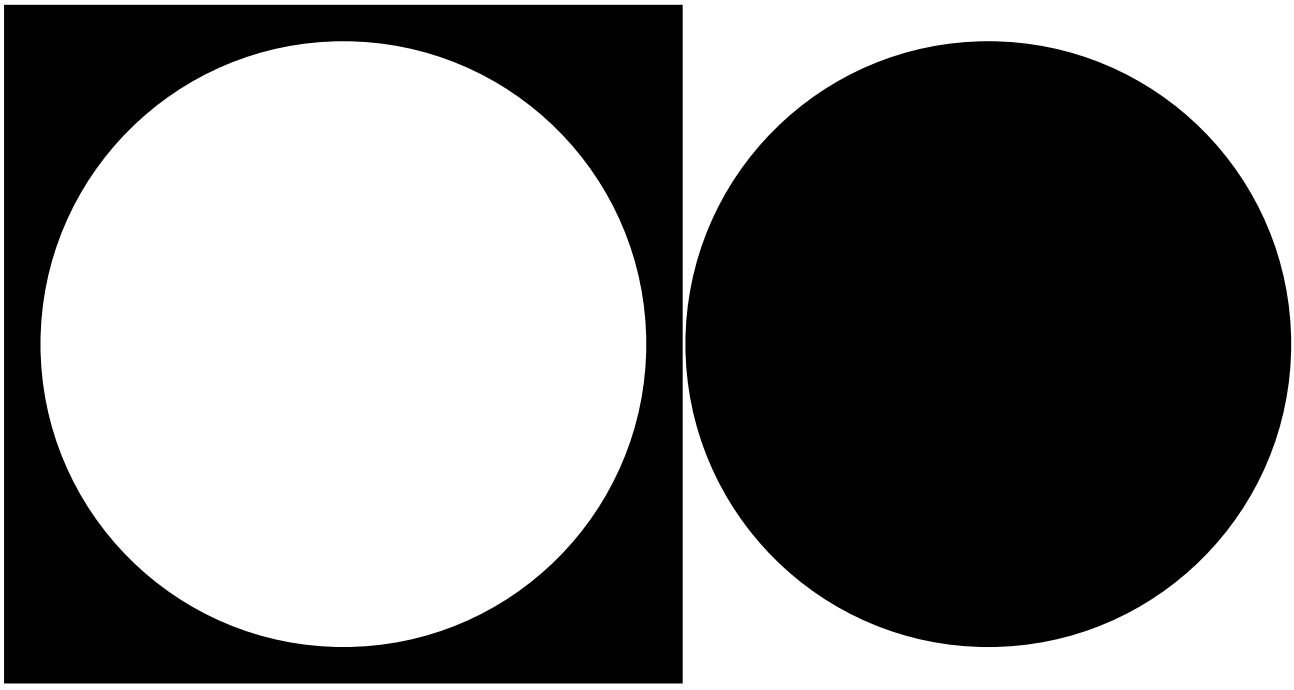


GLOBAL SUMMARY

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	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Bhutan	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Brunei Darussalam	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Cambodia	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
China	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Hong Kong	✗	✗	✓	nd	✗	✗	✗	✗	✗	✗
India	✓	✓	✓	nd	nd	nd	✗	✗	✗	✓
Indonesia	✓	✓	✓	nd	✗	✗	✓	✗	✗	✓
Japan	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Laos	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Macau	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
Malaysia	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
Maldives	✓	✗	✓	nd	✗	✗	✗	✗	✗	✗
Mongolia	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Myanmar	✓	✓	✓	nd	✓	✓	✗	✗	✗	✗
Nepal	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
North Korea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Philippines	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Singapore	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
South Korea	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Sri Lanka	✗	✗	✗	nd	✗	✗	✗	✗	✗	✗
Taiwan	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Thailand	✓	✓	✓	nd	✗	✗	✗	✗	✗	✗
Vietnam	✓	✓	✓	nd	✗	✗	✗	✗	✗	✓
EASTERN AND SOUTHERN AFRICA										
Angola	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Botswana	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Comoros	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eritrea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eswatini	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Ethiopia	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Kenya	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Lesotho	✗	✗	✗	nd	nd	nd	nd	nd	nd	nd
Madagascar	✗	✗	✗	nd	nd	nd	nd	nd	nd	nd
Malawi	✓	✗	✗	✗	✗	✗	✗	nd	✗	✗

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	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	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗

