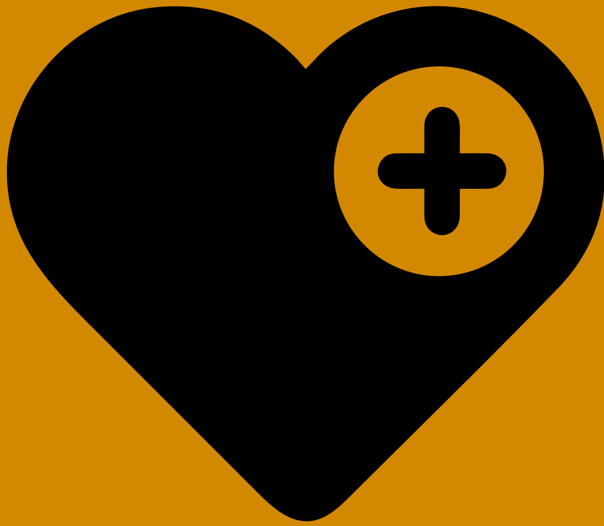


THE GLOBAL STATE OF HARM REDUCTION 2024

9TH EDITION

INTRODUCTION AND METHODOLOGY PAGE 8

GLOBAL SUMMARY PAGE 11

THEMATIC CHAPTERS

HEPATITIS PAGE 37
INDIGENOUS PEOPLE PAGE 62
PRISONS PAGE 73
YOUTH PAGE 92

REGIONAL OVERVIEWS

ASIA PAGE 109
EASTERN AND SOUTHERN AFRICA PAGE 121
EURASIA PAGE 132
LATIN AMERICA AND THE CARIBBEAN PAGE 143
MIDDLE EAST AND NORTH AFRICA PAGE 154
NORTH AMERICA PAGE 165
OCEANIA PAGE 179
WEST AND CENTRAL AFRICA PAGE 190
WESTERN EUROPE PAGE 202

ACKNOWLEDGEMENTS

The Global State of Harm Reduction 2024
© Harm Reduction International, 2024
ISBN: 978-1-915255-17-4
Research and oversight for this report was led by Colleen Daniels and Paulina Cortez in the Public Health and Social Policy team at Harm Reduction International.

Designed by ESCOLA
Copy-edited by Hester Phillips
Published by Harm Reduction International
61 Mansell Street Aldgate, London, E1 8AN
United Kingdom
E-mail: office@hri.global
Website: www.hri.global
Suggested citation: Harm Reduction International, (2024), *Global State of Harm Reduction 2024*, HRI, London.

Harm Reduction International (HRI) envisions a world in which drug policies uphold dignity, health and rights. We use data and advocacy to promote harm reduction and drug policy reform. We show how rights-based, evidence informed responses to drugs contribute to healthier, safer societies, and why investing in harm reduction makes sense. HRI is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

The Global State of Harm Reduction benefits from the generous support of the AIDS Healthcare Foundation, Drug Policy Alliance, Open Society Foundations, the Robert Carr Fund, the United Nations Office on Drugs and Crime, Viiv Healthcare, and the World Health Organization.

Thanks are also owed to colleagues at Harm Reduction International for their feedback and support in preparing this report: Cinzia Brentari, Catherine Cook, Giada Girelli, Gaj Gurung, Marcela Jofre, Ajeng Larasati, Lucy O'Hare, Maddie O'Hare, Suchitra Rajagopalan, and Anne Taiwo.

Thanks to Jamie Bridge and Sam Shirley-Beavan for their input and contribution to the global summary and data verification process.

AUTHORS

Gideon Lasco, Wangari Kimemia, Maria Plotko, Carolina Ahumada, Jorgelina Di Iorio, Isabelle Salameh, Elie Aaraj, Thomas Kerr, John Gobeil, Aniedi Akpan, Prince Bull Luseni, Robert Csák, Tríona Lenihan, David Geraghty, Tuari Potiki, Shawnee Brausch, Tracey Potiki, Charity Monareng, and Ruby Rose Lawlor.

CONTRIBUTORS

This report was made possible by the collaborative input of various actors: harm reduction organisations and networks, drug user organisations, researchers, academics and advocates. Harm Reduction International would like to acknowledge the invaluable contribution of these individuals and organisations.

Regional chapters

Asia: Murdo Biji; Simon Beddoe; Akihiko Sato, Kwansei Gakuin University; Promboon, Raks Thai Foundation; Rosan J. Ishak, Grapiks Foundation; Benedict Bernabe, The Red Whistle (TRW Org. Inc.); Mo Theo Za, Sadar Hati Foundation; Vichet Kem, Men's Health Cambodia (MHC); Bishnu Fueal Sharma, Recovering Nepal; Augusto Nogueira, ARTM - Associação Reabilitação de Toxicodependentes de Macau.

Eastern and Southern Africa: Joanne Csete; Julie Mac Donnell; Ahmed Said; Undule Mwakasungula, Drug Policy and Harm Reduction Platform - Malawi; Sulemani Muhirwa, Act for Change Organization (ACO); Andrew Scheibe, TB HIV Care; University of Pretoria; Wamala Twaibu, Uganda Harm Reduction Network (UHRN); SANPUD; Stand Action; Angela McBride, SANPUD; John Kimani, Kenya Network of People Who Use Drugs (KeNPUD); Timothy Tumagole, Captive Eye Organisation; Stelio Craveirinha, MOZPUD (Rede Nacional de Ajuda à Pessoas que Usam Drogas); Susan Wambui, Kenya Network of People Who Use Drugs; Stephanie Victoria, The Omari Project; Geraldine Kanyinga, Ministry of Health and Social Services; Cindy Trevedy, Ailes; Bheki Sithole, FHI 360; Vongai Charity Dheka, Students for Sensible Drug Policy Zimbabwe; Wilson, Zimbabwe Civil Liberties and Drug Network; Elvis Benimana, Health Development Initiative Rwanda; Job Mutombene, REAJUD; Chalton V. Moyo, Zimbabwe People Who Use Drugs Trust (ZimPUD); Aderito Tenhane, UNIDOS; Rehema Peter Mjindo, Women Support Group; Desmond Sakala, Harm Reduction Zambia Network; Adam Kaombwe,

Médecins du Monde; Kennedy Mutale, Decisive Minds; Tibebu Getachew, Organization for Social Health and Development (OSSHD); John Ondiek, United for a Purpose Brigade; Irakoze Bonheur, PARUDA.

Eurasia: Eurasian Harm Reduction Association; Irena Molnar; Eliza Kurcevic; Akmal Aliev, Ishonch va Hayot; Aleksandr Slatvitskiy, Klaipeda Mental Health Center; NGO I Can Live; Leonid Vlasenko; Katri Abel-Ollo, Mikk Oja, Researcher, National Institute for Health Development; Vigan Blakaj, Labyrinth; Мара м, Менеджер, Сайт ОЗТ; Borut Bah, Association for Harm Reduction Stigma; Alexei Lakhov, Humanitarian Action Fund; David Pešek, HR Facility, Drop-In, SANANIM; Maria Georgescu, ARAS; Сергей, Координатор, ОФ Аттика; Besnik Hoxha, Project Coordinator, Aksion Plus; Iva Jovovic, Life Quality Improvement Organisation Flight; Maka Gogia, Georgian Harm Reduction Network; Grazina Aleksaitiene, Support Foundation RIGRA; Nicoleta Dascalu, ARAS - Romanian Association Against AIDS; Genci Mucollari, Aksion Plus; Оксана Ибрагимова, Координатор, ОФ “Community Friends”; Doltu Svetlana, NGO AFI; Tijana Skelin, Udruga za Pomoc Mladima HELP – Split.

Latin America and the Caribbean: Intercambios AC; Ingrid Farias, Rede de Negros na Redução de Danos; Said Slim Pasaran, Integración Social Verter A.C.; Jonathan De Vicente Encarnación, México Unido Contra la Delincuencia, A.C.; Adriana Muro Polo, Elementa DDHH-México; José Arturo Costa Escobar, Escola Livre de Redução de Danos; Humberto Rotondo, Youth RISE and Proyecto Soma; Alexa Flores, Intercambios Puerto Rico; Paula Aguirre-Ospina, Elementa DDHH; Jessica, LANPUD, INPUD; Wemyss de Florimonte, Shades of the Sky Inc; Marten Colom, Foundation HE+HIV/Plus.sr; Evelyn Paz, LANPUD; Zara Snapp, Instituto RIA; Mariela Hernández Moraga, Fundación Latinoamérica Reforma; María Elena Ramos Rodríguez, Programa Compañeros, A.C. y Red Mexicana de Reducción de Daños; Decourcey Hutson, CARE Barbados; Hiwat Eurita, Double Positive; Isabel Pereira-Arana, Dejusticia; Marcela Tovar, CPAT; Roberta Marina dos Santos, Conectas Direitos Humanos; Ernesto Cortés, ACEID; Vanessa Rosario, Centro de Orientación e Investigación Integral; Luis Alberto Segovia Acosta, Prevencasa AC; Hugo Castro, Temeride; Francesca Brivio Grill, Proyecto Soma; Tania, Mizangas Movimiento de Mujeres y Disidencias Afro; Daniel Rojas Estipiñan, Corporación Acción Técnica Social - ATS; Dênis Roberto da Silva Petuco, EPSJV/Fiocruz; Fany Pineda Miranda, National Commission on Mental Health and Addictions; Camilo Obregón Fernández, Reduciendo Daño; Julian Andres Quintero López, Corporación Acción Técnica Social; Rocío del Pilar Deheza, Imaginario 9; Maria Angélica de Castro Comis, Rede Brasileira de Redução de Danos e Direitos Humanos; Carmen Albizu, UPR School of Public Health; Winfield Errol Tannis-Abbott, CARE Advocacy Reaching Out Empowering St Vincent and the Grenadines.

Middle East and North Africa: Ahmed Sabry; Ali Halassa, National Tuberculosis Program Manager, Ministry of Health; Bourouba, Association AIDS Algérie; Hiam Yaacoub, MOPH; Amin Zemaray, Organization for Harm Reduction in Afghanistan (OHRA); Raghda Algamil, General Secretariat of Mental Health and Addiction Treatment; Abdulhafedh Hasan Alward, Humanitarian Activist on HIV; Dr. Mohammed El Khammas, ALCS (Association de Lutte Contre le Sida); Mohammad Tariq Sonnan, UNODC; سهام منير, جمعية الأصدقاء; Michelle Wazan, Skoun, Lebanese Addictions Center; Salman Qureshi, Nai Zindagi; Zied, Association Tunisienne de Information et Orientation sur le Sida et la Toxicomanie; Tatyana Sleiman, Skoun; Jessica, MENANPUD Lebanon; غزلان ازندور, جمعية محاربة السيدا; عبدالله حناتله, سواعد التغيير وتمكين المجتمع; Arabia Osseiran, MENAHRA; Taline Torikian, MENA Rosa; Dr. Nadia Badran, Society for Inclusion and Development in Communities and Care for All; Mustafa El Nakib, X HIV Program Manager, WHO/MOPH.

