection of human rights in the Philippines, A/HRC/51/58.*

50 International Drug Policy Consortium, Bridge J (24 March, 2022), 'Breaking the consensus: Russia clashes with other UN CND Member States' [internet, cited 22 August, 2022]. Available from https://idpc.net/blog/2022/03/the-limits-of-consensus-russia-clashes-with-un-cnd-member-states-over-working-group-nomination.

51 UNAIDS (2021), *End Inequalities. End AIDS. Global AIDS Strategy 2021-2026* [Internet]. Available from www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf.

52 UNAIDS (1 November, 2021), 'On International Drug Users' Day, UNAIDS calls for action against the criminalization of people who use drugs and for community-led harm reduction programmes' [internet, cited 22 August, 2022]. Available from www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2021/november/20211101_international-drug-users-day.

53 World Health Organization, World Health Assembly (2022), *Second report of Committee B.*

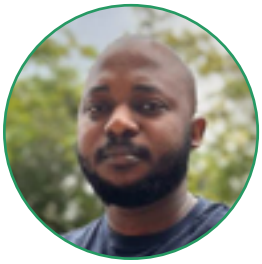
54 World Health Organization, World Health Assembly (2022), *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030.*

55 The Global Fund to Fight AIDS, Tuberculosis and Malaria (2022), *Fighting pandemics and building a healthier and more equitable world: Global Fund strategy.*

56 Global Fund Advocates Network (2022), *Fully Fund the Global Fund.*

COVID-19

BY
TEMITOPE SALAMI



OVERVIEW

The COVID-19 pandemic has continued to put a strain on the health and lives of people who use drugs and on harm reduction service delivery.[1] The Global State of Harm Reduction 2020 documented the ways in which the COVID-19 pandemic created new challenges for harm reduction services and people who use drugs, while also reporting on the innovation and flexibility of community and civil society organisations in responding to these challenges.[2] Harm reduction services have now had time to shift and institutionalise adaptations to service provision (such as mobile and online outreach programmes, telehealth services, take-home treatment options and 24 hour needle and syringe dispensaries). Yet more work is required to ease the unintended consequences of the COVID-19 pandemic on social and healthcare service provision for people who use drugs, particularly in low-income countries.

Despite improvements in harm reduction services in some regions, the challenges that the COVID-19 pandemic has brought still exist in many countries. Lack of information, and the spread of misinformation, has undermined confidence in the safety of COVID-19 vaccines, and vaccine hesitancy has contributed to low uptake of the COVID-19 vaccine among people who use drugs.[3–5] Other challenges include stigma, structural barriers to health and global inequity in vaccine availability.[1,6] When it comes to vaccine equity, there is an overall disparity between regions. Data from the United Nations Development Programme (UNDP) indicates that approximately 72% of people in high-income countries (or 3 in 4) have been vaccinated with at least one dose, but in low-income countries only 24% of people (or 1 in 4) have been vaccinated (as of September 2022).[7] Around the world, the COVID-19 pandemic's impact on new patterns of drug use is now recognised. For example, the risk of overdose has increased due to social isolation and physical distancing,[6,8,9] and women who use drugs have been disproportionately affected by the pandemic's negative consequences.[6,10–13] But there have also been positive effects, such as the emergence of innovative adaptations in harm reduction service provision.[3]

Despite the wave of disruptions to essential community care caused by the COVID-19 pandemic, many service providers, especially peer-led services, demonstrated resilient leadership by responding quickly and adapting service delivery. Innovative service options were provided to clients, such as online support and take-home doses of opioid agonist therapy (OAT) and naloxone. These actions ensured many people continued to access essential harm reduction interventions.

During a special session held in December 2021, the World Health Assembly (WHA) agreed upon the development of an international instrument on pandemic preparedness. The pandemic treaty, which is still under development, will set binding rules for the international community on preventing, responding to and recovering from future pandemics. However, community and civil society groups have had limited opportunities to meaningfully engage with policymakers at all levels of decision-making on the issue of better pandemic preparedness. Recognising the essential role that community and civil society played in the response to the COVID-19 pandemic, and the lessons learned from

this, a broad range of health-focused civil society (including communities and civil society from the harm reduction movement) are actively engaged in, and advocating for, the meaningful participation of community and civil society in the pandemic treaty drafting process.[14]

To build on gains made in harm reduction since 2020, countries must categorise harm reduction as an essential public health service during crises;[15] community-led organisations must be involved at the highest levels of decision-making, and governments must safeguard and improve funding for low-threshold harm reduction programmes. Research and development of guidelines on the effectiveness of take-home medications or other adaptations in OAT, needle and syringe programmes (NSPs) and naloxone delivery should be sustained and advanced. Integration of information on COVID-19, prevention and vaccine access into harm reduction programming and ongoing community guidance is critical to sustain progress in harm reduction provision.

In many countries, a lack of both transparency and resources hinders the collection and publication of accurate data on the state of COVID-19 vaccinations in prisons. Prison vaccination plans vary significantly; as of September 2021, only 20 countries had enabled 80% (or more) of people in prison to receive at least one dose of a COVID-19 vaccine.[16]

"To build on gains made in harm reduction since 2020, countries must categorise harm reduction as an essential public health service during crises"

ASIA

Overall, COVID-19 has led to major setbacks for harm reduction programmes in Asia, with NSP and OAT services incapable of meeting demand due to government restrictions, staff and equipment shortages, and inadequate funding for harm reduction.[17]

In Bangladesh, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Thailand and Vietnam, many drop-in centres offering NSPs have remained closed long after lockdown measures eased due to lack of funding.[17–19] In India, COVID-19-related containment measures caused supply chain disruptions in OAT provision, resulting in massive delays to meeting demand and restarting services.[17] Despite the suspension of face-to-face services, peer educators in Bangladesh, Myanmar and Nepal initiated secondary distribution of needles and syringes to people who were unable to access NSPs. In Myanmar, peer-led programmes ensured people were provided with sufficient take-home doses of OAT. In Nepal, the success of peer-led, take-home OAT has led to new guidelines being developed for future programming.[18–20]

Still, many people who use drugs do not have the same level of access to COVID-19 prevention, testing, treatment and care. Due to abstinence requirements in many countries, people experiencing homelessness who also use drugs cannot access housing unless they stop using drugs. In Macau, availability of public housing is critical for accessing COVID-19 services in state-led programmes as people need to provide an address for contact-tracing and treatment.[21] Where people who use drugs can access COVID-19 services, uptake is often low due to stigma and fear of incarceration. Recent reports suggest vaccinations are available in some prisons in Sri Lanka and Nepal,[19,22] but are not available in most prisons across the region.

EASTERN AND SOUTHERN AFRICA

The pandemic has had far-reaching consequences for harm reduction service availability in the region. In South Africa, limited coverage in NSP and OAT provision continued into 2021;[23,24] access to methadone was nearly impossible outside dispensaries and treatment centres, meaning most people were unable to get their medication.[23] During Mauritius' lockdown, in certain regions civil society advocacy led to the ban being lifted on NSPs and the secondary distribution of syringes by peers.[25] The COVID-19 pandemic has had a debilitating impact on HIV and harm reduction services for women who use drugs in Kenya, as limited operating hours, fewer outreach programmes and economic challenges resulted in poorer access to services and increased risk-taking, including engaging in sex work. Other clients have been displaced into rural areas where services are unavailable.[11,13]

Nevertheless, in Eastern and Southern Africa, the realities of the COVID-19 pandemic catalysed service adaptations and advanced the debate around take-home OAT doses. Indeed, the provision of take-home OAT increased substantially in the region between 2020 and 2022.[13,23–25] Advocacy from community and civil society groups led to the NSP programme in eThekwini (Durban), South Africa being reinstated after 18 months of COVID-19-related suspension.[24]

There are also examples of effective, low-threshold service adaptations implemented during the COVID-19 pandemic being continued after the acute phase of the crisis had passed.[3] This includes services at the Bellhaven Harm Reduction Centre, a low-threshold community space in Durban, South Africa which provide a range of evidence-based HIV, harm reduction and health-related services, including an NSP and OAT. In 2020, Bellhaven served up to 175 people per day.