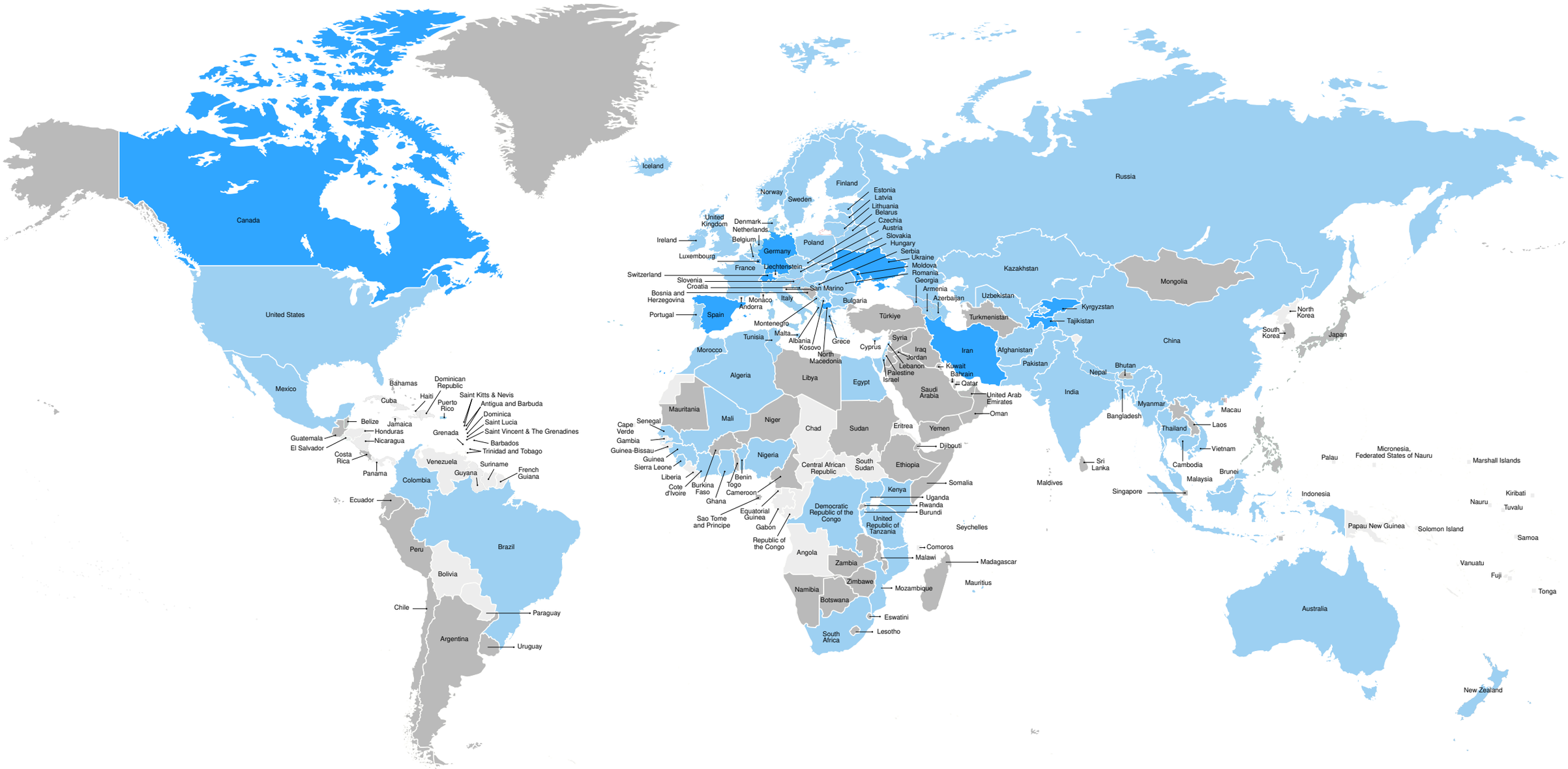
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone 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	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Argentina	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Bahamas	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Barbados	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Belize	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Bolivia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Brazil	✓	✓	✗	✗	✗	✗	✓	✗	✗	✗
Chile	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Colombia	✓	✓	✓	✓	✓	✓	✗	✗	✗	✗
Costa Rica	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cuba	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Dominican Republic	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Dominica	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Ecuador	nd	✗	✗	✗	✗	✗	✗	nd	✗	✗
El Salvador	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Grenada	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Guatemala	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Guyana	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Haiti	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Honduras	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Jamaica	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Mexico	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗
Nicaragua	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Panama	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Paraguay	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Peru	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
Puerto Rico	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Saint Kitts and Nevis	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Saint Lucia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd

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	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Suriname	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Trinidad and Tobago	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Uruguay	✓	✗	nd	✗	✗	✗	✗	✗	✗	✗
Venezuela	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
MIDDLE EAST AND NORTH AFRICA										
Afghanistan	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Algeria	✓	✓	✓	nd	✗	nd	✗	✗	✗	✓
Bahrain	nd	✗	nd	✗	✗	✗	✗	✗	✗	✗
Djibouti	nd	✗	nd	✗	✗	✗	✗	✗	✗	✗
Egypt	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Iran	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓
Iraq	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Israel	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Jordan	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Kuwait	nd	✗	✓	✗	✗	✗	✗	✗	✗	✗
Lebanon	✓	✓	✓	✗	✓	✓	✗	✗	✗	✓
Libya	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Morocco	✓	✓	✓	✗	✗	✗	✗	✗	✗	✓
Oman	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Pakistan	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
Palestine	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗
Qatar	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Saudi Arabia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Somalia	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Sudan	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Syria	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Tunisia	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗
United Arab Emirates	nd	✗	✓	✗	✗	✗	✗	✗	✗	✗
Yemen	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
NORTH AMERICA										
Canada	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United States of America	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓

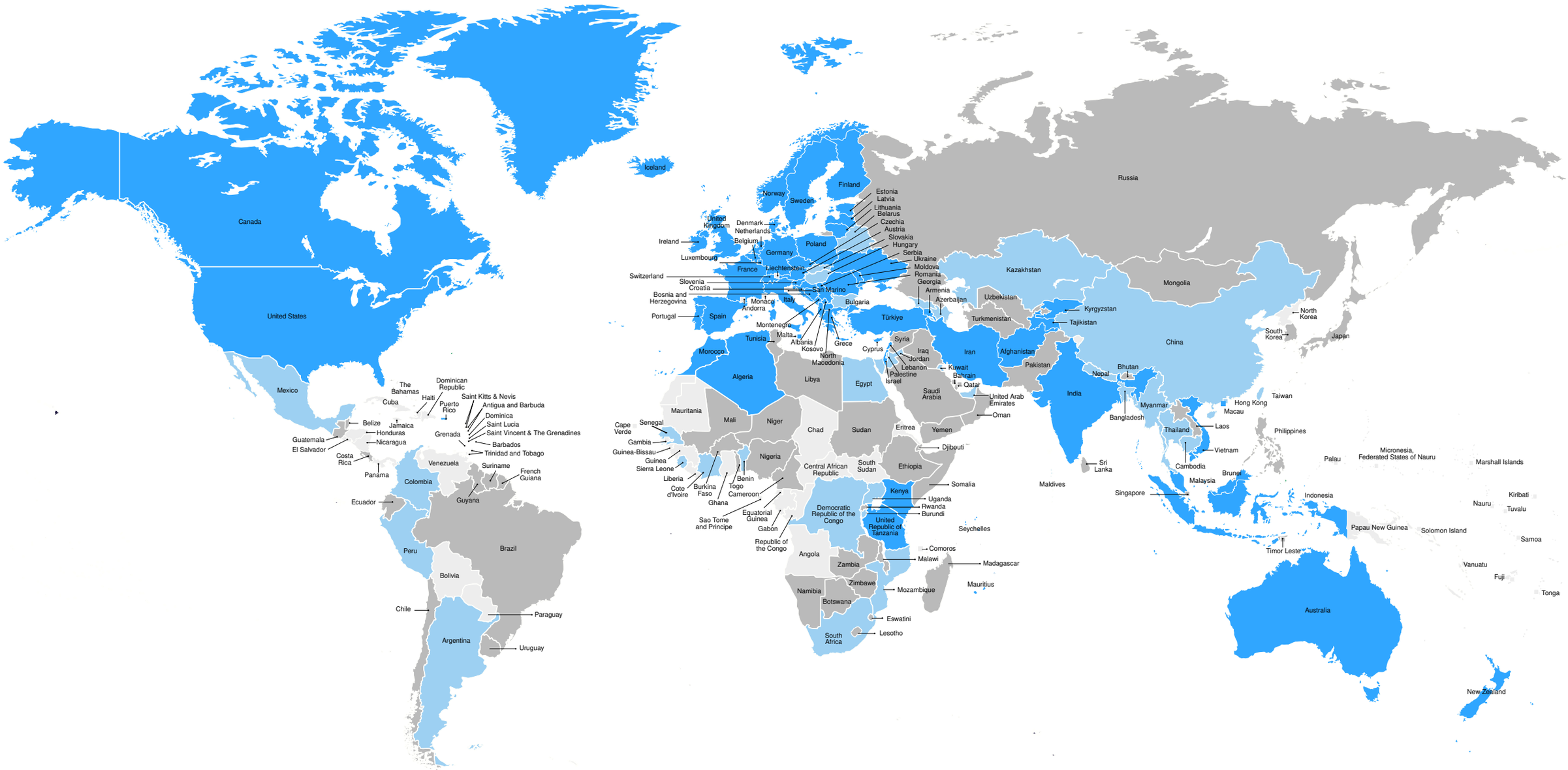
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone 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	nd	nd	nd
Fiji	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Kiribati	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Marshall Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Nauru	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Palau	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Papua New Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Samoa	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Solomon Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Timor Leste	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tonga	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tuvalu	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Vanuatu	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
WEST AND CENTRAL AFRICA										
Benin	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Burkina Faso	nd	✗	✗	✗	✗	✗	✗	✗	✗	✗
Burundi	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Cameroon	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Cape Verde	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Central African Republic	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Chad	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Congo	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Côte d'Ivoire	✓	✓	✓	✗	✗	✗	✗	✗	✗	✗
Democratic Republic of the Congo	✓	✓	✓	nd	nd	nd	nd	nd	nd	nd
Equatorial Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gabon	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gambia	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Ghana	nd	✓	nd	nd	nd	nd	nd	nd	nd	nd
Guinea	✓	✓	nd	nd	nd	nd	nd	nd	nd	nd
Guinea-Bissau	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Liberia	✓	nd	nd	nd	nd	nd	nd	nd	nd	nd

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	✓	✓	✗	nd	nd	nd	nd	nd	nd	nd
Mauritania	✗	✗	nd	nd	nd	nd	nd	nd	nd	nd
Niger	✗	✗	nd	nd	nd	nd	nd	nd	nd	nd
Nigeria	✓	✓	✗	nd	✗	nd	nd	nd	nd	nd
Sao Tome and Principe	✓	✗	nd	nd	nd	nd	nd	nd	nd	nd
Senegal	✓	✓	✓	nd	nd	nd	nd	nd	nd	nd
Sierra Leone	✓	✓	✓	✓	nd	nd	nd	nd	nd	nd
Togo	✓	✗	✗	nd	nd	nd	nd	nd	nd	nd
WESTERN EUROPE										
Andorra	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Austria	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Belgium	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Cyprus	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Denmark	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Finland	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
France	✓	✓	✓	✓	✓	✗	✓	✗	✗	✓
Germany	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Greece	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Iceland	✓	✓	✓	✓	nd	nd	nd	✗	✗	✓
Ireland	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Italy	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
Liechtenstein	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Luxembourg	✓	✓	✓	✓	✗	nd	nd	✗	✓	✓
Malta	✓	✓	✓	✗	✗	✗	nd	✗	✗	✓
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	✓	✓	✓	✓	✗	✗	✓	✗	✗	✓
Norway	✓	✓	✓	✓	✓	✗	nd	✗	✗	✓
Portugal	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
San Mari	nd	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Sweden	✓	✓	✓	✗	✓	✗	nd	✗	✗	✓
Switzerland	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓
Türkiye	✗	✗	✓	✗	✗	✗	nd	✗	✗	✓
United Kingdom	✓	✓	✓	✗	✓	✓	✓	✗	✗	✓
GLOBAL TOTAL	**108**	**93**	**94**	**18**	**34**	**23**	**25**	**6**	**11**	**60**

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



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

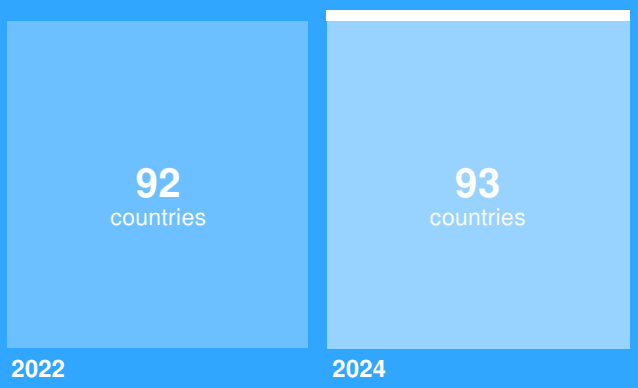


- OAT available in the community
- OAT available in the community and prison
- OAT not available
- No data