North America: Roxanne Saucier; Kellen Russoniello, Thesia Naidoo, Sheila Vakharia, Drug Policy Alliance; Zoe Brokos, Church of Safe Injection; L. Nicole Stringfellow, FABRIC, Incorporated; Jan Eliassen, Fargo Cass Public Health; Nicholas Voyles, Indiana Recovery Alliance; Em, AIDS Committee, SWAP Program; Timothy Santamour, Florida Harm Reduction Collective; Jessica Mclachlan, Calgary Harm Reduction Centre; Magnus Nowell, Camille Arkell, CATIE; Ashley Shukait, SOOAR, LEAF HR; Sarah Spencer, Megan's Place; Whitney Parrish Perry, Maine Access Points; Colin King, Health Brigade; Robert Lyle Cooper, Meharry Medical College; Mahjida Berryman, Northwest Ohio Syringe Services (NOSS), Toledo-Lucas County Health Department; Tammy Morris, Aliveness Project of NWI; Albert Park, HRH413; Mary Pounder, Comer Family Foundation; Will Godfrey, Filter (The Influence Foundation); Raynald Joseph, AIDS CARE Ocean State; Aissata Sako, CRCHUM; Sarah Fleming, Justice Resource Institute; Braunz E. Courtney, HEPPAC; Suzanne Bachmeyer, Caracole; Brandon Mitchell Styles, Metro Drug Coalition; Terrell Jones, OnPoint; John Burns, SOS Recovery Community Organization; Shawn Martin, Prince Edward Island Department of Health and Wellness; Patt Denning, PhD; Sandra Ka Hon Chu, HIV Legal Network; Amy Lieberman, Harm Reduction Legal Project; Kelsey Speed, University of British Columbia; Ricky Bluthenthal, Keck School of Medicine, University of Southern California; Mary Hawk, University of Pittsburgh School of Public Health, Behavioral and Community Health Sciences; Holly Rybinski, Brandywine Counseling; Annette Hubbard, Ninilchik Traditional Council; Atika Juristia, The J Healthcare Initiative; Clayton Ruley, Community Liver Alliance; Anami Dass, Harm Reductionist Media, Inc; Kayla DeMong, Prairie Harm Reduction; Dr. Evonne Kaho, Love Me Unlimited 4Life; Ryan, Meharry Medical College.

Oceania: Lisa Maher; John Ryan; Geoff Noller, Substance Use and Policy Analysis (Independent Consultancy); Dunedin School of Medicine, University of Otago, Aotearoa New Zealand; Carol Holly, Hepatitis SA; Wendy, KnowYourStuffNZ; Bwebwetaake Tioti, Ministry of Health and Medical Services; Sue Heard,

Kirby Institute, UNSW Sydney; Sarah Helm, NZ Drug Foundation; Chris Gough, CAHMA - Canberra Alliance for Harm Minimisation and Advocacy Inc. and AIVL - The Australian Injecting and Illicit Drug Users League Ltd.; Jason George, DISC Trust, New Zealand Needle Exchange Programme; Sione Crawford, Harm Reduction Victoria; Sarah Hiley, North Richmond Community Health/The Loop; Monica Barratt, RMIT University; Paul Dietze, Burnet Institute, National Drug Research Institute; Emily Ebdon, AIVL and TUHSL; Jayke Meki, Key Population Advocacy Consortium; Joel Murray, Neophile; Geoff, QuIHN Ltd; Australian Injecting and Illicit Drug Users League AIVL; Armindo Correia Belo (Zizi Belo), Asosiasaun Komunidade Progresso (A-KP).

West and Central Africa: Jamie Cartick; Ahmed Said; Evanno Jerome, Moussa Konate, Tia Felicien Yomi, Paroles Autour de la Santé et de l'Environnement; Omar Conteh, African Network for Information and Action against Drugs (RAID); Haidara Mohamed, SongES Niger; Aseme Josephine, Greater Women Initiative for Health and Rights; Samuel Cudjoe Hanu, Harm Reduction Alliance, Ghana; Foday Michael Koroma, Salone Harm Reduction Program; Habib Taigore Kamara, Social Linkages for Youth Development and Child Link; Maria-Goretti Loglo, IDPC Africa; Mbamba Lingom Frederic Arsene, Empower-Cameroon; Agossou Rodrigue, BORNES; Gnadjosse Koffi Dovene, Association Nigérienne de Lutte Contre la Drogue et l'Immigration Illicite (ANLCDI); Some T. Charles, Colibri Sud; Chukwu Emeka, Soft Pure Heart Health Givers Empowerment Initiative; Doussou M. K. Bruno; Nduwayo Polycarpe, Alliance Burundaise Contre le Sida et pour la Promotion de la Santé.

Western Europe: Machteld Busz; Linda Montanari, European Union Drugs Agency (EUDA); Nicolas Van der Linden, Modus Vivendi asbl; Anna Quigley, Citywide Drugs Crisis Campaign; Dirk Schäffer, Deutsche Aidshilfe (German AIDS Organisation); Diana Castro, APDES; Ioulia Bafi, Greek Monitoring Centre for Drugs & Alcohol - Greek REITOX Focal Point of the EMCDDA (Athens University Mental Health, Neurosciences & Precision Medicine Research Institute UMHRI); Simon Olivier, Centre Hospitalier Universitaire Vaudois (CHUV), Lausanne; Collège Romand de Médecine de l'Addiction and Swiss Society of Addiction Medicine; Tessa Windelinckx, NGO Free Clinic; Susanna Ronconi, Forum Droghe; Stefanie Knocks, Fachverband Sucht; Ioanna Liatsou, Hellenic Liver Patient Association; Josep Rovira Guardiola, Asociación Bienestar y Desarrollo; Rafaela Rigoni, Alice Pomfret, Correlation - European Harm Reduction Network; Marios Atzemis, C-EHRN/DPNSEE/ City of Athens; Christine Kluge Haberkorn, akzept e.V.; Marc Marthaler, Infodrog; Aura Roig, Metzineres; Nikos Avgerinos, Greek Organisation Against Drugs; Dominique Schori, Drug Information Center (DIZ) Zurich; Tony Duffin, Ana Liffey Drug Project; Ioannis Zacharopoulos, KETHEA.

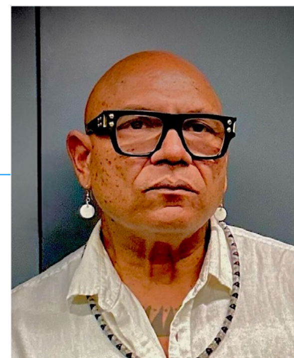
Thematic chapters

Hepatitis chapter: Antons Mozalevskis, Giten Khwairakpam, Dr. Niklas Luhmann.

Prisons chapter: Dr Marie Brasholt; Ludmila Lucia Mihailescu, Freelance; Gunnoo Deepak Roomesh, Mauritius Prison Service; Mark Stoove, Burnet Institute; Moch Ilham Dani Damanik, Yayasan Karitas Sani Madani (KARISMA); Nare Hovhannisyan, Center for Legal Initiatives NGO; Yasmeen Akhtar, Nai Zindagi; Paul Simpson, School of Population Health, UNSW Sydney; Dr. Michael Curtis, National Drug Research Institute, Curtin University; Burnet Institute; Yanina Stemkovska, UnMode; Irish Penal Reform Trust; Oleksii Zagrebelnyi, Charitable Organisation Free Zone; Madhurima Dhanuka, Commonwealth Human Rights International; Marta Valldaura, Metzineres; Dr. Mohammed El Khammas, ALCS (Association de Lutte Contre le Sida); Doltu Svetlana, NGO AFI; Xabier Etxebarria, Universidad Complutense de Madrid; Youssef Madad, Relais Prison/ Société; Mikhail Golichenko, HIV Legal Network; Nune Kalenderoglu, Jonathan Smith, Correctional Service Canada.

Indigenous people chapter: Scott Wilson; Josephine Davis, University of Auckland; Caroline Down; Hilda Mali, Te Korowai Hauora o' Hauraki; Jai Whelan, Ōtākou Whakaihu Waka / University of Otago, Harm Reduction Coalition Aotearoa; Teina Piripi, Te Hiku Hauora; Candy Cassidy-Ellice, Te Whatu Ora; Lilinoe Kauahikaua, Papa Ola Lokahi; Tuari Potiki, Te Rau Ora; Gilbert Taurua, University of Canterbury; Vanessa Kite, Rakau Ora Ltd; Denham, Jaycee Maunsell-Mcmenamin, Nadia Parker, and Maria Baker, Te Hiku Hauora; Tracey Potiki, Te Rau Ora; Carol Hopkins, Thunderbird Partnership Foundation; Keshia Cleaver, First Nations Health Authority; Kalesi T Volatabu, Drug Free World Fiji; Te Puea Winiata, Turuki Health Care; Donna Matahaere-Atariki, OHL trading as Te Kaika; Sarah Helm, NZ Drug Foundation Te Puna Whakaiti Pāmamae Kai Whakapiri; Josien Tokoe, Organisatie van inheemsen in Suriname (OIS); Sam Moncur, Te Rau Ora; Scott Wilson, Aboriginal Drug & Alcohol Council SA; Mirta Pereira Gimenez, Federación por la Autodeterminación de los pueblos indígenas (FAPI).

Youth chapter: Rebeca Marques Rocha; Isaac Olushola Ogunkola; Marialba Quesada; YouthRISE; Edie Scott; Jacob Chagnon, SSDP International; Vienna Club Commission; PsyCare Austria; SeksED; Paula Graciela Kahn, Community Health Project Los Angeles; Connor, SSDP; King River Wind, Harm Reduction Victoria; Nyanda Julius; Francesca Brivio Grill, Proyecto Soma; Liv Delair, Canadian Students for Sensible Drug Policy; Nikki Rieke, SSDP Australia; Jiavern Tham, HAYAT; Olufemi Bashorun, SSDP Nigeria; Sam Lasham, SSDP Aotearoa; Hanna Head, SOS-UK & SSDP UK; Aisling Hudson, UCD; Beatrix Vas; Rebeca Calzada, YouthRISE; Ailish Brennan; Ewelle Williams, SSDP; Róisín Downes, SSDP International; Nduwayezu Lambert, Institute for Economics and Enterprises.



FOREWORD

by SAM RIVERA

Love people until they are ready to love themselves. My mother, an emergency room nurse for 42 years, taught me this mantra and it guides my work everyday. I have had the honour to lead OnPointNYC as it opened one of the first two sanctioned Overdose Prevention Centres in the USA. These have now been open for nearly three years. In this time, the incredible staff at OnPoint NYC have successfully intervened in over 1,500 overdoses and prevented thousands more.

After decades practicing and providing harm reduction, it was crucial to me that, at OnPoint NYC, we continue the longstanding practices of whole person care developed by Indigenous, Black and Brown communties. This means healing the body, mind and spirit through wrap-around services, such as hygiene services, culturally nourishing food, mental health care and case management, acupuncture, sound therapy, respite spaces and strong community.

As the language of harm reduction becomes more popularised in the USA and across the globe, the *Global State of Harm Reduction 2024* reminds us that harm reduction is more than buzz words and services. True harm reduction is the epitome of meeting people where they are, without coercion or judgment. This requires developing a deep understanding of the people and communities we are serving.

As an Indigenous harm reductionist who is at the forefront of a cutting-edge harm reduction intervention in the USA, I am struck by how visible I am in contrast to Native people from the many lands I call home, who are made invisible by governments and institutional structures. This experience of intentional erasure through colonisation and oppression is true for so many Indigenous communities across the globe. This erasure strips us of access to our ancestral connections, healing practices and identity.

For the first time ever, the *Global State of Harm Reduction* includes a chapter dedicated to Indigenous people. The chapter looks at perceptions and practices of drug use among Indigenous people around the world and harm reduction programmes available to them. The report finds that there is still much work to do to increase access to harm reduction services among Indigenous communities, while also highlighting the ways Indigenous people blend their values, practices and knowledge with harm reduction to create interventions that support long term healing of the mind, body and spirit.