In Kenya, the Kenyan Network of People Who Use Drugs' (KenPUD) peer-to-peer model, which focuses on supporting groups of women who use drugs, has integrated COVID-19-related information and support into broader programming. KenPUD offers evidence-based information about COVID-19 vaccines, with tailored messages in Kiswahili and English, at the beginning and end of peer support meetings.

EURASIA

The impact of the COVID-19 pandemic on harm reduction services in the region was dwarfed by Russia's invasion of Ukraine in February 2022, which caused unthinkable death and damage and has displaced at least 14 million people.[26] Despite the best efforts of community and civil society, many people lack access to health services (e.g. support, NSPs and HIV prevention). Antiretroviral therapy (ART) and OAT provision is less available for displaced people and people who have sought refuge in neighbouring countries (with the exception of Poland and Romania where these medicines are available, but there are concerns about continuity due to limited funding), although the majority of the 17,000 people receiving OAT in Ukraine before the invasion were men,[27] and men are not allowed to leave the country.[28] Many HIV and harm reduction services have been re-established in Lviv, in Western Ukraine (see Spotlight: Ukraine, page 80).[29–31]

As in other regions, the COVID-19 pandemic has caused both positive and negative changes in Eurasia. Among positive developments, the digitisation of harm reduction information and services has expanded the pool of clients and made services more accessible.[34] In Czechia, more harm reduction programmes have been introduced, including stimulant pharmacotherapy[a] for people who use methylphenidate.[32] In Slovakia, civil society organisations were able to forge better ties with government during the COVID-19 pandemic to

a This refers to people who use stimulants being prescribed a stimulant by a medical professional with the aim of reducing harmful health and social effects of their stimulant use.

emphasise the need for harm reduction services, for example, cooperation improved between the city of Bratislava government and service providers. In addition, take-home OAT has been introduced in Slovakia, meaning people receiving methadone now only need to attend a clinic twice a week.[33]

COVID-19 vaccination, prevention and treatment is available in many countries in the region, but the majority of countries have rules that easily exclude people who use drugs.[32,33] In Slovakia, Odyseus, a community harm reduction service provider, runs a vaccination programme specifically for people who use drugs,[33] but these examples are rare.

LATIN AMERICA AND THE CARIBBEAN

Latin America and the Caribbean has experienced some of the biggest impacts of the COVID-19 pandemic. Increasing social inequity has limited access to NSP and OAT services and treatment for vulnerable groups, such as people who use drugs and LGBTQI+ people.[35] The COVID-19 pandemic has compounded the challenges presented by donor withdrawal over recent years; availability and coverage of programmes continue to decline, with harm reduction service providers and community groups unable to adequately fund their operations. Domestic funding for harm reduction is equally strained; in Argentina, Brazil, Bolivia, Colombia, Mexico and Peru there are reports that the COVID-19 response has been prioritised, leading to budget cuts to other health services.[36,37]

People who have been in prison face an increased risk of contracting COVID-19, as detention facilities are often overcrowded. Although governments in the region introduced measures to decongest prisons to reduce overcrowding - Brazil, Costa Rica, El Salvador and Panama continue to have the highest rates of incarceration negatively affecting prison health and causing exposure to COVID-19 virus, including for people who use drugs.[36,38,39]

MIDDLE EAST AND NORTH AFRICA

The COVID-19 pandemic continues to negatively affect the lives of people who use drugs and people living with HIV, hepatitis C and tuberculosis in the Middle East and North Africa region.[1] Stay-at-home orders and restrictions on mobility often prevented OAT and NSP services from being delivered throughout the region.[40–42] In Lebanon and Morocco, people experienced great difficulty accessing OAT dispensaries as they needed to obtain special permits to leave their homes.[41–43] In Morocco, service providers struggled to adequately support clients who remained in active programmes due to inadequate funding and staff shortages.[43]

It is unclear whether the COVID-19 vaccine is available (on a voluntary basis) in prisons across the region, although it is available in Pakistan, Algeria and Morocco according to civil society reports.[43–45] Compulsory COVID-19 testing for people in prison is practiced in Algeria and Pakistan,[44,45] while in Morocco, people's age and health condition, and the availability of vaccines, determine eligibility for COVID-19 testing, treatment and care.[43] In Egypt, vaccination is a requirement for accessing harm reduction services in prison.[40] Barriers to accessing COVID-19 services, such as stigma, discrimination, threat of incarceration and forced treatment, still exist for people who use drugs.

NORTH AMERICA

Overdoses in North America increased drastically during the COVID-19 pandemic, from a level that was already unprecedentedly high. The upsurge in overdose deaths has focused public attention on the need to expand drug checking services to mitigate the impact of a toxic drug supply.[46–50]

In many ways, the challenges posed by the COVID-19 pandemic remain significant for harm reduction services in North America. The availability of short-term, restricted funding[46,51–56] for the COVID-19 response[57–60] has accelerated the implementation of harm reduction programmes (e.g. drug consumption

rooms, new federal funding in the United States, and increased safer supply in Canada through prescribing regimes), although major disparities in progress have been recorded across the United States (see North America chapter, page 110)

Public health guidance issued by the United States during the COVID-19 pandemic led to some NSP and OAT services closing, either temporarily while restrictions were in place or permanently.[53,54,61–64] Innovation and expansion of telehealth, mail order and mobile services[51,65–67] resulted in increased participation in some services[47] and a decrease in others.[61,68,69] This increased isolation for some people, who lost touch with their services and were unsure of whether and where services were operational.[62,70]

The situation in Canada is similar, with lockdown restrictions leading to forced closures of facilities or reduced opening hours.[48,71–74] The requirement to be vaccinated against COVID-19 reduced access for some, given significant vaccine hesitancy among people who use drugs.[75,76] The loss of social bonds and service providers' connection with clients[49,71] increased syringe sharing.[77] Some provincial services rose to the challenge, despite these difficulties. For example, in Manitoba, NSPs were recognised as an essential service and have remained open throughout the COVID-19 pandemic[78] and community-led organisations greatly increased their outreach services.[72,73] In both Canada and the United States, there have been changes in the adoption of drug consumption rooms (DCRs) (also referred to as overdose prevention centres or supervised injection sites).[b] DCRs were not universally categorised as essential health services in Canada,[74] leading to closures and reduced operations in many areas.[74,79]

Supply chain issues caused naloxone shortages, which led to higher prices.[47,67,80,81] But an increase in the use of mail order improved access to naloxone, particularly for people in rural areas of the United States.[54,68] In Canada, greater integration of naloxone with other services (such as homeless shelters) improved access.[74]