GLOBAL AVAILABILITY OF HARM REDUCTION SERVICES IN 2024

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

93 countries have at least one NSP in 2024



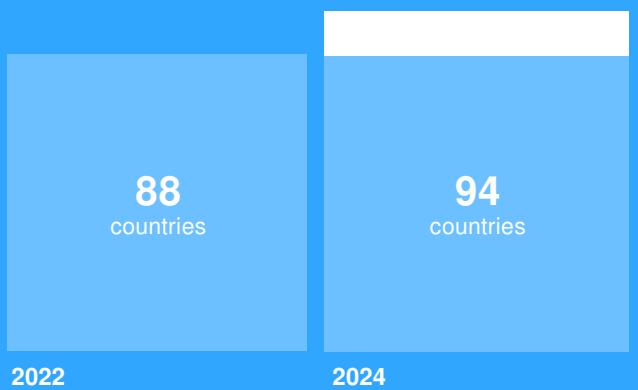
▲ +1

+ Brazil
  Bulgaria
  Ghana

- Dominican Republic
  Guinea

OPIOID AGONIST THERAPY (OAT)

94 countries have at least one OAT programme in 2024



▲ +6

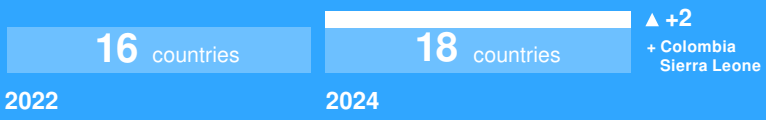
+ Benin
  Egypt
  Jordan
  Kuwait
  Peru
  Sierra Leone
  The United Arab Emirates

- Nigeria

GLOBAL AVAILABILITY OF HARM REDUCTION SERVICES IN 2024

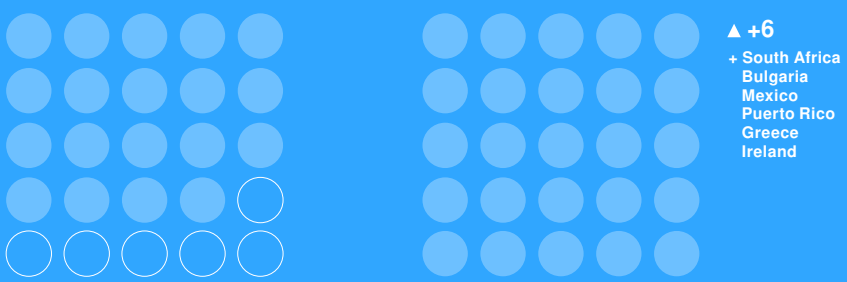
DRUG CONSUMPTION ROOMS (DCRs)

18 countries have legal and operational DCRs in 2024



SAFER SMOKING KITS

25 countries have at least one safer smoking kit distribution programme in 2024



2022
Safer smoking equipment is distributed in at least **19 countries**

2024
Safer smoking equipment is distributed in at least **25 countries**

PEOPLE WHO USE DRUGS STILL LACK HARM REDUCTION SERVICES

Overall, there has been a slight increase in the availability of harm reduction services since the *Global State of Harm Reduction* report in 2022. However, substantial regional differences still exist. The stigmatisation and criminalisation of people who use drugs remain significant issues. They impede access to existing harm reduction services and undermine the political and financial support needed to implement and expand these services.[1,2,3]

The number of countries with at least one needle and syringe programme (NSP) has risen slightly since 2022: 93 countries now provide at least one NSP, compared to 92 in 2022.

However, there have been some changes in the countries where NSP is available. Brazil has joined the list after introducing NSPs.[4,5] In an encouraging development in Bulgaria, NSPs are available again in two cities (Sofia and Plovdiv); they had previously closed in 2020 due to a lack of domestic funding.[6,7] In Accra, Ghana, a pilot NSP is operational as of this year.[8] However, in the Dominican Republic and Guinea, we can no longer confirm that NSPs are available. The need for NSPs still far outstrips availability, and the latest review finds 190 countries and territories where injecting drug use has been documented, meaning people who inject drugs in 97 countries are unable to access an NSP anywhere.[9,10]

Having at least one NSP is a low target for countries to meet, and around the world these services need to be scaled up. According to a recent systematic review, only Oceania has high coverage of NSPs,[a] and this only relates to two countries in the region (Australia and Aotearoa New Zealand). Central Asia and Western Europe both have moderate coverage, but NSP coverage is low in all other regions.[11] Current levels of coverage are not sufficient to effectively prevent the spread of HIV or hepatitis C virus (HCV), as they are not reaching the World Health Organization (WHO) recommended coverage level.[12,13]

The quality of the harm reduction services that are available is also important. Here, details matter. For instance, there is evidence that low dead space syringes[b] are a cost-effective tool to decrease HIV and HCV prevalence among people who inject drugs.[14,15,16] They should be available at all NSPs,

a Coverage is defined as the number of needles and syringes distributed per person who injects drugs per year: low coverage is under 100 needles; moderate coverage is 100–199 needles; high coverage is 200 needles or above. The World Health Organization-recommended coverage to reach HCV elimination goals is 200 needles per person per year by 2025 and 300 by 2030. (Source: 10)

b Dead space is the total area of a syringe and the needle where any fluid can remain when the plunger is fully depressed. When people who inject drugs share needles and syringes, the volume of dead space determines the volume of blood that can be transferred from one person to another. In general, out of the typically available syringes at an NSP, the one-piece 1ml insulin-type syringes with fine gauge fixed needles have the smallest dead space, and the two-piece, larger volume syringes with detachable large diameter needles have the largest dead space.

but are not being provided. Harm Reduction International (HRI) conducted a mapping of the types of needles and syringes that are provided at NSPs in 26 countries around the world. It found that low- and middle-income countries are less likely to distribute low dead space syringes while high-income countries are more likely to distribute a range of needles and syringes.[c 17]

Opioid agonist therapy (OAT) programmes are now in 94 countries, compared to 88 in 2022 – although coverage remains varied and limited.