In the Kainai Nation in Canada, for example, Dr Esther Tailfeathers leads harm reduction programmes for young people, emphasising a continuum of care model that spans prevention to aftercare. Indigenous health practitioners in Australia combine Western medicine with local Indigenous knowledge and healing techniques, which includes strong community links and culturally appropriate processes.

These innovations are important examples of how we are reintegrating and reintroducing our traditional ancestral practices into our global consciousness. I believe this year's inaugural chapter will be the first of many chapters in the *Global State of Harm Reduction* exploring the contributions of Indigenous healing and the growth of advocacy to dismantle the ways colonisation has corrupted and coopted Indigenous medicine while punishing us for seeking our own wellness. As the global community will increasingly come to see, "we are the medicine".

Seneko Kakona (abundant blessings),

Sam Rivera
Executive Director, OnPointNYC

FOREWORD

by LAURA GIL

In March 2024, the United Nations Commission on Narcotic Drugs (CND), in its 67th session, voted for the first time in its history to introduce the concept of harm reduction in a Resolution. A year prior to that, the United Nations Human Rights Council had supported harm reduction in its documents. National and local governments have been providing an array of services to people who use drugs for decades. It was time that the UN recognised the importance of harm reduction.

The *Global State of Harm Reduction 2024* reminds us that harm reduction is an effective means to save lives, protect human rights and improve public health. Harm reduction is also one of the most cost-effective ways to do so.

In Colombia, we receive the latest edition of this report with cautious optimism. We celebrate international normative advances in harm reduction, the inclusion of harm reduction in 108 countries' policies, and the increase, albeit minimally, in the diversity of services at national level. Yet, we are fully aware of the challenges ahead.

At the United Nations in Vienna, the epicenter of global drug policy, a backlash on harm reduction based on the denialism of science is looming ahead. In a post-truth world, the principle of scientific-based evidence that United Nations Member States so dearly embraced in a number of CND official documents appears to have become hollow.

So many national policies that make harm reduction available continue to criminalise and stigmatise people who use drugs, or lack commitment to cultural change towards people who use drugs. Contradictions produce ineffective public policy here, there and everywhere, and, when the matter in question is drug use, ineffectiveness endangers lives.

The tightening of public finances at the national level leads to funding shortcuts for services whose beneficiaries are vulnerable populations that are distant from the priorities of national political agendas. Or governments provide funding only to public health providers, keeping community organisations from becoming first responders in harm reduction services. Harm reduction is more than a health intervention.

The lack of participation of people who use drugs, their families and their communities in the formulation and implementation of policies is concerning. People who use drugs are full citizens with the right to establish a dialogue around their needs, their expectations and the decision making around them.

Despite our efforts, Colombia remains in debt on so many of these fronts. Thirty years after personal use has been decriminalised, people who use drugs still face police action, human rights violations and suffer discrimination. The first drug consumption room opened in Colombia in 2023, yet naxolone can still only be provided by medical professionals, and funding for NGOs involved in drug checking and other services remains low. Still, if we speak honestly, that is because our commitment to harm reduction is firm.

In 2025, the Harm Reduction International Conference will be held in Bogotá, Colombia. We invite governments, national and local, civil society, researchers, and, of course, people who use drugs to join forces to ensure that harm reduction becomes a priority for all.

Laura Gil
Ambassador at large for global drug policy,
Republic of Colombia

INTRODUCTION AND METHODOLOGY

INTRODUCTION

This is the ninth edition of the *Global State of Harm Reduction*. Every two years since 2008, Harm Reduction International (HRI) has mapped responses to drug-related health harms around the world, including HIV and viral hepatitis. The report has become a key publication for researchers, policymakers, civil society organisations, advocates and United Nations' agencies interested in mapping harm reduction policy adoption and programme implementation globally.

The *Global State of Harm Reduction* has always been produced through a collaborative effort between community and civil society representatives and researchers.

The report includes nine regional chapters authored by experts from each region. This year's report differs slightly from previous editions as we emphasise key regional issues and populations that continue to be neglected by harm reduction services. Identified through responses to the Global State of Harm Reduction survey, each regional chapter presents data on the availability of harm reduction services and addresses two key issues that require special attention. The *Global State of Harm Reduction 2024* report also includes three new thematic chapters focused on harm reduction for Indigenous people, people in prison and youth. We also continue to include data to map the implementation of viral hepatitis services for people who use drugs.

In all our work, HRI defers to and respects local and regional terminology preferences, and is committed to the use of non-stigmatising, accurate language. In this regard, we take our lead from the INPUD and ANPUD *Language Statement and Reference Guide*.[a] Furthermore, we are committed to being inclusive and anti-racist. We capitalise Black and Brown when referring to Black and Brown people, used in a racial, ethnic or cultural sense, and Indigenous when referring to the original inhabitants of a place.

This report and other *Global State of Harm Reduction* resources can be found at www.hri.global.

METHODS

The information presented in the regional chapters of the *Global State of Harm Reduction 2024* has been gathered using two primary research strategies. HRI, in collaboration with regional partners, disseminated an extensive global survey to community and civil society organisations, multilaterals, donors, service providers, programme managers and academics as well as other national and regional experts, in five languages: Arabic, English, French, Spanish and Russian. This survey sought quantitative and qualitative information on the harm reduction services available in each country, region or territory.

Researchers then undertook an extensive literature review of research papers and reports from intergovernmental organisations, multilateral agencies, international non-governmental organisations, academics, civil society, harm

a INPUD, ANPUD (2020), *Words Matter! Language Statement & Reference Guide* [internet]. Available from www.inpud.net/en/words-matter-language-statement-reference-guide.

reduction organisations and networks of people who use drugs.

Epidemiological data in many of the regional chapters has been sourced from two global systematic reviews, supplemented by national or regional published data and experts. These reviews identified the prevalence of injecting drug use, the sociodemographic characteristics of, and risk factors for, people who inject drugs, the prevalence of blood-borne viruses[b] and coverage of needle and syringe programmes (NSP), opioid agonist therapy (OAT), drug consumption rooms (DCRs), HIV testing, antiretroviral treatment (ART) and condom programmes.[c]

Figures published through international reporting systems, such as those undertaken by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO), may differ from those collated here. This is due to variations in the scopes of monitoring surveys, reliability criteria and regional classifications.

There are still significant gaps in the data, which serve as an important reminder of the need for a greatly improved monitoring and data reporting system on HIV and drug use around the world.

Regions have been largely defined using the coverage of regional harm reduction networks. Accordingly, this report examines Asia, Eastern and Southern Africa, Eurasia, Latin America and the Caribbean, the Middle East and North Africa, North America, Oceania, West and Central Africa and Western Europe. All regional updates have been peer reviewed by experts in the field (*see* Acknowledgements).

The information presented in the Indigenous people, Prisons, and Youth chapters of the *Global State of Harm Reduction 2024* was gathered using three research strategies.

Data on the availability of harm reduction services for Indigenous people, prison-based programmes, and youth, including OAT and NSP in prisons, was collected through the *Global State of Harm Reduction* survey, which also informed the regional chapters. In addition, separate thematic surveys were employed for each new thematic chapter to gather information on barriers to access and other relevant issues specific to each focus area.

For the Indigenous people chapter, a thematic survey was distributed to Indigenous people and organisations identified as representing the Indigenous experience. This survey aimed to identify harm reduction measures or programmes for Indigenous communities, as well as gather information about their involvement in planning and implementation, and explore key factors contributing to drug-related harms among Indigenous people across the world.

For the Prisons chapter, a separate survey, available in both English and French, was sent to national experts in prison health. These experts included representatives from prison authorities, academia and civil society organisations. The survey sought to understand the delivery of harm reduction services in prisons and identify barriers to access where available. Focus countries were selected based on the availability of harm reduction services in prisons, geographical spread and the availability of suitable respondents.

To inform the Youth chapter, a thematic survey was disseminated to young members of youth-led organisations, focused on harm reduction and drug policy reform. This survey gathered data on barriers to accessing harm reduction services and drug education.

b Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health,* vol. 11, no. 5, e659-672.

c Colledge-Frisby, S., et al., (under review), 'The global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: A multi-stage systematic review of the evidence', *The Lancet Global Health.*

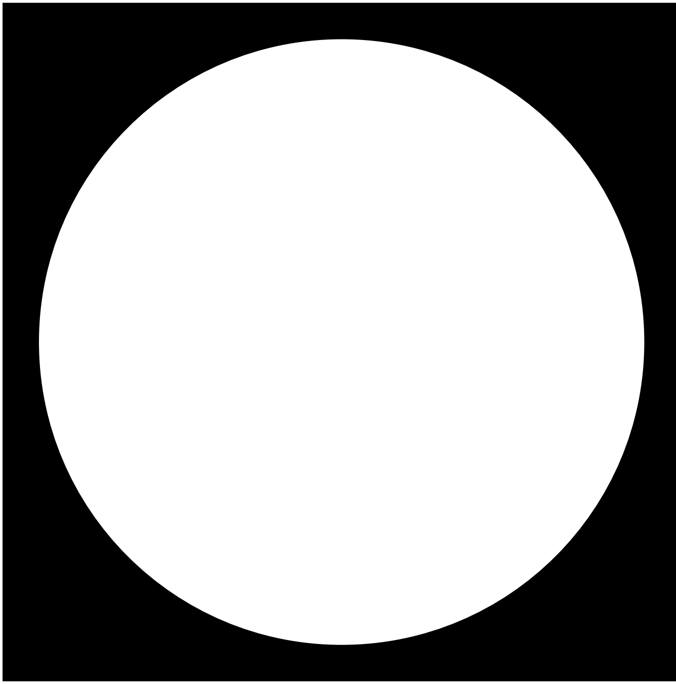
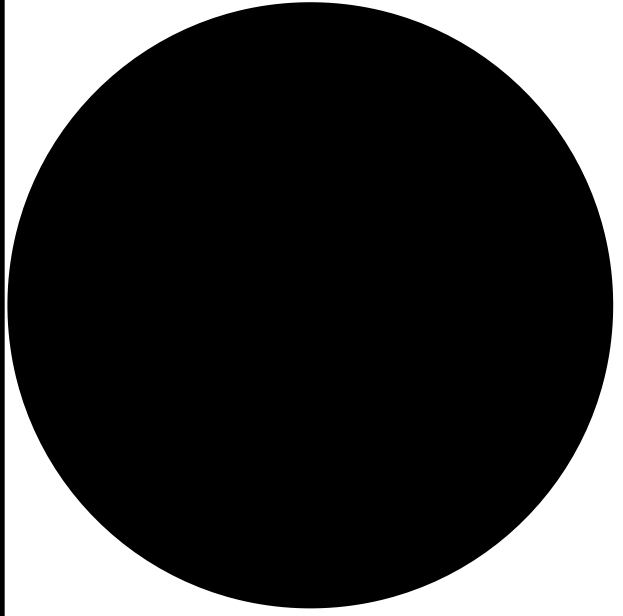
Finally, these three chapters were supplemented with desk-based research, with an emphasis on research and grey literature published since the previous edition of the report. All thematic chapters have been peer reviewed by experts in the field (*see* Acknowledgements).

The *Global State of Harm Reduction 2024* global and thematic surveys efforts led to contributions from 284 people in 101 countries.

LIMITATIONS

The report aims to provide a global snapshot of harm reduction policies and programmes; as such it has limitations. It does not comprehensively evaluate the quality of the services in place, although where possible it does highlight areas of concern.