Preliminary evidence suggests people in prison have access to voluntary COVID-19 vaccinations in both Canada and the United States. Nonetheless, it is unclear if vaccination is a requirement for accessing harm reduction services. In both countries, drug checking and safer smoking services were significantly impacted by supply chain issues during the COVID-19 pandemic (e.g. there was a shortage of safer smoking equipment, such as crack pipes and drug checking equipment), which negatively affected service availability and coverage.[46,60,65,74,79]

OCEANIA

In Aotearoa-New Zealand and Australia, compared to the general population, there has been a marginal improvement in the availability and accessibility of COVID-19 prevention, testing, treatment and vaccination for people who use drugs.[82–86] The New Zealand Needle Exchange Programme (NZNEP) recently received funding for community access to COVID-19 testing for people who inject drugs, for example.[83]

There have been considerable gains in NSP and OAT delivery in Aotearoa-New Zealand and Australia, notwithstanding COVID-19-related difficulties in access and distribution (including stretched services, COVID-19-related staff shortages, and the closure of some sites and limited operating hours in others).[82,85–88] In both countries, NSPs and OAT were classified as essential services and remained open, albeit with variations across jurisdictions.[83,88]

Access to OAT was maintained through an increase in take-home doses, including long-acting injectable options (such as depot buprenorphine). In Australia,

b The increase in opioid overdoses during the COVID-19 pandemic may have facilitated the opening of two centres in New York City. [65,66] In Canada, some jurisdictions allowed for more flexible models which more adequately met client needs (e.g. on-site safer consumption provision in isolation shelters), which were not available before COVID-19.[74]

increased access to depot buprenorphine in prisons enabled more people to receive treatment. A study conducted in Sydney, Australia found that 24-69% of people on OAT had access to take-home doses and telehealth services.[86–89] Aotearoa-New Zealand adopted less draconian monitoring and increased flexibility in OAT service delivery by dispensing extra take-home options. Civil society sources report that this did not result in an increase in overdoses.[85]

In Australia, at the start of the COVID-19 pandemic, the New South Wales Users and AIDS Association (NUAA) moved to online service delivery of NSP, putting in place protocols and training to ensure the programme would remain open. It incorporated COVID-19 prevention measures (including physical distancing, wearing masks and hand-washing), and throughout the lockdowns worked to prevent both overdoses and COVID-19. For three months, under state-wide lockdown conditions, NUAA provided needle and syringe supplies in specific areas of Sydney where need was greatest as well as in public housing blocks with COVID-19 outbreaks and homeless shelters. Drawing on its longstanding relationships with government health clinics, NUAA was able to offer COVID-19 vaccines at its services, one of only a few examples of fully integrated COVID-19 vaccines and harm reduction services.[3] Prison health for people who use drugs is accessible in the region, based on certain criteria (such as age, pre-existing conditions, mental health, ethnicity and drug use).[82] A prison COVID-19 protection framework (a traffic light system) was introduced in Aotearoa-New Zealand in March 2020 to prioritise which populations received the vaccine.[83] Vaccination against COVID-19 is a requirement to access harm reduction services in Timor Leste.[90]

WEST AND CENTRAL AFRICA

In West and Central Africa, lockdown measures affected harm reduction programmes with service providers experiencing severe shortages of vaccines, equipment and staff, and difficulties reaching clients.[91–93]

Poor access to COVID-19 vaccines in Africa has limited their availability in prisons.[11,24,91,94–96] In Liberia, where vaccines are available in prison, vaccination is a requirement to access harm reduction services.[92] Barriers to COVID-19 prevention, testing and treatment continue to exist, especially for people who do not have access to harm reduction services.[23,93,97]

Lockdown measures negatively affected the supply of syringes to service providers in Cote d'Ivoire,[91] Liberia[92] and Sierra Leonne. However, in Sierra Leone, peer networks where able to deliver needles and syringes through secondary distribution channels.[93]

WESTERN EUROPE

To contain the negative consequences of the COVID-19 pandemic on the gains made in drug policy and harm reduction service delivery in Western Europe, conscious efforts were made to adapt services and foster information sharing and knowledge exchange among experts and service providers.[1]

Limited operational capacities and mobility restrictions due to lockdowns created significant barriers to accessing harm reduction services across the region. In Austria, the United Kingdom and Switzerland, low threshold facilities experienced staff shortages and had to limit the distribution of sterile needles and syringes, with many sites operating on an appointment-only basis.[98–101] Supply shortages (e.g. of syringes, citric acid and solvents) significantly reduced the availability of NSPs, while the temporary closure of drop-in centres reduced daily staff contacts with clients in Italy, Germany and Portugal.[102–104] In many cases, harm reduction services were not prioritised, which meant communities of people who use drugs were neglected. In turn, this increased the risks associated with minimal access to treatment, such as social isolation and overdose.[105] In Portugal, for example, harm reduction health workers were assigned to other services as a matter of urgency.[104]

In Belgium, the 12-month closure of the DCR in Liege (between September 2020 – August 2021) denied people access to an essential service. The DCR in Brussels opened in May 2021.[106] The shutdown of fixed-site services and limited capacity of mobile DCRs, including in Portugal and Switzerland, meant that people who use drugs faced major barriers to health and treatment during the COVID-19 pandemic.[101,104]

Like in some other regions, delivery of naloxone, safer smoking and drug checking were significantly hampered due to insufficient peer-to-peer distribution channels and outreach services, the unavailability of nasal naloxone and the increased cost of materials (such as pipes). This resulted in overdoses increasing in Italy, Germany and the United Kingdom (Scotland).[99,102,107,108] In addition, drug checking was limited in Italy, Spain and Austria (linked to restrictions on the parties and nightclubs where drug checking services usually operate).[102,105,109]

Notwithstanding the challenges of the past three years, harm reduction practitioners report adaptations of services and some positive developments since 2020. For example, in Bath, United Kingdom, peer-to-peer provision of NSP and home deliveries of naloxone have been successfully piloted.[100,107] Due to the increase in smoking as a mode of consumption, NSPs increased provision of inhalation and smoking equipment in Wallonia, Belgium. In Brussels, sample analysis for monitoring purposes is back to normal levels, following a 39% drop during lockdown.[106] Extended opening hours and closer collaboration with social services have increased clients' access to DCRs in Germany,[108] while innovations in NSP and OAT delivery have increased service uptake across the region.

Peer networks have been critical in implementing adaptations.[99,100,102,107,108] Underscoring the resourcefulness of service providers and peer networks, the adoption of low-threshold services, take-home dispensing, the use of telemedicine, peer-to-peer relationships (secondary syringe distribution), and rural mail order all improved service access for people who use drugs (despite the challenges of unevenly distributed services and the lack of appropriate coverage in the region's rural and remote areas). Other innovative solutions include the utilisation of needle and syringe vending machines in shelters for after-hours provision (in Scotland), click-and-collect options, and other mobile outreach services.

"Peer networks have been critical in implementing adaptations. Underscoring the resourcefulness of service providers and peer networks, the adoption of low-threshold services, take-home dispensing, the use of telemedicine, peer-to-peer relationships (secondary syringe distribution), and rural mail order all improved service access for people who use drugs."