The new countries include Egypt, Kuwait, the United Arab Emirates,[18,19] Peru, Benin and Sierra Leone,[20] although there is limited access. In Benin, a pilot OAT programme began at one site in the capital Porto-Novo, in December 2023.[21,22] In Sierra Leone, there is a small-scale OAT programme led by peer educators and run by a community-led group.[23] Peru began implementing OAT, although access is again very limited and only available in medical settings.[24] In West and Central Africa, Nigeria, has ceased its OAT programme.[25]

According to a systematic review, Western Europe has the highest OAT coverage with almost 70 OAT clients per 100 people who inject drugs,[d] followed by Oceania (data only from Australia and Aotearoa New Zealand) and South Asia.[26] Coverage is only moderate in North America (where an estimated 21% of people who inject drugs receive OAT). It is low in every other region. Coverage is particularly low in Central Asia, Eastern Europe, Eastern and Southern Africa and West and Central Africa. Across these regions, fewer than 2% of people who inject drugs have access.[27] OAT is prohibited by federal law in Russia despite around 90% of its 1.3 million people who inject drugs using opioids and needing access to the service.[28,29]

The number of countries with drug consumption rooms (DCRs) remains very small, but it has increased from 16 to 18 since 2022.

The two new countries on this list are Colombia and Sierra Leone. In Colombia, the first DCR opened in 2023 in Bogotá.[30] The facility is a community-based service for people who inject drugs, with peers involved in the operation as well as the development, implementation and evaluation of the facility.[31] Another DCR is expected to open in the country in 2024.[32] In Sierra Leone, a drop-in centre has opened an informal DCR, also staffed by peers.[33] Although local police and donors that support the drop-in centre are aware of its operation it is not officially sanctioned or funded.[34] Slovenia is close to having officially-sanctioned DCRs in the country – the hard-won result of a decades of advocacy.[e] In 2023, two civil society organisations were approved by Slovenia's Ministry of Health to open DCRs.[35] The first will open in Nova Gorica, a town in western Slovenia, and will provide services relating to sniffing, smoking and injecting. A second will open in the capital Ljubljana for sniffing only, due to the lack of appropriate infrastructure to support safer smoking.[36]

The majority of countries that currently have DCRs are in Western Europe. A recent report by Correlation – European Harm Reduction Network reviewed 11 countries and found that support from local governments and peer involvement was key to the successful establishment and operation of DCRs.[37] It noted that DCRs have to adapt to changes in the profiles and needs of their target groups. For example, it found a growing need to expand DCR services to people using methamphetamine, GHB and crack cocaine, and people who inhale opioids and crack cocaine.[38] Another significant recent study found that DCRs can provide people who use drugs with important safe spaces to consume drugs, which

c Evidence that using high dead space syringes increases people's risk of contracting HIV and HCV due to the residual fluid in them emerged decades ago. Despite this, routine national data collection does not generally include information on the type of syringes distributed in harm reduction programmes. More should be done to monitor this. (Sources: 11-13)

d Coverage is defined as the number of people accessing OAT per 100 people who inject drugs: low coverage is defined as under 20 people; moderate coverage is 20–39 people; high coverage is 40 people or above. (Source: 10)

e The first officially sanctioned pilot facility (funded by the Ministry of Health) was due to open in 2015. However, after a two-year consideration by the National Medical Ethics Committee it was not opened due to a judgement was made that DCR staff would 'indirectly cooperate' in illegal activities. (Source: 35)

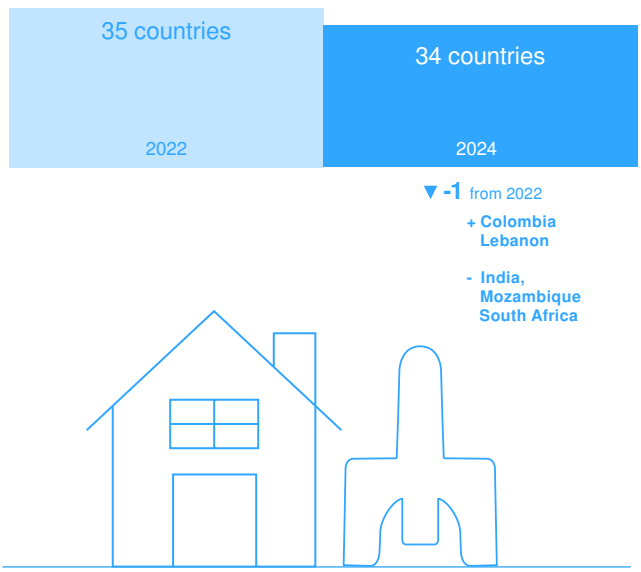
reduces the risk of death and infection, and they can also build the trust needed to connect people to other vital services.[39]

North America's first DCR – Insite in Vancouver, Canada – celebrated its 20th anniversary in 2023. With 3 million injection room visits since its opening, it has had no toxic drug or overdose deaths on its premises. Meanwhile, almost 12,000 overdoses have been reversed at the facility, and more than 71,000 referrals have been made to other services. This adds to decades of evidence in support of DCRs. DCRs can provide a pragmatic approach to a complex social and public health issue by saving lives directly, and indirectly by connecting people to healthcare and social welfare services.[40] There is an urgent need for greater attention and guidance on DCRs at the UN level.

Take-home naloxone programmes are now available in 34 countries, a slight decrease from 35 in 2022.

Take-home naloxone is now available in two new countries, Colombia and Lebanon.[41,42] However, its availability in India, Mozambique and South Africa has now changed. A recent review on harm reduction services in India concluded that details about its take-home naloxone service are largely unavailable, such as programme coverage and number of services.[43] In South Africa, there are no community-based naloxone distribution programmes so naloxone is only available in medical settings. This is despite the fact that most people who inject drugs in South Africa use heroin and could use access to naloxone. This is a common barrier people face when trying to access naloxone.[44,45] In Colombia, alongside the recent developments in DCR availability, take-home naloxone is now officially available, after years of illegal naloxone distribution among peers. However, legal barriers still exist as national guidelines require trained medical personnel to administer naloxone.[46]

Naloxone programmes available



“108 countries include harm reduction in national policies. However, criminalisation and punitive responses to drugs remain dominant in most places. These approaches undermine harm reduction efforts and they continue to fuel stigma and discrimination and deter people who use drugs from seeking vital, life-saving services.”