While the *Global State of Harm Reduction 2024* aims to cover important areas for harm reduction, primarily it focuses on public health aspects of the response to drug use. The report does not document all the social and legal harms people who use drugs face, nor does it cover all the health harms related to legal or illegal drug use.

GLOBAL SUMMARY

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	✓	✓	✓	✗	✗	✗	✓	✗	✗	✗

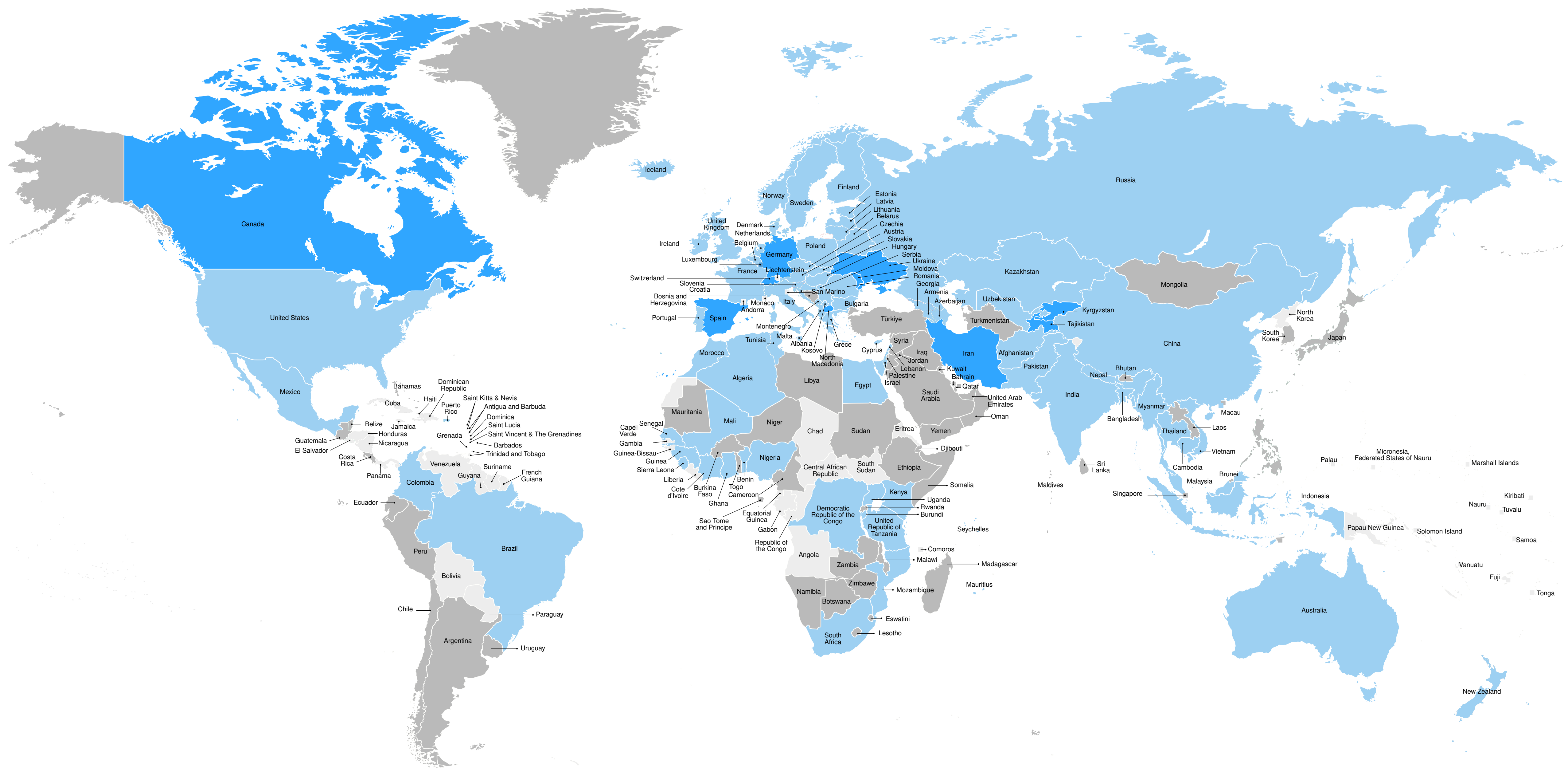
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone 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

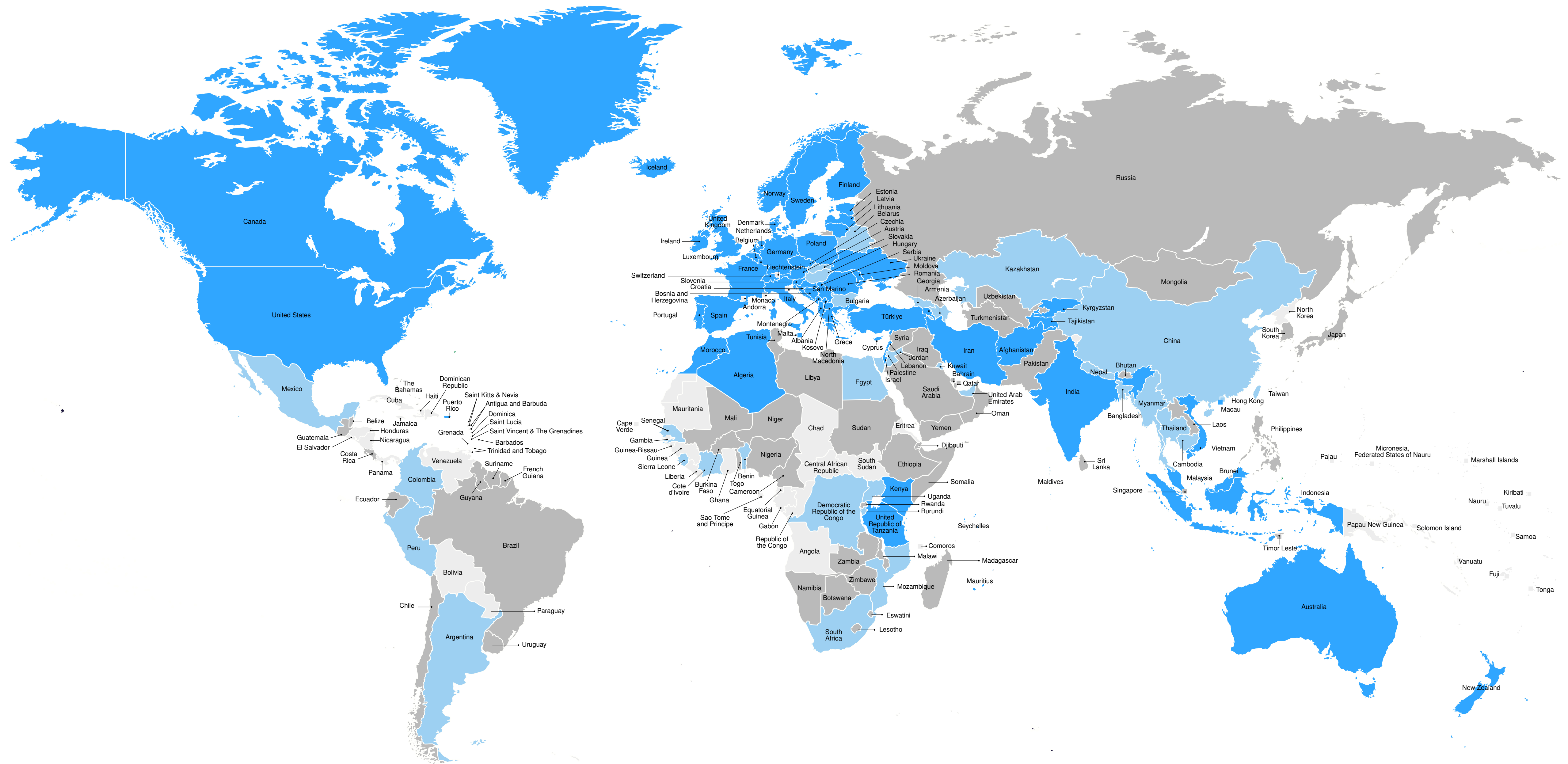
Country/territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room operational	Take-home naloxone available	At least one naloxone 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



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

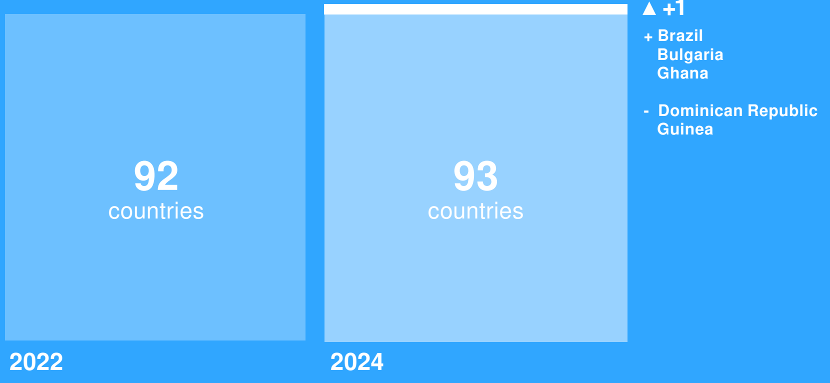
M1.2 GLOBAL AVAILABILITY OF OPIOID AGONIST THERAPY (OAT) IN THE COMMUNITY AND IN PRISONS



GLOBAL AVAILABILITY OF HARM REDUCTION SERVICES IN 2024

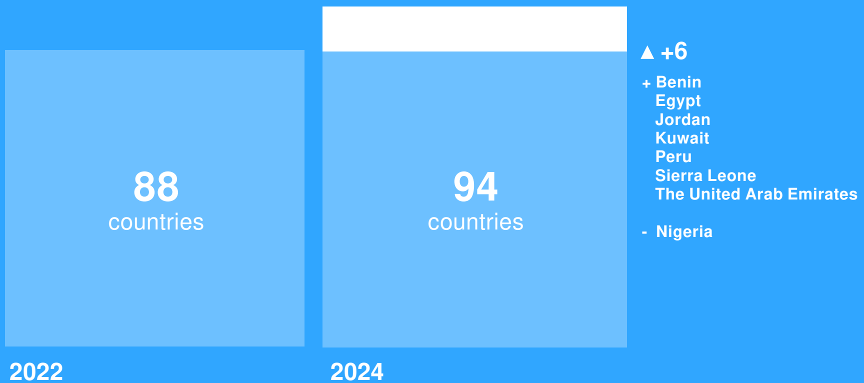
NEEDLE AND SYRINGE PROGRAMMES (NSPs)

93 countries have at least one NSP in 2024



OPIOID AGONIST THERAPY (OAT)

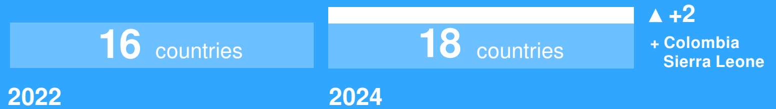
94 countries have at least one OAT programme in 2024



GLOBAL AVAILABILITY OF HARM REDUCTION SERVICES IN 2024

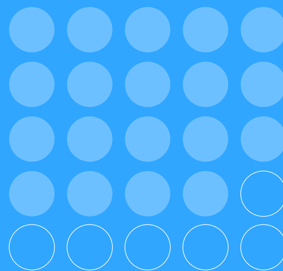
DRUG CONSUMPTION ROOMS (DCRs)