1. Harm Reduction International (2020), The *Global State of Harm Reduction 2020.* Available from www.hri.global/global-state-of-harm-reduction-2020.
2. Harm Reduction International (2021), 'Global State of Harm Reduction - 2021 Update' [internet, cited 9 September, 2022 Sep 9. Available from www.hri.global/global-state-of-harm-reduction-2021.
3. UNODC and HRI (2022), *Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance* [pending publication].
4. Strathdee SA, Abramovitz D, Harvey-Vera A, Vera CF, Rangel G, Artamonova I, et al. (2022), 'Correlates of Coronavirus Disease 2019 (COVID-19) Vaccine Hesitancy Among People Who Inject Drugs in the San Diego-Tijuana Border Region', *Clin Infect Dis Off Publ Infect Dis Soc Am,* 75(1): 726–33.
5. Dietze PM, Hall C, Price O, Stewart AC, Crawford S, Peacock A, et al. (2022), 'COVID-19 vaccine acceptability among people in Australia who inject drugs: Implications for vaccine rollout', *Drug Alcohol Rev,* 41(2):484–7.
6. UNODC (2022), *UNODC World Drug Report 2022: Booklet 2.* Available from www.unodc.org/unodc/en/data-and-analysis/wdr-2022_booklet-2.html.
7. UNDP Data Futures Platform, 'Vaccine Access' [internet, cited 15 September, 2022]. Available from https://data.undp.org/vaccine-equity/accessibility/.
8. Mwangi C (2022), 'Impact of harm reduction services on women who use drugs and indigenous people' [interview response, Kenya].
9. Nguyen T, Buxton JA (2021), 'Pathways between COVID-19 public health responses and increasing overdose risks: A rapid review and conceptual framework', *Int J Drug Policy,* 93:103236.
10. Thomas R (2022), 'Impact of harm reduction services on women who use drugs and indigenous people' [interview response,Canada].
11. Apondi B (2022), 'Global State of Harm Reduction 2022 survey response, Kenya'.
12. Doorly-Jones S (2022), 'Impact of harm reduction services on women who use drugs and indigenous people' [interview response, South Africa].
13. Mwangi C (2022), 'Global State of Harm Reduction 2022 survey response, Kenya'.
14. Harm Reduction International (2022), 'Call for Proposals: Promoting civil society and community participation in the Pandemic Treaty process' [internet,14 September, 2022]. Available from www.hri.global/contents/2225.
15. Csák R, Shirley-Beavan S, McHenry AE, Daniels C, Burke-Shyne N (2021), 'Harm reduction must be recognised an essential public health intervention during crises', *Harm Reduct J*, 18(1):128.
16. Harm Reduction International (2021), *COVID-19 vaccinations for prison populations and staff: Report on global scan.* Available from www.hri.global/contents/2171.
17. Joseph F (2022), 'Global State of Harm Reduction 2022 survey response:Afghanistan, Bangladesh, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Philiphinnes, Thailand, Vietnam'.
18. Han ZM (2022), 'Global State of Harm Reduction 2022 survey response,Myanmar'.
19. Sharma BF (2022), 'Global State of Harm Reduction 2022 survey response, India'.
20. Khan S (2022), 'Global State of Harm Reduction 2022 survey response,Bangladesh'.
21. Nogueira A (2022), 'Global State of Harm Reduction 2022 survey response, Macau'.
22. Billimoria H (2022), 'Global State of Harm Reduction 2022 survey response, Sri Lanka'.
23. McBride A (2022), 'Global State of Harm Reduction 2022 survey response, South Africa'.
24. Shelly S (2022), 'Global State of Harm Reduction 2022 survey response,South Africa'.
25. Naik K (2022), 'Global State of Harm Reduction 2022 survey response,Mauritius'.
26. UNHCR Operational Data Portal, 'Situation Ukraine Refugee Situation [internet, cited 10 September, 2022]. Available from https://data.unhcr.org/en/situations/ukraine.
27. European Monitoring Centre for Drugs and Drug Addiction (2022), *Responsiveness and preparedness in addressing drug-related needs of displaced Ukrainians in EU countries bordering with Ukraine.* Available from https://data.europa.eu/doi/10.2810/847636.
28. Human Rights Watch (1 September, 2022), "'We Had No Choice": "Filtration" and the Crime of Forcibly Transferring Ukrainian Civilians to Russia' [internet cited 21 September, 2022]. Available from www.hrw.org/report/2022/09/01/we-had-no-choice/filtration-and-crime-forcibly-transferring-ukrainian-civilians.
29. Aidsmap (26 August, 2022), 'Community organisations have formed the backbone of the HIV response in Ukraine' [internet cited 21 September, 2022]. Available from https://www.aidsmap.com/news/aug-2022/community-organisations-have-formed-backbone-hiv-response-ukraine.
30. Foreign Policy Magazine, Kellman S (31 August, 2022), 'War-Torn Ukraine Is Also an HIV and Tuberculosis Hot Spot' [internet, cited 21 September, 2022]. Available from https://foreignpolicy.com/2022/08/31/ukraine-russia-war-hiv-tuberculosis-epidemic-medication-health-care/.
31. Al Jazeera, Nolan D (1 July, 2022) 'The volunteers risking their lives to help drug users in Ukraine' [internet, cited 21 September, 2022]. Available from www.aljazeera.com/features/2022/6/1/the-volunteers-risking-their-lives-to-help-drug-users-in-ukraine.
32. Pesek D (2022), 'Global State of Harm Reduction 2022 survey response,Czechia'.
33. Jasekova D (2022), 'Global State of Harm Reduction 2022 survey response,Slovakia'.
34. EHRA (2020), *Harm reduction programmes during the COVID-19 crisis in Central and Eastern Europe and Central Asia.* Available from https://harmreductioneurasia.org/wp-content/uploads/2020/05/regional-review_-FINAL_ENG.pdf.
35. ECLAC (2022), *The sociodemographic impacts of the COVID-19 pandemic in Latin America and the Caribbean.* Available from https://repositorio.cepal.org/bitstream/handle/11362/47923/1/S2200158_en.pdf.
36. Quintero J (Colombia), Ramos ME (Mexico) (2022), 'Global State of Harm Reduction 2022 survey response'.
37. CND Blog (18 March, 2022), 'Side Event: Drug Policy in Latin America: Challenges for People Who Use Drugs' [internet,cited 15 September, 2022]. Available from https://cndblog.org/2022/03/side-event-drug-policy-in-latin-america-challenges-for-people-who-use-drugs/.
38. Vila M (Argentina), Achá G (Bolivia), da Silva Petuco DR (Brazil), Comis A (Brazil), Cortes E (Costa Rica), Perdomo M (Honduras), Deheza R (Uruguay), Cantizano N (El Salvador);,Gutiérrez Guzmán, AV (Colombia), Ramos ME (Mexico), Paz E (Ecuador), Quintero, J (2022) 'Global State of Harm Reduction 2022 survey response'.
39. Harm Reduction International, 'COVID-19, Prisons and Drug Policy: Global scan March-June 2020' [internet, cited 21 September, 2022]. Available from www.hri.global/covid-19-prison-diversion-measures.
40. Tariq M (2022), 'Global State of Harm Reduction 2022 survey response,Egypt'.
41. Sleiman T (2022), 'Global State of Harm Reduction 2022 survey response, Lebanon'.
42. Wazan M (2022), 'Global State of Harm Reduction 2022 survey response, Lebanon'.
43. Bentaouite M (2022), 'Global State of Harm Reduction 2022 survey response, Morocco'.
44. Rehman H (2022), 'Global State of Harm Reduction 2022 survey response, Pakistan'.
45. Sidmohand S (2022), 'Global State of Harm Reduction 2022 survey response, Algeria'.
46. Campbell MB (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
47. Dasgupta N (2022), ' Global State of Harm Reduction 2022 survey response, United States'.
48. Westfall J (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
49. Mercredi J (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
50. Park JN (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
51. Murray S (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
52. Brothers T (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
53. Bolt M (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
54. Russell D (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
55. Purchase S (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
56. Spencer S (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
57. Volyes N (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
58. Phillips C (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
59. Zabielski B (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
60. Murphy C (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
61. Jones L (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
62. Seigel Z (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
63. Eskildsen N (2022), 'Global State of Harm Reduction 2022 survey