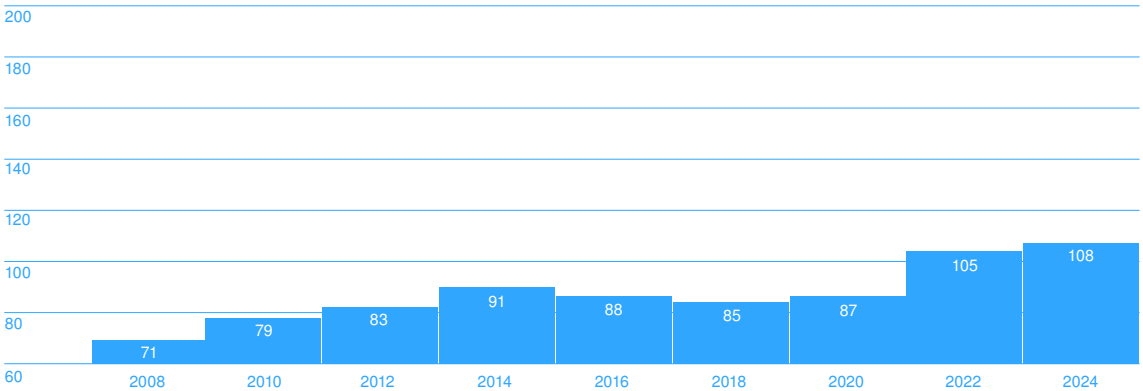
HARM REDUCTION IS CITED IN NATIONAL POLICIES, BUT PUNITIVE RESPONSES STILL DOMINATE

One hundred and eight countries include harm reduction in national policies. However, criminalisation and punitive responses to drugs remain dominant in most places. These approaches undermine harm reduction efforts and continue to fuel stigma and discrimination and deter people who use drugs from seeking vital, life-saving services.[47,48,49,50] This key contradiction must be addressed for meaningful progress to be made.

108 countries include explicit supportive mentions of harm reduction in national policy documents (up from 105 in 2022).[f]

This includes 11 countries in: Eastern and Southern Africa (Ethiopia, Malawi, Mozambique and Zimbabwe), Latin America and the Caribbean (Brazil, Chile and Costa Rica), West and Central Africa (Cameroon, Sao Tome and Principe and Togo) and Asia (Cambodia). However, we could not confirm the continued inclusion of harm reduction in national policies in eight countries that were on the list in 2022 (Dominican Republic, Ghana, Libya, Oman, Philippines, Samoa, Syria and Vanuatu).

Number of countries with explicit supportive reference to harm reduction in national policy documents in *Global State of Harm Reduction* reports, 2008-2024



f In the *Global State of Harm Reduction 2022*, the number of countries with explicit supportive reference to harm reduction in national policy documents was 104. However, the correct total for 2022 was 105, as Uruguay was incorrectly counted as a country with no explicit references. In Uruguay, explicit supportive references to harm reduction have been included in policy documents at least since 2017, when a regulation guaranteeing the right to mental health protection (Ley N° 19529) was issued.

But supportive references to harm reduction in national policies can mean very different things in different places. For instance, in Ethiopia and Mozambique only OAT is included in national HIV plans.[51] In contrast, Zimbabwe's HIV plan includes three harm reduction services (OAT, NSP and naloxone distribution). Malawi has explicit references to harm reduction in several national policy documents, including the health sector's strategic plan as well as the country's specific plans on drugs, HIV, hepatitis and sexually transmitted infections (STIs).[52] In Brazil, supportive references to harm reduction appear in several national plans (on drugs, HIV, hepatitis, and STIs), including references to different services (OAT, NSP, infectious disease care and services for non-injecting drug use).[53,54] This is in line with international recommendations for more comprehensive responses.[55]

Supportive references to harm reduction in national policies are still being undermined by underfunding and punitive responses to drugs.

The slight global increase in the number of countries where harm reduction is explicitly included in policy documents does not reflect the harsh realities that people who use drugs experience. For example, in Mozambique, where OAT is included in the national HIV plan, there have been reports of police arresting people for carrying injecting equipment.[56] In Iran, which mentions harm reduction in its national HIV policy, the government executed 459 people in 2023 for drug-related offences, the highest number since 2015.[57] In South Africa, the Networking HIV and AIDS Community of Southern Africa reported 600 human rights violations against people who use drugs in just three months in 2023 (including assaults and unlawful arrests).[58]

The public health imperative for tackling punitive and prohibitive response to drugs is clear. It is well established in the scientific literature that OAT and NSP, especially when provided together, can reduce the transmission of blood-borne infection, while the criminalisation of drug use can increase HIV and HCV transmission.[59,60] It is for this reason that in 2023 a United Nations Human Rights Council resolution on drug policy included – for the first time – explicit support for harm reduction and the decriminalisation of people who use drugs.[61] Similarly, in 2024, a United Nations Commission on Narcotic Drugs resolution on overdose was the first to explicitly mention harm reduction.[62]

Despite the scientific evidence and increasing international recommendations, the approach to drug use continues to be dominated by punitive and coercive policies and practices.[63,64,65] Human rights violations and repressive anti-drug campaigns continue around the world. In Asia, for instance, tens of thousands of people have been arrested for drug-related offences in Sri Lanka, and a vocal supporter of the death penalty for drug offences has been elected as President in Indonesia.[66,67,68] Hundreds of drug-related killings have also been documented in the Philippines (post-President Duterte).[69,70] Botswana and Nigeria have now passed laws that sanction the death penalty for drug trafficking.[71,72,73]