18 countries have legal and operational DCRs in 2024

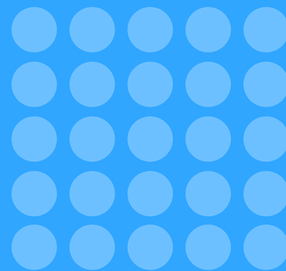


SAFER SMOKING KITS

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)

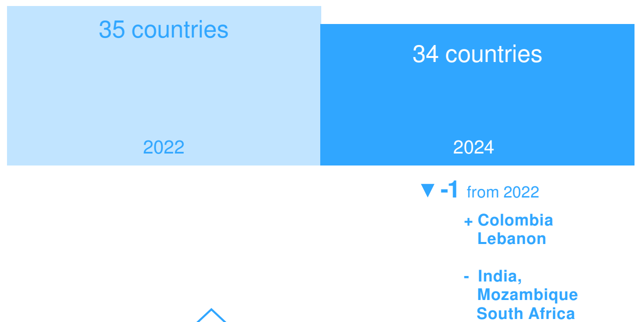
reduces the risk of death and infection, and they can also build the trust needed to connect people to other vital services.[39]

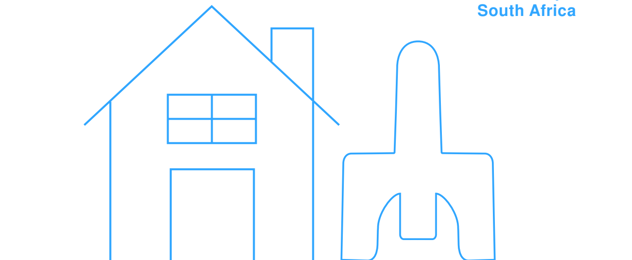
North America's first DCR – Insite in Vancouver, Canada – celebrated its 20th anniversary in 2023. With 3 million injection room visits since its opening, it has had no toxic drug or overdose deaths on its premises. Meanwhile, almost 12,000 overdoses have been reversed at the facility, and more than 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.”

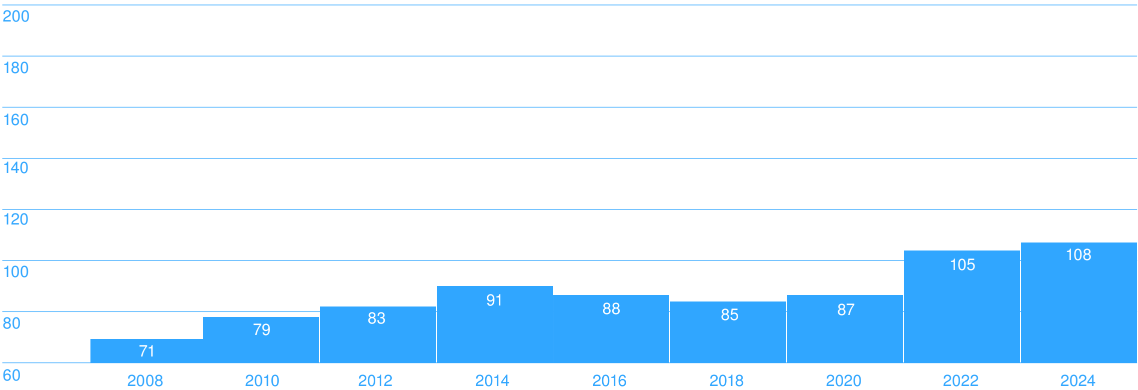
HARM REDUCTION IS CITED IN NATIONAL POLICIES, BUT PUNITIVE RESPONSES STILL DOMINATE

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 are considering 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]

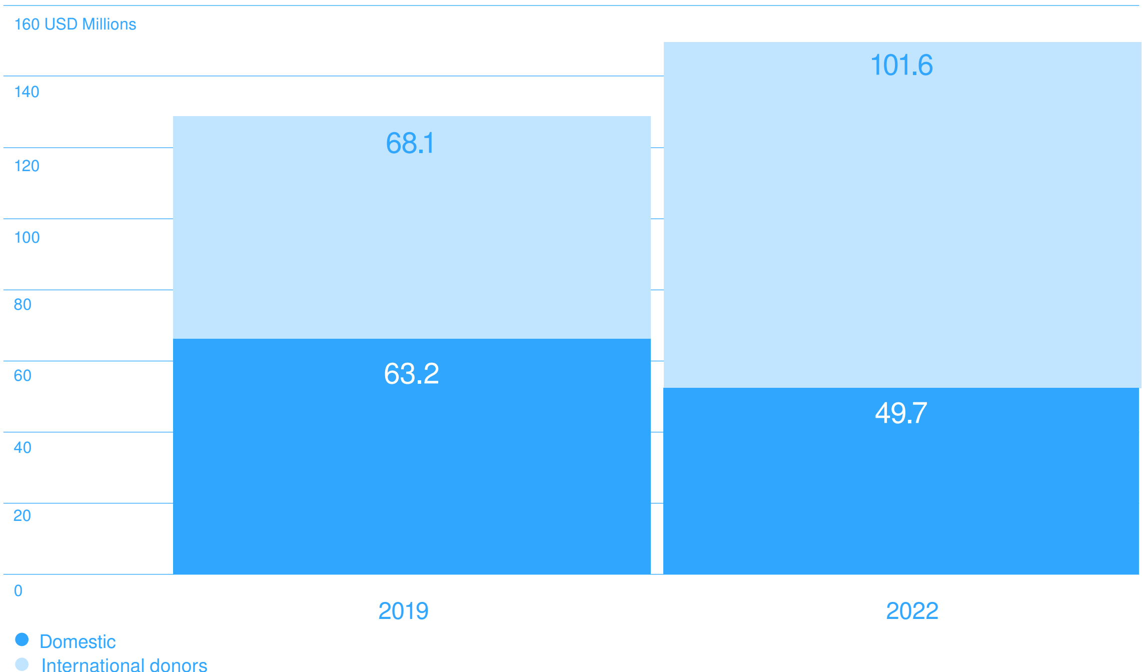
g UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIV and frequently lack adequate access to services.

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]

1 Rockstroh, J.K., et al., (2023), 'The path to hepatitis C elimination: who are we leaving behind and why?', *Journal of the International AIDS Society*, vol. 26, no. 7, e26136.
2 Harris, M. and T. Rhodes, (2013), 'Hepatitis C treatment access and uptake for people who inject drugs: a review mapping the role of social factors', *Harm Reduction Journal*, vol. 10, no. 1, p.7.
3 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e659–72.
4 Escobar, J.A.C., (2024) 'Global State of Harm Reduction 2024 survey response, Brazil'.
5 Farias, I., (2024), 'Global State of Harm Reduction 2024 survey response, Brazil'.
6 National civil society partners, (2024), 'Global State of Harm Reduction 2024 survey response, Bulgaria'.
7 Sárosi, P., (25 August 2020), 'The Oldest Harm Reduction Organisation in Bulgaria Shut Down' [online article, accessed August 2024], Drug Reporter, Budapest. Available from: https://drogriporter.hu/en/the-oldest-harm-reduction-organisation-in-bulgaria-shut-down.
8 Bridge, J., (2024), 'Global State of Harm Reduction 2024 survey response, IDPC'.
9 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e659–72.
10 Colledge-Frisby, S., et al., (2023), 'Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e673–83.
11 Ibid.
12 Zule, W.A. and G. Bobashev, (2009), 'High dead-space syringes and the risk of HIV and HCV infection among injecting drug users', *Drug and Alcohol Dependence*, vol. 100, no. 3, p.204–13.
13 Csák, R., (2023), *Low Dead Space Syringes: Analysis and Benefits For People Who Inject Drugs*, Harm Reduction International, London.
14 Ibid.
15 Trickey, A., et al., (2022), 'The Effectiveness of Low Dead Space Syringes for Reducing the Risk of Hepatitis C Virus Acquisition Among People Who Inject Drugs: Findings From a National Survey in England, Wales, and Northern Ireland', *Clinical Infectious Diseases*, vol. 75, no. 6, p.1073–7.
16 Hancock, E., et al., (2020), 'Detachable low dead space syringes for the prevention of hepatitis C among people who inject drugs in Bristol, UK: an economic evaluation', *Addiction*, vol. 115, no. 4, p.702–13.
17 Csák, R., (2023), *Low Dead Space Syringes: Analysis and Benefits For People Who Inject Drugs,* Harm Reduction International, London
18 Sonan, T., (2024), 'Global State of Harm Reduction 2024 survey response, Egypt'.
19 Aghaei, A.M., et al., (2023), 'Prevalence of injecting drug use and HIV, hepatitis B, and hepatitis C in people who inject drugs in the Eastern Mediterranean region: a systematic review and meta-analysis', T*he Lancet Global Health,* vol. 11, no. 8, e1225–37.
20 Rotondo, H., (2024), 'Global State of Harm Reduction 2024 survey response, Peru'; Agossou, R., (2024), 'Global State of Harm Reduction 2024 survey response, Benin'; Doussoh, M.K.B., (2024), 'Global State of Harm Reduction 2024 survey response, Benin.'; Kamara, H.T., (2024), 'Global State of Harm Reduction 2024 survey response, Sierra Leone'.
21 Doussoh, M.K.B., (2024), 'Global State of Harm Reduction 2024 survey response, Benin.'
22 Africa Synergy Group Pluss, 'Programme pilote de substitution des opiacés par la méthadone : Renforcement de capacité du personnel spécialisé et des paires éducateurs', [online article, accessed August 2024], ASG Pluss, Benin. Available from https://asg-pluss.com/programme-de-substitution-des-opiaces-par-la-methadone-au-benin-formation-du-personnel-specialise-et-des-paires-educateurs/.
23 Kamara, H.T., (2024), 'Global State of Harm Reduction 2024 survey response, Sierra Leone'.
24 Rotondo, H., (2024), 'Global State of Harm Reduction 2024 survey response, Peru'.
25 Akpan, A., (2024), 'Global State of Harm Reduction 2024 survey response, Nigeria.'
26 Colledge-Frisby, S., et al., (2023), 'Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e673–83.
27 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: A systematic review', *The Lancet Global Health*, vol. 11, no. 5, e659–e672.
28 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e659–72.
29 Colledge-Frisby, S., et al., (2023), 'Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e673–83.
30 Estipiñan, D.R., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; Castro, H., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; López, J.A.Q., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'.
31 Ibid.
32 Castro, H., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; López, J.A.Q., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'.
33 Kamara, H.T., (2024), 'Global State of Harm Reduction 2024 survey response, Sierra Leone'.
34 Ibid.
35 Sárosi, P., (26 January 2024), 'Drug Consumption Rooms Are Coming to Slovenia – An Interview with Katja Krajnc' [online article, accessed August 2024], Drug Reporter, Budapest. Available from https://drogriporter.hu/en/drug-consumption-rooms-are-coming-to-slovenia-an-interview-with-katja-krajnc.
36 Ibid.
37 Moura, J., et al., (2023), *Drug Consumption Rooms in Europe – Operational* Overview, Correlation – European Harm Reduction Network, Amsterdam.
38 Ibid.
39 Stevens, A., et al, (2024), 'Overdose prevention centres as spaces of safety, trust and inclusion: A causal pathway based on a realist review', *Drug and Alcohol Review*, vol. 43, no. 6, p.1573-1591.
40 Vancouver Coastal Health, (14 September 2023), 'Canada's first supervised consumption site celebrates 20 years of saving lives' [online media release, accessed August 2024], VCH, Vancouver. Available from http://www.vch.ca/en/press-release/canadas-first-supervised-consumption-site-celebrates-20-years-saving-lives.
41 Estipiñan, D.R., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; Castro, H., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; López, J.A.Q., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'.
42 Badran, N., (2024), 'Global State of Harm Reduction 2024 survey response, Lebanon'; Sleiman, T., (2024), 'Global State of Harm Reduction 2024 survey response, Lebanon'.
43 Parmar, A., R. Chakraborty R and Y.P.S Balhara, (2024), 'Current status of harm reduction in India: Are we doing enough?', *Indian Journal of Psychiatry*, vol. 66, no. 4, p.388–91.
44 Wilson, M. et al., (2022), 'Personal experience and awareness of opioid overdose occurrence among peers and willingness to administer naloxone in South Africa: findings from a three-city pilot survey of homeless people who use drugs', *Harm Reduction Journal*, vol. 19, no. 1, p.17.
45 Scheibe, A., (2024), 'Global State of Harm Reduction 2024 survey response, South Africa'.
46 López, J.A.Q., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'.
47 van Hout, M.C., P. Haddad and E. Aaraj, (2022), 'The Impact of COVID-19 on Drug Use and Harm Reduction Programming in the Middle East and North Africa (MENA) Region: a Regional Consultation of Stakeholders and People Who Use Drugs', *International Journal of Mental Health Addiction*, vol. 20, no. 4, p.2072–85.
48 Lai, G. and C. Stoicescu, (2020), 'Drug policy in Asia: the origins and extremities of prohibition', in *Research Handbook on International Drug Policy*, edited by D.R. Bewley-Taylor and K. Tinasti, Edward Elgar Publishing, Cheltenham, UK.
49 Lasco, G., (2020), 'Drugs and drug wars as populist tropes in Asia: Illustrative examples and implications for drug policy', *International Journal on Drug Policy*, vol. 77, e102668.
50 UNAIDS, (2024), *The urgency of now: AIDS at a crossroads*, UNAIDS, Geneva.
51 Getachew, T., (2024), 'Global State of Harm Reduction 2024 survey response, Ethiopia'.
52 Mwakasungula, U., (2024), 'Global State of Harm Reduction 2024 survey response, Malawi'.
53 Escobar, J.A.C., (2024) 'Global State of Harm Reduction 2024 survey response, Brazil'.
54 da Silva Petuco, D.R., (2024), 'Global State of Harm Reduction 2024 survey response, Brazil'.
55 World Health Organization Regional Office for Africa, (2018), *Report on key populations in African HIV/AIDS: national strategic plans*, WHO Regional Office for Africa, Brazzaville, Congo.