response, United States'.
64. Fields H (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
65. Vakharia S (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
66. Santamour T (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
67. Meaders S (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
68. McCormick T (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
69. Kign C (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
70. Steffin M (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
71. Bonn M (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
72. Illsley S (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
73. Agioritis M (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
74. Speed K (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
75. Trimble C (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
76. Shariff SZ, Richard L, Hwang SW, Kwong JC, Forchuk C, Dosani N, et al. (2022), 'COVID-19 vaccine coverage and factors associated with vaccine uptake among 23 247 adults with a recent history of homelessness in Ontario, Canada: a population-based cohort study', *Lancet Public Health*,7(4):366–77.
77. Fletcher I (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
78. Bailey K (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
79. Vanderschaeghe SJ (2022), 'Global State of Harm Reduction 2022 survey response, Canada'.
80. Pardo B (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
81. Troy T (2022), 'Global State of Harm Reduction 2022 survey response, United States'.
82. Koning A (2022), 'Global State of Harm Reduction 2022 survey response, Aotearoa'.
83. Noller G (2022), 'Global State of Harm Reduction 2022 survey response, Aotearoa'.
84. Lay C (2022), 'Global State of Harm Reduction 2022 survey response, Australia'.
85. George J (2022), 'Global State of Harm Reduction 2022 survey response, Aotearoa'.
86. Dietze P (2022), 'Global State of Harm Reduction 2022 survey response, Australia'.
87. Ritter A (2022), 'Global State of Harm Reduction 2022 survey response, Australia'.
88. Madden A (2022), 'Global State of Harm Reduction 2022 survey response, Australia'.
89. Lintzeris N, Deacon RM, Hayes V, Cowan T, Mills L, Parvaresh L, et al. (2022), 'Opioid agonist treatment and patient outcomes during the COVID-19 pandemic in south east Sydney, Australia', *Drug Alcohol Rev,* 41(5):1009–19.
90. Beck M (2022), 'Global State of Harm Reduction 2022 survey response, Timor Leste'.
91. Lacina T (2022), 'Global State of Harm Reduction 2022 survey response, Cote d'Iviore'.
92. Grant EF (2022), 'Global State of Harm Reduction 2022 survey response, Liberia'.
93. Kamara HT (2022), 'Global State of Harm Reduction 2022 survey response, Sierra Leonne'.
94. Dioulasso B (2022), 'Global State of Harm Reduction 2022 survey response, Burkina Faso'.
95. Tall AM (2022), 'Global State of Harm Reduction 2022 survey response, Mali'.
96. Kanyinga GH (2022), 'Global State of Harm Reduction 2022 survey response, Namibia'.
97. Loglo MGA (2022), 'Global State of Harm Reduction 2022 survey response, Ghana'.
98. Sturm K (2022), 'Global State of Harm Reduction 2022 survey response, Austria'.
99. Horsburgh K (2022), 'Global State of Harm Reduction 2022 survey response, Scotland'.
100. Eastwood N (2022), 'Global State of Harm Reduction 2022 survey response, United Kingdom'.
101. Marthaler M (2022), 'Global State of Harm Reduction 2022 survey response, Switzerland'.
102. Ronconi S (2022), 'Global State of Harm Reduction 2022 survey response, Italy'.
103. Stover HJ (2022), 'Global State of Harm Reduction 2022 survey response, Germany'.
104. Curado A (2022), 'Global State of Harm Reduction 2022 survey response, Portugal'.
105. Aranda E (2022), 'Global State of Harm Reduction 2022 survey response, Spain'.
106. Van der Linden N (2022), 'Global State of Harm Reduction 2022 survey response, Belgium'.
107. Southwell M (2022), 'Global State of Harm Reduction 2022 survey response, United Kingdom'.
108. Schaffer D (2022), 'Global State of Harm Reduction 2022 survey response, Germany'.
109. Simonitsch M (2022), 'Global State of Harm Reduction 2022 survey response, Austria'.

VIRAL HEPATITIS

BY
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OVERVIEW

Hepatitis B and C are preventable and treatable, with services that can be delivered easily and cheaply within primary healthcare and at harm reduction sites. However, most countries are still not on track to meet the World Health Organization (WHO) target to eliminate hepatitis C and B as a public health threat by 2030. In many cases, the exclusion of people who use drugs from national programmes is a key factor in this failure. WHO's 2016-2021 targets for viral hepatitis have already been missed (with the exception of the target on hepatitis B prevalence in children under five years old, which was achieved), and more systematic efforts are needed to achieve global hepatitis targets.[1,2] Yet 80% of high-income countries are not on track to meet the WHO's 2030 targets, and 67% are projected to be off-track by at least 20 years.[3]

Access to hepatitis C diagnosis, treatment and care for people who use drugs is often hindered by accessibility and affordability. Other factors, such as a lack of safe injecting equipment, violence, human rights abuses, criminalisation, punitive and restrictive policies, gender, ethnicity, and race, also make certain groups most at risk of HIV vulnerable to viral hepatitis. Stigma and discrimination continue to stop people most at risk of hepatitis C from getting tested or seeking treatment. The stigma people who inject drugs experience in formal healthcare settings often makes people feel negatively about seeking healthcare in the future.[4,5]

Almost 4 in 10 people who inject drugs have active hepatitis C and 1 in 12 have active hepatitis B, according to a global systematic evidence review.[6] Transmission of blood-borne viruses, including HIV and hepatitis C and B, which can happen when people share unsterile injecting equipment, are a leading contributor to illness and death among people who inject drugs. Eastern Europe and Latin America are the regions with the highest current hepatitis C prevalence among people who inject drugs.[6]

Almost 4 in 10 people who inject drugs have active hepatitis C

1 in 12 people who inject drugs have active hepatitis B

HEPATITIS C SERVICES: ISSUES AND CHALLENGES

Although updated international guidance calls for decentralised, integrated services for hepatitis C diagnosis, treatment and care, this is still not the norm in most countries.[7]

EURASIA

In Eastern Europe and Central Asia, nearly half (49.1%) of people who inject drugs are living with hepatitis C.[6] The main barriers to accessing hepatitis diagnosis and treatment in the region include poor coverage of harm reduction services, poor access to cost-effective harm reduction services, low hepatitis C testing, linkage to care and treatment, restrictions for accessing direct-acting antivirals (DAAs), and a lack of national strategies and government investment to support WHO elimination goals.[8,9] Many of these barriers are common in regions across the world.

EASTERN AND SOUTHERN AFRICA AND WEST AND CENTRAL AFRICA

In Eastern and Southern Africa and West and Central Africa, barriers to accessing hepatitis C diagnosis and treatment remain an issue, as the costs of both services are mainly borne by the person living with hepatitis. The only country in both regions to fund testing and treatment is Rwanda, where treatment costs are covered by private sector fundraising. Treatment is still not readily available in Malawi.[10] Reliable data on hepatitis C among people who inject drugs remains scarce in both regions.