INSUFFICIENT FUNDING CONTINUES TO HINDER SERVICES

Harm reduction services such as NSP and OAT are cost-effective and cost-saving public health interventions.[74,75] They improve public health outcomes and contribute to reducing the negative social and economic impacts associated with drug use. Despite this, harm reduction is seriously underfunded in most regions.[76,77] HRI has monitored this funding for over 15 years, and the findings have been consistently bleak. The latest research identified USD 151 million in harm reduction funding in low- and middle-income countries in 2022 – only 6% of the estimated USD 2.7 billion needed annually by 2025. This leaves a funding gap of 94%.[78] Despite global commitments and international HIV prevention guidelines supporting the scaling up of harm reduction services, funding is woefully insufficient. Harm reduction programmes accounted for only 0.7% of total HIV funding in 2022, despite 8% of new HIV infections occurring among people who inject drugs.[79,80]

The number of international harm reduction donors remains small, leaving harm reduction vulnerable to their shifting priorities.

There is an increasing dependence on the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). In 2022, it accounted for 73% of all donor funding for harm reduction, compared to just 31% in 2007. As it is a public health donor, this has meant that most harm reduction funding is focused on public health outcomes (rather than other, broader issues of social justice for people who use drugs). Significantly, funding for advocacy, policy change efforts and community system strengthening has diminished. The Open Society Foundations' (OSF) funding for harm reduction, which includes such initiatives, has almost halved since 2019. In 2016 and 2019, OSF was the largest international harm reduction donor outside of the Global Fund and and the United States' President's Emergency Plan for AIDS Relief (PEPFAR).[81]

Cuts to support have also been reported by community groups around the world. For example, the Uganda Harm Reduction Network reported that at least three donors have ended harm reduction funding in Uganda since 2022.[82]

Community groups led by key populations, including people who use drugs[g], continue to face structural barriers, including complicated reporting requirements. This limits their access to funding. The majority of donors do not record data on their funding for community-led organisations, and there are no mechanisms to hold donors or donor governments accountable for their political commitments to international agreements like the Global AIDS Strategy or the UN resolution on the human rights implications of drug policy.[83,84]

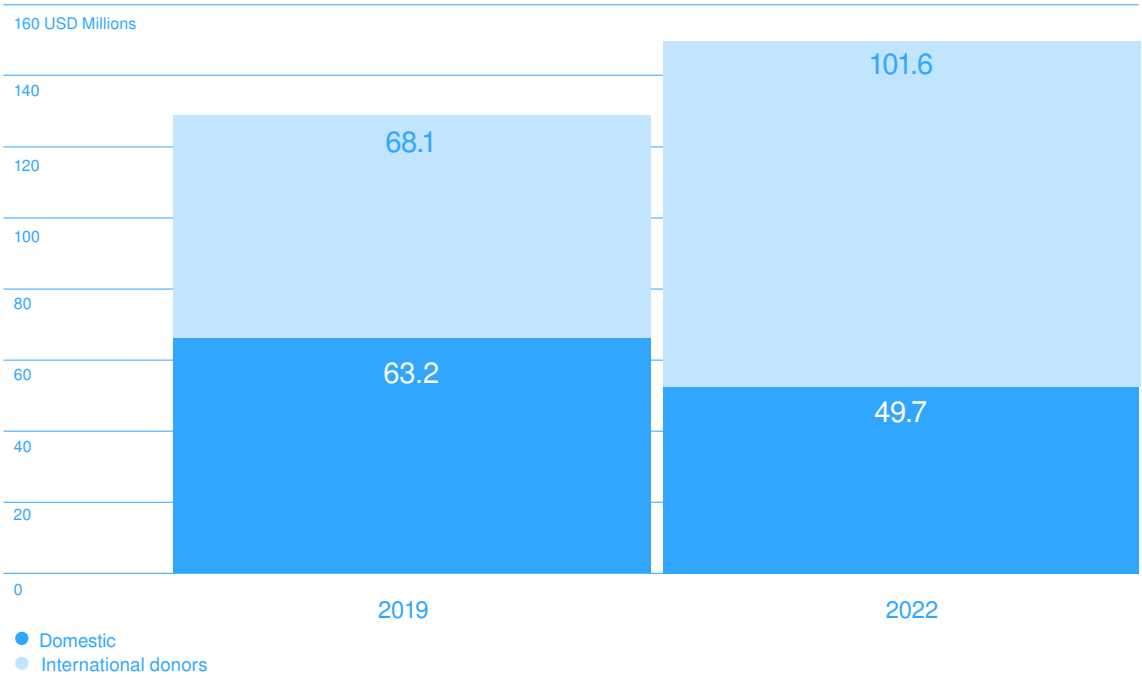
g UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

Domestic funding for harm reduction is even more fragile, and a lack of data prevents civil society from being able to monitor levels and hold governments accountable.

HRI's latest research identified USD 49.7 million in domestic funding for harm reduction, representing 33% of all harm reduction funding identified in 2022 and a reduced amount since 2019. Domestic investment in harm reduction accounted for a mere 0.4% of all domestic funding for HIV in 2022. HIV spending on key populations lags far behind the estimated need across all regions but particularly in the Middle East and North Africa. There is also little transparency around domestic government spending in many countries, including on harm reduction services, making it hard to monitor and hold officials to account.[85]

Increased funding for advocacy efforts could help change this situation and increase domestic investment for sustainable harm reduction responses. Decriminalising drug use and people who use drugs will maximise the impact of existing harm reduction investments. For example, in Portugal, the number of people who use drugs entering treatment has increased significantly since decriminalisation in 2000.[86] Drug-related deaths have also fallen and have remained below the European Union (EU) average ever since decriminalisation.[87] The country now accounts for 1.7% of new HIV diagnoses linked to injecting drug use in the EU. Prior to decriminalisation, it accounted for 50%.[88] This reflects the health, social and economic benefits of investing in harm reduction and how harm reduction programmes, and repealing punitive drug laws and policies, benefits wider communities.