56 Mutombene, J., (2024), 'Global State of Harm Reduction 2024 survey response, Mozambique'.
57 Harm Reduction International, (2023), *The Death Penalty for Drug Offences: Global Overview 2023*, HRI, London.
58 Networking HIV and AIDS Community of Southern Africa, (6 September 2023), 'NACOSA Advocates for People-Centred Drug Policy' [online article, accessed August 2024], NACOSA, Cape Town. Available from http://www.nacosa.org.za/2023/09/06/nacosa-advocates-for-people-centred-drug-policy.
59 UNAIDS, (2024), *The urgency of now: AIDS at a crossroads*, UNAIDS, Geneva.
60 Tonin, F.S., F. Alves da Costa and F. Fernandez-Llimos, (2024), 'Impact of harm minimization interventions on reducing blood-borne infection transmission and some injecting behaviors among people who inject drugs: an overview and evidence gap mapping', *Addiction Science and Clinical Practice*, vol. 19, no. 1. p9.
61 UN General Assembly, (2023), *Human Rights Council contribution with regard to the human rights implication of drug policy, A/HRC/52/L.22/Rev.1*, UN HRC, UNGA, New York.
62 Commission on Narcotic Drugs, (2024) *Resolution 67/4: Preventing and responding to drug overdose through prevention, treatment, care and recovery measures, as well as other public health interventions, to address the harms associated with illicit drug use as part of a balanced, comprehensive, scientific evidence-based approach*, UNODC, Vienna.
63 Rockstroh, J.K. et al., (2023), 'The path to hepatitis C elimination: who are we leaving behind and why?', *Journal of the International AIDS Society*, vol. 26, no. 7, e26136.
64 UNAIDS, (2024), *The urgency of now: AIDS at a crossroads*, UNAIDS, Geneva.
65 Cooke, G.S., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology & Hepatology*, vol. 9, no. 4. p. 346–65.
66 Harm Reduction International et al., 'Joint statement: Sri Lanka: Stop abusive anti-drug operation and release those arbitrarily detained' [online statement, accessed August 2024], HRI, London. Available from https://hri.global/publications/sri-lanka-stop-abusive-anti-drug-operation-and-release-those-arbitrarily-detained.
67 United Nations Office of the High Commissioner for Human Rights, (22 January 2022), 'UN experts call on Sri Lanka to immediately suspend and review "Yukthiya" anti-drug operation' [media statement, accessed August 2024], OHCHR, Geneva. Available from www.ohchr.org/en/press-releases/2024/01/un-experts-call-sri-lanka-immediately-suspend-and-review-yukthiya-anti-drug.
68 Lekhtman, A., (22 February 2024), 'Fears for Drug Users and Many Others After Indonesia's Presidential Election', [online article, accessed August 2024], Filter Magazine, New York. Available from https://filtermag.org/indonesia-presidential-election-drug-war.
69 Valenzuela, N., (21 March 2024), 'Under Marcos, the Philippines drug war drags on' [online article, accessed August 2024], Deutsche Welle, Bonn. Available from https://www.dw.com/en/philippines-drug-war-what-changed-under-president-marcos/a-68635719.
70 Dahas, 'The Latest Numbers' [web page, accessed August 2024], Dahas, Third World Studies Center, Philippines. Available from https://dahas.upd.edu.ph/sources.
71 Tumagole ,T., (2024), 'Global State of Harm Reduction 2024 survey response, Botswana'.
72 Ontebetse, K., (28 April 2024), 'Govt approves death penalty for drug dealers, child rapists' [online article, accessed August 2024], Sunday Standard, Gaborone. Available from https://www.sundaystandard.info/govt-approves-death-penalty-for-drug-dealers-child-rapists/.
73 West Africa Drug Policy Network, (4 June 2024), 'WADPN Urges Nigerian Senate to Reconsider Death Penalty for Drug Offences' [online article, accessed September 2024], WADPN, Accra. Available from www.wadpn.org/post/wadpn-urges-nigerian-senate-to-reconsider-death-penalty-for-drug-offences.
74 Harm Reduction International, (2020), *Making the investment case: Cost-effectiveness evidence for harm reduction*, HRI, London.
75 Davis, C., C. Cook and G. Gurung, (2024), *The cost of complacency: a harm reduction funding crisis,* Harm Reduction International, London.
76 Harm Reduction International, (2020), *Making the investment case: Cost-effectiveness evidence for harm reduction*, HRI, London.
77 Davis, C., C. Cook and G. Gurung, (2024), *The cost of complacency: a harm reduction funding crisis,* Harm Reduction International, London.
78 Ibid.
79 UNAIDS, (2024), *The urgency of now: AIDS at a crossroads*, UNAIDS, Geneva.
80 Davis, C., C. Cook and G. Gurung, (2024), *The cost of complacency: a harm reduction funding crisis,* Harm Reduction International, London.
81 Ibid.
82 Global HIV Prevention Coalition, (7 May 2024), 'Low-income countries such as Madagascar lack funds to fight Aids' [online article, accessed August 2024], GPC Resource Hub, Geneva. Available from https://hivpreventioncoalition.unaids.org/en/news/low-income-countries-such-madagascar-lack-funds-fight-aids.
83 UN General Assembly, (2023), *Human Rights Council contribution with regard to the human rights implication of drug policy, A/HRC/52/L.22/Rev.1*, UN HRC, UNGA, New York.
84 UNAIDS, (2021), *End Inequalities. End AIDS. Global AIDS Strategy 2021-2026*, UNAIDS, Geneva.
85 Davis, C., C. Cook and G. Gurung, (2024), *The cost of complacency: a harm reduction funding crisis,* Harm Reduction International, London.
86 Drug Policy Alliance, (20 February 2019), 'Drug Decriminalization in Portugal - Learning from a Health and Human-Centered Approach' [online article and video, accessed August 2024], DPA, New York. Available from https://drugpolicy.org/resource/drug-decriminalization-in-portugal-learning-from-a-health-and-human-centered-approach.
87 Transform, (13 May 2021), 'Drug decriminalisation in Portugal: Setting the record straight' [online article, accessed August 2024]. Transform Drug Policy Foundation, London. Available from https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight.
88 Ibid.
89 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'; Guardiola, J.R., (2024), 'Global State of Harm Reduction 2024 survey response, Spain'; Schäffer, D., (2024), 'Global State of Harm Reduction 2024 survey response, Germany'; Bafi, I., (2024), 'Global State of Harm Reduction 2024 survey response, Greece'.
90 van Selm L., et al., (2024), 'A call to create integrated services to better address the needs of migrants who use drugs in Europe', *Harm Reduction Journal*, vol. 21, no. 1, p.9.
91 Rogialli, A., R.P. Gayo and I. Jeziorska, (2023), *Adequate drug-related responses for migrants in Berlin. Recommendations for policy and practice from the SEMID-EU project*, Correlation - European Harm Reduction Network, Amsterdam.
92 Harm Reduction International, (2022), *Harm reduction services in Switzerland*, HRI, London.
93 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'; Guardiola, J.R., (2024), 'Global State of Harm Reduction 2024 survey response, Spain'.
94 Barrett, D., et al, (2022), 'Child-centred harm reduction', *International Journal of Drug Policy,* vol. 109, e103857.
95 Harm Reduction International, (2022), *Harm reduction services in Switzerland*, HRI, London.
96 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
97 Schäffer, D., (2024), 'Global State of Harm Reduction 2024 survey response, Germany'.
98 Barrett, D., F. Petersson and R. Turner, (2022), 'Best interests and low thresholds: legal and ethical issues relating to needle and syringe services for under 18s in Sweden', *Harm Reduction Journal*, vol. 19, no. 1, p.15.
99 Clifford, A. and A. Shakeshaft, (2017), 'A bibliometric review of drug and alcohol research focused on Indigenous peoples of Australia, New Zealand, Canada and the United States', *Drug and Alcohol Review*, vol. 36, no. 4, p.509–22.
100 Ibid.
101 Rotary 5360, (2023), 'Dr. Esther Tailfeathers - discusses the Opioid Crisis and Recovery Programs' [online video, accessed August 2024], Rotary 5360, Calgary. Available from www.youtube.com/watch?v=TIlF1VXd9Io.
102 Boyd, T., et al., (2021), 'Quantifying opioid use disorder Cascade of Care outcomes in an American Indian tribal nation in Minnesota', *Drug Alcohol Dependence,* vol. 222, e108661.
103 Colledge-Frisby, S., et al., (2023), 'Global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 5, e673–83.
104 Parmar, A., R. Chakraborty and Y.P.S Balhara, (2024), 'Current status of harm reduction in India: Are we doing enough?', *Indian Journal of Psychiatry*, vol. 66, no. 4, p.388–91.
105 National AIDS Control Organisation India, (2023), *Sankalak: Status of National AIDS & STD Response* (*Fifth edition, 2023*), NACO, Ministry of Health and Family Welfare, New Delhi.
106 Aghaei, A.M., et al., (2023), 'Prevalence of injecting drug use and HIV, hepatitis B, and hepatitis C in people who inject drugs in the Eastern Mediterranean region: a systematic review and meta-analysis', *The Lancet Global Health*, vol. 11, no. 8, e1225–37.
107 International Drug Policy Consortium, (2023), *OFF TRACK: Shadow report for the mid-term review of the 2019 Ministerial Declaration on drugs*, IDPC, London.
108 Fazel, S., I.A. Yoon and A.J. Hayes, (2017), 'Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women', *Addiction*, vol. 112, no. 10, p.1725–39.
109 Harm Reduction International et al., (2023), *Joint submission to OHCHR's report on human rights challenges in addressing and countering all aspects of the world drug problem*, HRI, London.
110 Favril, L., (2023), 'Drug use before and during imprisonment: Drivers of continuation', *International Journal of Drug Policy*, vol. 115, e104027.
111 Communication with Meroueh, F. as part of the Global State of Harm Reduction 2024 survey follow up; European Union Drugs Agency, (2024), *Harm reduction – the current situation in Europe (European Drug Report 2024)*, p. 12-13, EUDA, Lisbon; Ronconi, S., (2024), 'Global State of Harm Reduction 2024 survey response'; Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'; EUDA, Lisbon; Abel-Ollo K. and M. Oja, (2024), 'Global State of Harm Reduction 2024 survey response';

Vlasenko, L., (2024), 'Global State of Harm Reduction 2024 survey response'; Ka Hon Chu, S. and A. Juristia, (2024), 'Global State of Harm Reduction 2024 survey response'; Santamour, T et al., (2024), 'Global State of Harm Reduction 2024 survey response'; Hiley, S., P. Dietze and G. Davey, (2024), 'Global State of Harm Reduction 2024 survey response'.