In Kenya, an estimated 16% of people who inject drugs have been diagnosed with hepatitis C, however only 20% of people diagnosed receive treatment, indicating issues with linking people to treatment and care.[11] Access to DAAs has also been a challenge in Kenya due to pharmaceutical costs.[12] Resources for hepatitis C prevention are low and this is reflected by a lack of evidence on current knowledge and perceptions of hepatitis C among people who inject drugs. Increasing hepatitis C care and access to prevention resources is likely to provide opportunities to improve uptake of services. A recent study suggests that hepatitis C prevalence among the sexual and injecting partners of people who inject drugs is more than 12 times higher than among Kenya's general population where hepatitis C prevalence is less than 1%. More efforts are needed to ensure sexual and injecting partners are included in outreach for people who inject drugs.[13]

NORTH AMERICA

In Canada, hepatitis C prevalence is high among people who inject drugs in some areas, however, there are important service gaps relating to linkage to treatment and care. A national survey found that continued access to hepatitis C testing and prevention services, targeted strategies to address barriers to accessing HIV and hepatitis C treatment and care, and improvements in ongoing support for housing and mental health are needed.[14]

OCEANIA

In Aotearoa New Zealand, the stigmatising attitudes of some health professionals means people who use drugs are more likely to access hepatitis C treatment via the New Zealand Needle Exchange Program (NZNEP). Funded by the Ministry of Health, NZNEP is peer-led and peer-based, and it is committed to providing a health and human rights-based service for people who use drugs. Aotearoa New Zealand has a national hepatitis C action plan, which includes people who inject drugs as a priority population. However, it is unlikely that the country will meet the WHO targets for elimination by 2030. Sterile injecting equipment, hepatitis C testing and treatment and harm reduction information is generally available. Māori people are disproportionately affected by hepatitis C. In 2019, 26% of hepatitis C infections among people with hepatocellular carcinoma (liver cancer) were Māori, despite Māori people only making up 14% of the country's population.[15] Future national planning in New Zealand must place a greater emphasis on initiatives to improve awareness, testing and treatment of hepatitis

C among Māori people, and improve access to services for this population group; a lesson for other countries where Indigenous people who inject drugs are at disproportionately higher risk of hepatitis C.[16]

Australian Aboriginal and Torres Strait Islander people are also disproportionately affected by hepatitis C. At the end of 2020, 18% of Australian Aboriginal and Torres Strait Islander people were living with active hepatitis C, despite making up just 3% of the Australian population.[17] Injection drug use with unsterile injecting equipment is the primary route of transmission of hepatitis C. Data also suggests that, between 2014 and 2020, the proportion of syringe sharing was consistently higher among Aboriginal and Torres Strait Islander people than among non-Indigenous people.[17] Aboriginal and Torres Strait Islander people experience racism and discrimination in all aspects of daily life as well as within the healthcare sector. Between 2019-2021, 54% of Aboriginal and Torres Strait Islander people attending drug treatment clinics or needle and syringe programmes (NSPs) reported experiences of stigma and discrimination in relation to their drug use, and 63% reported stigma and discrimination in relation to their hepatitis C diagnosis.[17] As a result, a key recommendation is for Aboriginal-controlled health services to expand and include harm reduction services, such as NSPs.

EURASIA AND WESTERN EUROPE

In some European countries, people who use drugs must be enrolled in an opioid agonist therapy (OAT) programme or an abstinence-oriented programme to receive hepatitis C treatment. In Romania, for example, people living with both HIV and hepatitis C, must have a negative drug test result before starting DAA treatment. If someone is not enrolled in one of these programmes, additional steps and approvals from public authorities are required before being able to access treatment.[18] In Croatia, Bulgaria, Hungary, Poland, Romania and Slovakia, national treatment guidelines penalise people who are actively using drugs and deny them access to hepatitis C treatment. Cost is another major barrier, if borne by the client. In some countries, such as Belgium, Poland and Romania, DAA is only reimbursable if someone has social security or health insurance. This works for citizens, but not for non-citizens. In Slovakia, hepatitis C treatment is only paid for if people can prove they have not used drugs for a year, with corroborating toxicology results every three months.[18]

"People who inject drugs are often excluded from treatment due to restrictive guidelines, have poor access to health services or experience stigma when disclosing their status as a person who uses drugs, all of which stop people from using hepatitis care"

Another barrier comes from medical staff and doctors who are reluctant to provide hepatitis C treatment to people who use drugs due to unfounded adherence and reinfection concerns. Evidence shows that this perception is false. In a recent study, despite study participants using both alcohol and drugs, the median adherence for hepatitis C drugs ledipasvir/sofosbuvir was 96%.[19]

An assessment of hepatitis C services in 35 European countries suggests that regional and national hepatitis care varies substantially and is often below WHO targets, with fewer than 1% of people who inject drugs living in countries with high provision of hepatitis C services.[20] Even in places where such services exist, people who inject drugs face many difficulties in accessing hepatitis care. People who inject drugs are often excluded from treatment due to restrictive guidelines, have poor access to health services or experience stigma when disclosing their status as a person who uses drugs, all of which stop people from using hepatitis care.

The COVID-19 pandemic has had an impact on all stages of the hepatitis C care cascade and has reduced access to essential medical services among people most affected by HIV, including people who use drugs. Populations that are marginalised have also struggled to maintain access to harm reduction and drug treatment services.[21]

PROGRESS IN SCALING UP HEPATITIS C TESTING AND TREATMENT FOR PEOPLE WHO USE DRUGS

Some countries have made progress in synergizing national responses to harm reduction and hepatitis C programming for people who inject drugs. One thing many of the more successful programmes have in common is that they are decentralised, community-based and/or community-led. Those programmes that have expanded hepatitis C testing and treatment services at the same site within primary healthcare and harm reduction facilities have achieved great success in reaching and treating people.

ASIA

In India, a community driven test-and-treat pilot (CONE Manipur) has the potential to improve hepatitis C services for people who inject drugs.[22] This community-led, comprehensive, simplified hepatitis care model, which aims to expand access to care for chronic hepatitis, includes same-day hepatitis C testing and treatment initiation at drug rehabilitation centres in Manipur.[23] An assessment of the pilot found 95% of eligible clients were screened for hepatitis B and C, 40% of whom tested positive for hepatitis C antibodies. All of those testing positive for hepatitis C antibodies received a hepatitis C RNA viral load test[24]; 61.5% tested positive for hepatitis C (RNA), of whom 96% had viremia and began standard treatment (sofosbuvir and daclastasvir) that day. The median time from screening to hepatitis C treatment initiation was around eight hours.[24] To address low hepatitis C treatment uptake, this successful model should be replicated and scaled up through India's National Viral Hepatitis Control Programme.