Amount of harm reduction funding (USD millions) by funding source in 2019 and 2022



THE MOST UNDERSERVED GROUPS OF PEOPLE WHO USE DRUGS

Some people who use drugs face multiple, intersecting vulnerabilities which impede their access to harm reduction services. This includes women, LGBTQI+ people, Indigenous people, migrants and people in prison. In addition to stigmatisation because of their drug use, these groups are already marginalised and discriminated against. This results in them being particularly underserved. Young people who use drugs also face additional barriers to accessing services.

Language can also be a significant barrier for migrants who need access to harm reduction services.[89] Interpreters and multicultural mediators are needed to ensure migrants who use drugs can access harm reduction services.[90,91]

Harm reduction for people aged below 18 years is still seen as a controversial issue.[92,93,94]

There are age restrictions to accessing harm reduction services in many countries around the world. In Western Europe, where harm reduction has a longer history than other regions and the policy environment is generally more favourable, under 18s are not formally permitted to use DCRs, NSPs or drug checking services.[95,96,97,98]

Indigenous people and people from other racialised communities face racism on top of stigmatisation for drug use.

Rates of drug-related harm are higher for Indigenous people, according to research from Canada, the USA, Australia and Aotearoa New Zealand.[99] For example, opioid overdose deaths are seven times higher for Kainai peoples in Alberta, Canada than for the general population.[100,101,102]

Uneven geographical coverage of harm reduction services is still a serious barrier to access around the world.[103]

Even where these services exist and are recognised as important at the national level, people living in remote or rural areas still find them hard to access. For example, in India, 95% of people who inject drugs are covered by harm reduction services in 12 states, while only 22% are covered by these services in the state of Assam and 39% in Delhi.[104,105] Having to travel long distances to access services reduces or even nullifies their value to these underserved groups. Most OAT services, for instance, require daily visits.[106]

Punitive drug policies have led to the overrepresentation of people who use drugs in prisons, where access to harm reduction services is even more inadequate.

An estimated one-third to half of people in prison have a history of drug use.[107,108,109] Many people continue or start injecting drugs while in prison, and high-risk behaviours such as sharing paraphernalia and unsafe tattooing also increase in prison and other closed settings.[110] Despite the evident need for harm reduction services in prisons, they are typically even less likely to be available than they are outside prison. For instance, only 11 countries have an NSP in at least one prison – this is just 12% of the 93 countries that provide NSPs to people outside of prison. Apart from Canada, all identified NSPs in prisons are in Eurasia (Armenia, Kyrgyzstan, Moldova, Tajikistan and Ukraine) and Western Europe (Spain, Luxembourg, Germany, and Switzerland). Naloxone is available in at least one prison in just 11 countries across Europe, North America and Australia.[111]

Globally, OAT in prisons is available in at least 60 countries. However, the availability of this service varies widely between regions. In Asia, only five countries provide OAT in at least one prison. In most European and Eurasian countries, OAT is available in at least some prisons. But services are not always equally accessible within these countries. People often experience administrative and bureaucratic barriers that stop them from getting the services they need, for example, prison-based OAT being limited to people who had prescriptions before being incarcerated.[112,113]

DRUG CHECKING SERVICES AND HARM REDUCTION FOR STIMULANTS

Another major gap globally is the lack of diverse harm reduction services to match the diversity of drugs being used around the world. In Latin America and the Caribbean, for instance, stimulant drugs are more frequently used than opioids. Yet the availability of harm reduction interventions for these substances is insufficient.[114,115,116] Some civil society organisations run peer-led drug-checking initiatives designed for stimulants in Argentina, Brazil, Chile, Uruguay, Peru, Colombia and Mexico,[h] but these interventions are typically unsanctioned and lack official government support.[117]

Drug checking services help people who use drugs to reduce the risks associated with unknown types or quantities of substances and unwanted interactions.

These services have traditionally been aimed at people who use stimulants in the nightlife scene.[118] In Western Europe, where drug checking services are available in 12 countries, these services have also produced data and information on the substances available and emerging trends across the region.[119,120,121] In Eurasia, where nine countries have introduced drug checking services to some extent, they all appear to be operating in a legally grey area. An exception is Slovenia, where drug checking services are part of a National Early Warning System on psychoactive substances. In Hungary, Estonia, Czechia, Croatia, Lithuania, Georgia, Ukraine and Poland, drug checking services distribute reagent test kits (mostly in nightlife settings), people perform tests themselves and are invited to come back to discuss the results.[122]

Safer smoking initiatives are another harm reduction intervention that can be beneficial for people who use stimulants, as smoking can make people more susceptible to respiratory illnesses and viral infections, especially if people use makeshift pipes.[123]

These initiatives could be part of a beneficial package of harm reduction strategies for people who inject drugs, offering alternatives to injecting.[124] We can report that safer smoking equipment is distributed in at least 25 countries, up from 19 in 2022, with new smoking equipment distribution initiatives reported in Bulgaria, Greece, Ireland, Mexico, Puerto Rico and South Africa. This is an important though limited development. People who smoke drugs are a seriously underserved subpopulation of people who use drugs. For example, in Africa, we can identify only one country that makes safer smoking equipment available (South Africa). Similarly in Asia, we can report availability in only one country (Indonesia).[125]

h These civil society organisations are Corporacion Acción Técnica Social in Colombia, Integración Social Verter A. C in Mexico, Imaginario 9 in Uruguay, EPSJV/Fiocruz in Brazil, Intercambios Asociación Civil in Argentina, Proyecto Soma in Perú and Reduciendo Daño in Chile.

Stimulant prescription or stimulant substitution treatment has risen since 2022.

Six countries report it as available to some extent (Australia, Canada, Czechia, Mexico, Switzerland and Ukraine) compared to two countries in 2022. However, these tend to be pilot programmes (Ukraine and Switzerland) or off-label prescriptions of already available medications (typically obesity or ADHD medications). The only exception is Czechia, where there is a relatively new, official protocol on stimulant prescription which was approved during the COVID-19 pandemic.[126]

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