112 European Monitoring Centre for Drugs and Drug Addiction, (2022), *Prison and drugs in Europe: current and future challenges*, Publications Office of the European Union, Luxembourg.

113 Komalasari, R., S. Wilson and S. Haw, (2021), 'A systematic review of qualitative evidence on barriers to and facilitators of the implementation of opioid agonist treatment (OAT) programmes in prisons', *International Journal of Drug Policy,* vol. 87, e102978.

114 da Silva Petuco, D.R., (2024), 'Global State of Harm Reduction 2024 survey response, Brazil'; Morales, J., (2024), 'Global State of Harm Reduction 2024 survey response, Guatemala'.

115 del P Deheza, R., (2024), 'Global State of Harm Reduction 2024 survey response, Uruguay'; Touzé, G., (2024), 'Global State of Harm Reduction 2024 survey response, Argentina'; Encarnación, J.D.V., (2024), 'Global State of Harm Reduction 2024 survey response, Mexico'.

116 United Nations Office on Drugs and Crime, (2023), *World Drug Report 2023 - Executive Summary*, UNODC, Vienna.

117 Rotondo, H., (2024), 'Global State of Harm Reduction 2024 survey response, Peru'; López, J.A.Q., (2024), 'Global State of Harm Reduction 2024 survey response, Colombia'; da Silva Petuco, D.R., (2024), 'Global State of Harm Reduction 2024 survey response, Brazil'; Pasaran, S.S., (2024), 'Global State of Harm Reduction 2024 survey response, Mexico'; del P Deheza, R., (2024), 'Global State of Harm Reduction 2024 survey response, Uruguay'; Fernández, C.O., (2024), 'Global State of Harm Reduction 2024 survey response, Chile'; Ahumada, C., (2024), 'Global State of Harm Reduction 2024 survey response, Argentina'.

118 Trans European Drug Information, 'Drug checking' [web page, accessed August 2024], TEDI Network, EUDA, Lisbon. Available from www.tedinetwork.org/drug-checking.

119 Trans European Drug Information, (2023), *Drug Checking services as an answer to shifting drug markets,* TEDI Network, EUDA, Lisbon.

120 Jones, G., et al., (2024), *European Drug Checking Trends 2018-2023. Civil Society Monitoring of Harm Reduction in Europe 2023*, Trans European Drug Information, Correlation – European Harm Reduction Network, Amsterdam.

121 Magnolini, R., et al., (2023), 'Substances from unregulated drug markets – A retrospective data analysis of customer-provided samples from a decade of drug checking service in Zurich (Switzerland)', *International Journal of Drug Policy*, vol. 114, e103972.

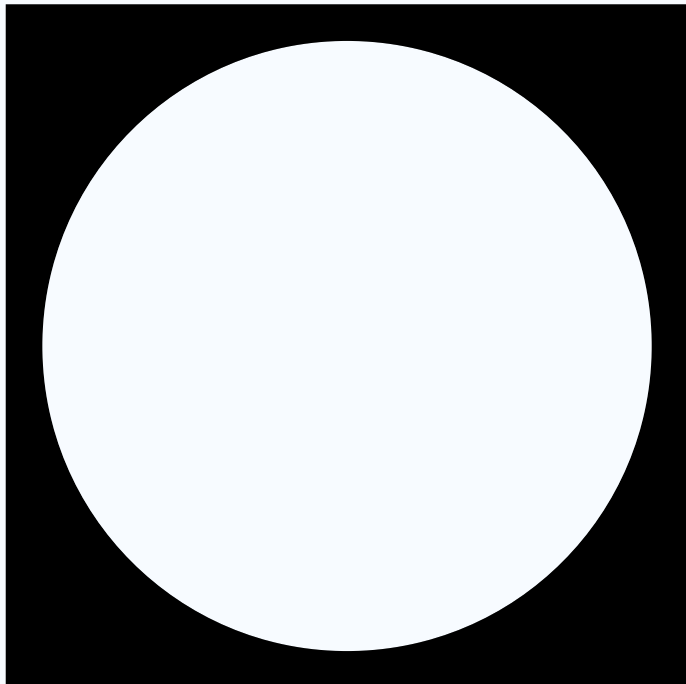
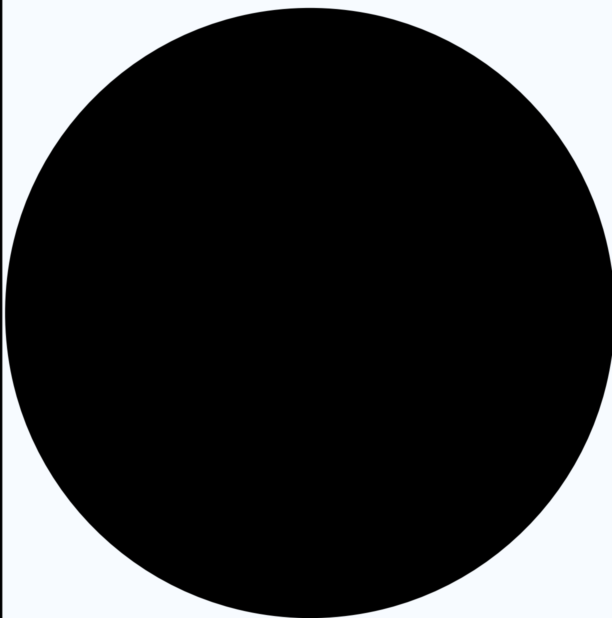
122 Stöver, H., (2022), *Regional analysis of the provision of drug checking services in the Central and Eastern Europe and Central Asia region*, Eurasian Harm Reduction Association, Vilnius; DrogArt, 'Promoting safer drug use and harm reduction in Slovenia' [web page, accessed August 2024]; DrogArt, Ljublijana, Solvenia. Available from www.drogart.org; Czech Drug Users' Union, 'Harm reduction and drug policy advocacy in the Czech Republic' [web page, accessed August 2024], CDUU, Prague. Available from https://czsub.cz; Kushakov, I. et al., 'The first study of psychoactive substance use and drug checking', [AIDS 2022 poster presentation], International AIDS Society, Geneva; Społeczna Inicjatywa Narkopolityki, 'Jesteśmy SIN' [web page, accessed August 2024], SIN, Warsaw. Available from https://sin.org.pl; Mandala, 'Nothing about us without us', [web page, accessed August 2024], Mandala, Tbilisi. Available from www.mndl.ge; Young Wave, 'What's wrong with you? Harm reduction of psychoactive substances', [web page, accessed August 2024], YW, Vilnius, Available from: https://youngwave.lt; Gogia, M., (2024), 'Global State of Harm Reduction 2024 survey response, Georgia'; Pešek, D., (2024), 'Global State of Harm Reduction 2024 survey response, Czechia'; Vlasenko, L. (2024), 'Global State of Harm Reduction 2024 survey response, Ukraine'; Jovovic, I., (2024), 'Global State of Harm Reduction 2024 survey response, Croatia'.

123 Harris, M., (2020), 'An urgent impetus for action: safe inhalation interventions to reduce COVID-19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom', *International Journal of Drug Policy*, vol. 83, e102829.

124 Reid, M.C., et al., (2023), 'High levels of interest in access to free safer smoking equipment to reduce injection frequency among people who inject drugs in Seattle, Washington', *Drug and Alcohol Dependence Reports*, vol. 7, e100163.

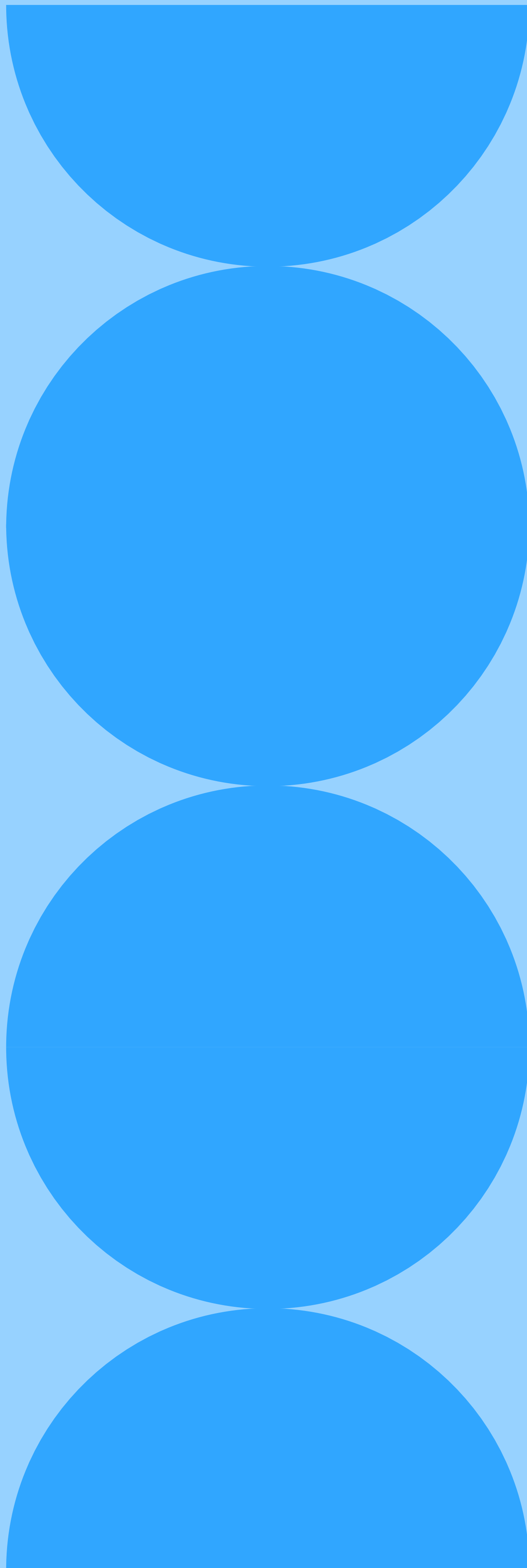
125 Rigoni, R., S. Woods and J.J. Breeksema, (2019), 'From opiates to methamphetamine: building new harm reduction responses in Jakarta, Indonesia', *Harm Reduction Journal,* vol. 16, no. 1, p.67.