In Thailand, C-FREE is another community-based testing and treatment programme for HIV and hepatitis that has achieved high hepatitis C cure rates. C-FREE was implemented in six drop-in centres for people who use drugs and their partners; harm reduction services were provided alongside testing for HIV, hepatitis B and hepatitis C every three months. This model of care is designed to eliminate the barriers to treatment people who use drugs and their partners commonly face by providing services in settings where people feel comfortable. Of the clients who met the programme's hepatitis C treatment eligibility criteria, 87.9% started sofosbuvir/velpatasvir and 73.3% completed treatment. Of these, 61.6% reached a sustained virological response. This shows that community-based hepatitis treatment for people who use drugs is safe and highly effective. National programmes should urgently integrate community-based HIV and hepatitis B and C test-and-treat services as the standard of care for people who use drugs to decrease deaths and prevent onward transmission of these infections.[25]

Vietnam has increasingly integrated hepatitis B and C care for people who inject drugs, gay men and other men who have sex with men and other groups most affected by HIV within the framework of harm reduction, PrEP and other programmes for at-risk populations. Vietnam successfully reached its target when it initiated 16,000 people with hepatitis C on treatment. The HIV/hepatitis C coinfection programme's technical working group advocated to Vietnam's national HIV programme and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to expand reach, moving from the initial target population of people living with HIV and hepatitis C to include people with hepatitis C who were receiving methadone and people in prisons. This enabled the programme to utilise all 16,000 Global Fund-supported DAA treatment courses and broaden access to hepatitis C care to include people who are at risk of HIV and hepatitis C.[26] Building on its success, the programme will continue to leverage the Global Fund grant to procure additional DAAs to treat another 5,000 people in 2022-2023. Treatment will be for people living with HIV and hepatitis C and people accessing methadone.[27]

In 2019, Malaysia decentralised hepatitis C care by enabling primary healthcare facilities to test and treat hepatitis C. Now the country is focusing on improving hepatitis C care for populations most affected by HIV and people in prison. To address co-infections, policies are now in place for the integration of hepatitis B and C screening, treatment

and care in HIV clinics.[28] In 2021, the Malaysian government announced it would conduct a study on the impact of using hepatitis C self-testing as part of its commitment to eliminate hepatitis C by 2030.[29]

"Community-based hepatitis treatment for people who use drugs is safe and highly effective. National programmes should urgently integrate community-based HIV and hepatitis B and C test-and-treat services as the standard of care for people who use drugs to decrease deaths and prevent onward transmission of these infections"

EURASIA

Georgia has improved health services for people who use drugs by taking an evidence-based approach to hepatitis C elimination. Since the beginning of the Georgia Hepatitis C Elimination Program in 2015, the proportion of people who use drugs living with chronic hepatitis C infection has fallen from 51.1% to 17.8%.[33] Under this programme, harm reduction services have been expanded considerably in both scope and scale. Service delivery locations have been increased, for example, by providing hepatitis C and B antibody screening at NSP sites and through mobile services.[33] These screening efforts have substantially increased the number of people who inject drugs in Georgia who are aware of their hepatitis C infection status, from 17,103 in 2016 to 27,967 in 2021. Hepatitis C treatment services have also been integrated into three NSP sites (in Tbilisi, Batumi, and Zugdidi) and one OAT site. At harm reduction integrated sites, 997 people who inject drugs were enrolled in hepatitis C treatment, including 173 people during 2021. These harm reduction services are maintained with support from the Global Fund and the Georgian government's HIV and Drug Addiction Prevention Programs. The share of state funding for NSP services increased from 14% to 30% between 2020 and 2021.[34] A hepatitis C self-testing programme is also being explored through a feasibility and acceptability study with people who inject drugs, gay men and other men who have sex with men in Tbilisi. Around 82% of people who inject drugs in the study were able to complete a self-test correctly.[33]

MIDDLE EAST AND NORTH AFRICA

In Egypt, the government has reintroduced and scaled up NSPs and introduced OAT within the framework of hepatitis C elimination. Its harm reduction programme for people who inject drugs now includes syringe distribution, plus hepatitis B and C rescreening and treatment for at-risk individuals who missed the national screening programme, including people who inject drugs and people in prison.[32] This national programme shows that community-based hepatitis C screening is possible.

WEST AND CENTRAL AFRICA

In Nigeria, the new *National Strategic Framework for Viral Hepatitis (2022-2026)* has expanded the definition for key populations to include people who inject drugs, people in correctional centres and people in closed settings – a positive shift in policy. It also includes targets and objectives for harm reduction coverage as well as hepatitis C testing and treatment for people who inject drugs. However, there is a need for integrated, targeted and context-specific interventions to address Nigeria's high prevalence of viral hepatitis.

WESTERN EUROPE

In Iceland, injecting drug use has been a key driver of hepatitis C transmission. In 2016, the country initiated a nationwide hepatitis C elimination programme called TraP HepC. By 2020, the country had already met the WHO goals of diagnosing 90% of infections and treating 80% of diagnosed infections by 2030. This was achieved by establishing new models of care for marginalised people, including good access to sterile needles and syringes, and prompt re-treatment without stigma for people who get reinfected.[30,31]

WAYS TO IMPROVE SERVICE DELIVERY

Poor access to services is a major issue in addressing hepatitis C and B among people who use drugs. Integrated, person-centred service delivery and prioritising key populations in every setting will improve accessibility. As seen in the examples of progress given above, the role of community-led and community-based services, as well as peer navigators to guide people through health services, is critical.

Interventions such as hepatitis C self-testing – whereby a person collects their own specimen (oral fluid or blood) then performs the test and interprets the result, often in a private setting, either alone or with someone they trust – can complement existing testing services. WHO guidelines now recommend easy access to hepatitis C self-testing, but there is little uptake from programmes. Hepatitis C self-testing is easy and can be done anywhere, which enables programmes to reach vulnerable and stigmatised populations such as people who use drugs, people who sell sex, LGBTQI+ people and men who have sex with men.

Another way to improve the quality of services is to improve data, including monitoring data relating to viral hepatitis among people who inject drugs. Accurate and reliable hepatitis prevalence data (disaggregated by gender), population-based studies, and estimates of the diagnosed and treated proportion of a population, are lacking. This undermines the development of strategies and allocation of budget to eliminate viral hepatitis, as seen in Eastern and Southern Africa. However, this should not be a reason for delaying viral hepatitis screening, detection and linkage to care.[35] Instead, the focus should be on increasing political will and securing sustainable funding to implement programmes.

POLICY DEVELOPMENTS

Since 2020, new global goals, strategies and commitments have provided a guiding framework for national strategic planning for viral hepatitis. The WHO's global health sector strategies, The Joint United Nations Programme on HIV/AIDS (UNAIDS)' Global AIDS Strategy 2021-2026, and the United Nations General Assembly's 2021 Political Declaration on HIV and AIDS, if implemented, will all contribute to the elimination of hepatitis.

In 2022, the WHO published Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections for the period 2022-2030 to guide the health sector to end these epidemics by 2030.[36] The new strategies call for countries to actively prioritise populations most affected by HIV in all settings. They also provide guidance on the frequency of hepatitis C testing for people at ongoing risk of infection and the provision of treatment, without delay, to people who have recently acquired hepatitis C and those at ongoing risk.

If the 2030 targets are achieved, the number of new annual HIV and viral hepatitis infections could drop from 4.5 million in 2020 to less than 500,000 in 2030, and the number of deaths could reduce from 2.3 million to less than 1 million over the same period. The number of new cases of cancer due to HIV, viral hepatitis and STIs could drop from 1.2 million to less than 700,000.[36]

1. WHO (2016), *Global health sector strategy on viral hepatitis* 2016-2021.
2. World Health Organization (2021), *Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. Accountability for the global health sector strategies 2016–2021: actions for impact.*
3. Razavi H, Sanchez Gonzalez Y, Pangerl A, Cornberg M (2019), *Global timing of hepatitis C virus elimination: estimating the year countries will achieve the World Health Organization elimination targets.*
4. Muncan B, Walters SM, Ezell J, Ompad DC (2020), '"They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City', *Harm Reduct J*, 17(1):53.
5. Biancarelli DL, Biello KB, Childs E, Drainoni M, Salhaney P, Edeza A, et al. (2019), 'Strategies used by people who inject drugs to avoid stigma in healthcare settings', *Drug Alcohol Depend*, 198:80–6.
6. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), 'A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm', *Lancet Glob Health.*
7. World Health Organization (2022), *Updated recommendations on HCV simplified service delivery and HCV diagnostics: policy brief.*
8. Mabileau G, Scutelniciuc O, Tsereteli M, Konorazov I, Yelizaryeva A, Popovici S, et al. (2018), 'Intervention Packages to Reduce the Impact of HIV and HCV Infections Among People Who Inject Drugs in Eastern Europe and Central Asia: A Modeling and Cost-effectiveness Study', *Open Forum Infect Dis,* 5(3). Available from https://academic.oup.com/ofid/article/5/3/ofy040/4868640.
9. Day E, Hellard M, Treloar C, Bruneau J, Martin NK, Øvrehus A, et al. (2019), 'Hepatitis C elimination among people who inject drugs: Challenges and recommendations for action within a health systems framework', *Liver Int Off J Int Assoc Study Liver*, 39(1):20–30.
10. Shah R, Agyei-Nkansah A, Alikah F, Asamoah-Akuoko L, Bagou YCO, Dhiblawe A, et al.(2021), Hepatitis C virus in sub-Saharan Africa: a long road to elimination. *Lancet Gastroenterol Hepatol*, 6(9):693–4.
11. Ministry of Health (Kenya) National AIDS and STI Control Programme (2018), *Third National Behavioural Assessment of Key Populations in Kenya: Polling Booth Survey Report.*
12. Ludwig-Barron NT, Guthrie BL, Mbogo L, Bukusi D, Sinkele W, Gitau E, et al. (2021), 'Barriers and facilitators of HIV and hepatitis C care among people who inject drugs in Nairobi, Kenya: a qualitative study with peer educators', *Harm Reduct J*, 18(1):133.
13. Sambai BC, Kingston H, Monroe-Wise A, Mbogo L, Juma E, Ludwig-Barron N, et al. (2022), 'Characteristics associated with HIV and hepatitis C seroprevalence among sexual and injecting partners of HIV positive persons who inject drugs in Nairobi and coastal Kenya', *BMC Infect Dis*, 22(1):73.
14. Tarasuk J, Zhang J, Lemyre A, Cholette F, Bryson M, Paquette D (2020),'National findings from the Tracks survey of people who inject drugs in Canada, Phase 4, 2017-2019', *Can Commun Dis Rep Releve Mal Transm Au Can*, 46(5):138–48.
15. Schauer C, van Rijnsoever M, Gane E (2019), 'Surveillance factors change outcomes in patients with hepatocellular carcinoma due to chronic hepatitis C virus infection in New Zealand', *J Viral Hepat*, 26(12):1372–6.
16. University of Auckland, Gane E (2019), *HepC Elimination in New Zealand: How are we tracking?*
17. Kirby Institute, UNSW Sydney (2021), *Progress towards hepatitis C elimination among Aboriginal and Torres Strait Islander people in Australia: monitoring and evaluation report, 2021.*
18. European Harm Reduction Network, Rigoni R, Tammi T, van der Gouwe D, Moura J, Prins-Schiffer K (2021), *Civil Society Monitoring of Harm Reduction in Europe, 2021. Data Report.*
19. Brooks KM, Castillo-Mancilla JR, Morrow M, MaWhinney S, Rowan SE, Wyles D, et al (2021), 'Adherence to Direct-Acting Antiviral Therapy in People Actively Using Drugs and Alcohol: The INCLUD Study', *Open Forum Infect Dis*,8(1):ofaa564.
20. Maticic M, Pirnat Z, Leicht A, Zimmermann R, Windelinck T, Jauffret-Roustide M, et al. (2020), 'The civil society monitoring of hepatitis C response related to the WHO 2030 elimination goals in 35 European countries', *Harm Reduct J*, 17(1):89.
21. Lanièce Delaunay C, Greenwald ZR, Minoyan N, Artenie AA, Jeong D, Marathe G, et al. (2021), 'Striving toward hepatitis C elimination in the era of COVID-19', *Can Liver J,* 4(1):4–7.
22. World Health Organization, HIV, Hepatitis and STIs Department, personal communication, 2022.
23. Shobha S, Ramakant B (2022), Hepatitis: Will new evidence for "same-day test and treat" be a game-changer? E-PAO2022.
24. Singh KL, Dhabali T, Rosie R, Nalinikanta R, Sharma SR, Sarin S, et al. (2022) 'Outcomes of a community led comprehensive HCV and HBV care provision model, including same-day "test and treat" to facilitate micro-elimination of HCV among people who inject drugs in Manipur, India', *J Hepatol*, 77:S219–20.
25. Wansom T (2021), *High HCV cure rates in C-FREE, first community-based study offering testing and treatment of viral hepatitis and HIV among people who use drugs and their partners in Thailand.*
26. Ministry of Health, Socialist Republic of Vietnam (2021), *Quyết định 1207/QĐ-BYT điều trị viêm gan C trên người đồng nhiễm HIV/viêm gan C.*
27. Singh G, personal communication, 2022.
28. Ministry of Health (Malaysia), HIV/STI/Hepatitis C Section (2020),*Global AIDS Monitoring: Malaysia HIV/AIDS Progress Report.*
29. FIND (2021), 'Malaysia continues national journey to battle hepatitis C with global partners'.
30. Dalgard O, Midgard H, Kielland KB (2021), 'Hepatitis C in Iceland: a milestone for global elimination', *Lancet Gastroenterol Hepatol*, 6(8):599–600.
31. Olafsson S, Fridriksdottir RH, Love TJ, Tyrfingsson T, Runarsdottir V, Hansdottir I, et al.(2021), 'Cascade of care during the first 36 months of the treatment as prevention for hepatitis C (TraP HepC) programme in Iceland: a population-based study', *Lancet Gastroenterol Hepatol*, 6(8):628–37.
32. Hassanin A, Kamel S, Waked I, Fort M (2021), 'Egypt's Ambitious Strategy to Eliminate Hepatitis C Virus: A Case Study', *Glob Health Sci Pract*, 9(1):187–200.
33. Georgian Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health, and Social Affairs, National Center for Disease Control and National Centre for Disease Control and Public Health (2022), *Georgia Hepatitis Elimination Program Progress Report 2020-2021.*
34. Adee M, Zhuo Y, Zhong H, Zhan T, Aggarwal R, Shilton S, et al. (2021), 'Assessing cost-effectiveness of hepatitis C testing pathways in Georgia using the Hep C Testing Calculator', *Sci Rep*, 11(1):21382.
35. Sonderup M, Afihene M, Ally R, Apica B, Awuku Y, L C, et al. (2017), 'Hepatitis C in sub-Saharan Africa: the current status and recommendations for achieving elimination by 2030', *Lancet Gastroenterol Hepatol*, 2(12). Available from https://pubmed.ncbi.nlm.nih.gov/29132760/.
36. WHO (2022) *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030.*