126 Minařík, J., (2020), *Pharmacological Treatment of Methamphetamine Dependence with Central Stimulants*, Czech Medical Society of Jan Evangelista Purkyně, Prague.

THEMATIC CHAPTERS

THEMATIC CHAPTER: HEPATITIS



AUTHOR OF HEPATITIS THEMATIC CHAPTER: Robert Csák

Dr Robert Csák is a sociologist and researcher. His research has focused on the various aspects of harm reduction. He has worked in needle and syringe programmes, done community outreach, HIV and HCV testing and counselling for over 10 years. He has worked on the *Global State of Harm Reduction 2020 and 2022* and is the author of Harm Reduction International's report on Low Dead Space Syringes.

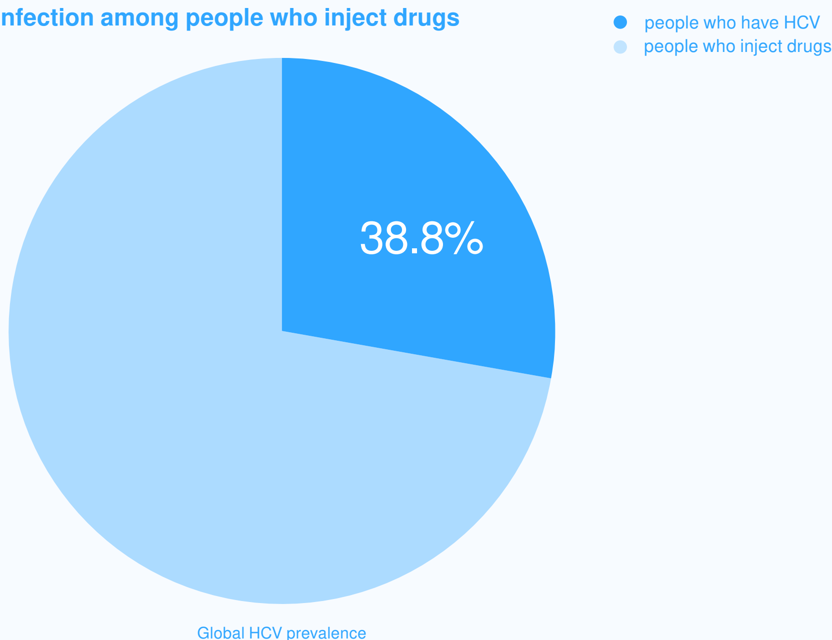
HEPATITIS

People who use drugs are at greater risk of acquiring hepatitis B and hepatitis C. This can be related to sharing drug use equipment as well as sexual activities. Harm reduction interventions are essential to the global commitment to eliminate hepatitis C by 2030.

ELIMINATION TARGETS OUT OF REACH

People who inject drugs are disproportionately affected by hepatitis C virus (HCV). According to the latest estimate published in *The Lancet* in 2023, the global prevalence of current HCV infection among people who inject drugs is 38.8%. This means that around 5.8 million people who inject drugs are living with HCV.[1] There are considerable regional differences in HCV prevalence among people who inject drugs. The highest prevalence[a] is in Eastern Europe where 48.4% of people who inject drugs have HCV (1.1 million), while the lowest is in the two regions of Eastern and Southern Africa and West and Central Africa where combined prevalence is 15.3% (192,000).[b 2,3] The largest number of people who inject drugs with HCV is found in East and Southeast Asia, where 1.5 million people are living with the virus (a prevalence of 40.1%).[4]

Global prevalence of HCV infection among people who inject drugs



Global HCV prevalence

a Prevalence rates in this chapter refer to current HCV infection rates among people who inject drugs, unless otherwise stated.
b HCV prevalence data was available for only 13 countries out of 47 in the two regions (Eastern and Southern Africa; West and Central Africa).

People who inject drugs sharing contaminated injecting equipment drives infections, contributing to an estimated 43.6% of new HCV infections globally.[5] A World Health Organization (WHO) analysis indicates that 10 countries account for nearly 80% of all global HCV infections among people who inject drugs, with the most infections occurring in the USA, followed by, China, Russian Federation, India, Ukraine, Italy, Vietnam, Kazakhstan, Japan and Pakistan.[6]

Most countries are off course to reach WHO viral hepatitis elimination targets.[7,8] Only 14 countries are on track to reach these goals (Australia, Austria, Canada, Denmark, Egypt, Spain, Finland, France, United Kingdom, Iceland, Malta, Norway, Rwanda, Saudi Arabia), most of which are high-income countries.[9]

Viral hepatitis is still one of the leading causes of infectious disease deaths worldwide. This is despite effective hepatitis B virus (HBV) vaccines having been available for more than four decades. And it is despite chronic HCV being a curable health condition due to the availability of tolerable (interferon free) direct-acting antiviral therapies, with cure rates above 95%, and the costs of diagnosis and treatment continuing to fall.[10] Globally, 90% of HBV infections remain undiagnosed, and 98% of HBV infections have not been treated.[11,12]

The situation is marginally better for HCV but still dire: 79% of infections remain undiagnosed, and 87% of infections have not been treated.[13,14] One of the main reasons for this lack of progress is that HCV disproportionately affects marginalised populations, people who inject drugs and people who are in prison and other closed settings, and HCV prevention, treatment and harm reduction among people who inject drugs is not implemented at scale.[15,16,17]

According to the latest available data, which covers 61% of people who inject drugs worldwide, fewer than half (47%) have ever tested for HCV.[18] In most countries with available data, fewer than 25% of people who inject drugs living with HCV receive treatment.[19]

People who inject drugs are often neglected in HBV prevention efforts even though drug use is included in international guidelines as a risk factor for HBV. This has been the case since at least 2012, when it was included in WHO's guidelines on viral hepatitis and position paper on HBV vaccination.[20,21,22]

The persistent stigmatisation of people who use drugs, and the criminalisation of drug use, creates and maintains barriers that prevent people who use drugs from accessing services, leaving them behind in efforts to eliminate hepatitis.[23,24,25] At least seven countries (Bosnia and Herzegovina, Brunei, Croatia, Guyana, Libya, North Macedonia, Uruguay)[c] require people to abstain from drug use in order to receive HCV treatment, despite there being no evidence to support this approach.[26]

HCV elimination targets cannot be achieved without implementing harm reduction programmes.

The WHO has developed indicators to help countries monitor and assess their progress toward eliminating viral hepatitis. Indicators relating to needle and syringe programmes (NSP) and opioid agonist therapy (OAT) were included as core indicators.[d] This means data on these indicators should be feasible

c There is no data on HCV treatment restrictions in Albania, Bolivia, China and the Philippines, so no conclusions can be made on whether these countries use abstinence as a perquisite for treatment.
d NSP-related indicator: number of needles and syringes distributed per person who injects drugs per year. OAT-related indicator: coverage of opioid agonist therapy among people who inject drugs.

to collect, monitor and track in most contexts.[27] This adds to the long line of international guidelines and recommendations that consistently include harm reduction services among the interventions that are crucial to prevent the spread of blood-borne viruses and reach global viral hepatitis and HIV targets.[28,29,30] The global targets for viral hepatitis elimination include an indicator for people who inject drugs. This sets a 2025 target for reducing annual new HCV infections among people who inject drugs to 3 per 100 persons and 2 per 100 persons by 2030.[31] It is clear that the public health steps needed to reach these goals involves embracing harm reduction and community-based services. The WHO explicitly recommends integrating HCV testing and treatment into harm reduction services.[32,33]

Box 1: Harm reduction-related global viral hepatitis target indicators [128]

Indicator	Target	Calculation	
Coverage of NSP at population level	At least 300 syringes and needles distributed per person who injects drugs per year	Number of sterile needles and syringes distributed in the past 12 months by NSPs (data can include the number of needles/syringes sold to people who inject drugs by pharmacies or other outlets in the reporting period)	**Divided by** population-size estimate of people who inject drugs in relevant geographical area at country level
Coverage of OAT among people who inject drugs	At least 40% of people who inject drugs receive opioid agonist therapy	Estimated number of people who inject drugs who are receiving OAT in the reporting year or the latest year with available data	**Divided by** Estimated number of opioid-dependent people who inject drugs in the country in the reporting year or the latest year with available data

“The persistent stigmatisation of people who use drugs, and the criminalisation of drug use, creates and maintains barriers that prevent people who use drugs from accessing services, leaving them behind in efforts to eliminate hepatitis.”

To eliminate HCV, enhanced models of care for people who inject drugs are needed. HCV care must address the unique barriers that people who inject drugs face when trying to access HCV care at the individual, provider and systems level. A recent systematic review found that

integrating HCV care into services already being accessed by people who inject drugs, plus peer support, on-site HCV rapid tests and providing 'patient navigators' improves linkage to care.[34]

A patient navigator is a person who supports individuals receiving healthcare by identifying the barriers they face and providing extra support as needed. This is especially important, given the substantial stigma, discrimination and inhumane treatment people who use drugs can experience in healthcare settings. The study also found that integrated care, motivational interviewing and on-site HCV rapid tests increased HCV treatment initiation.[35]

To effectively address the barriers to care that people who use drugs face, combined and varied interventions are needed. This can include patient education to improve people who use drugs' understanding of HCV and HCV treatment, patient navigation, peer support and testing/treatment reminders.[36] Harm reduction organisations are equipped to implement these services, and many already do; some despite unfavourable national policy environments.

To substantially increase access to testing and treatment for viral hepatitis (and HIV and sexually transmitted infections), stigma and discrimination in healthcare settings needs to significantly decrease so that everyone can access the services they need. An inclusive, non-discriminatory and supportive environment for these services is one of the key actions the WHO recommends to advance a public health approach and reach elimination goals, especially in low- and middle-income countries.[37] Harm reduction services, especially community-based and community-led ones, provide exactly that. Most recent guidelines and strategies strongly recommend decentralising the delivery of care and treatment to enable more people from key populations[e] to access services and to increase community engagement in relation to advocacy and service delivery.[38] This makes harm reduction programmes an obvious choice. To achieve this, governments need to do more to partner with harm reduction organisations to give them a greater role in reaching public health goals, accompanied by adequate funding.

e 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.

HEPATITIS BY REGION[c]

c The below subsections are based on the regions used by the *Global State of Harm Reduction* which are different from other regional systems (for example UN regions); cited articles and reports might used.

Asia

The latest data estimates HCV prevalence to be between 34-40% (40.1% in East and Southeast Asia, 34.5% in South Asia). HBV prevalence is estimated to be between 6.6-16.1% (16.1% in East and Southeast Asia, 6.6% in South Asia). This suggests HCV prevalence is increasing since the last estimate in 2017.[39] Indonesia has the highest HCV prevalence at 67%; this equates to a significant number of people as an estimated 200,000 people inject drugs in the country.[40,41] However, the highest absolute number of people who inject drugs who have HCV in the region can be found in China. There, 2.5 million people inject drugs and HCV prevalence among this population is estimated to be 35.8%.[42] The proportion of people living with viral hepatitis in China who have been diagnosed has risen; between 2016 and 2022, it increased from 19% to 24% for HBV and from 22% to 33% for HCV.[43] Although this progress is encouraging, integrating HCV testing and treatment into harm reduction programmes and substantially increasing harm reduction programme coverage among people who inject drugs are crucial steps that need to be taken to reach WHO elimination goals.[44]

The region is far from reaching HCV testing and treatment elimination targets. By 2025, the regional goal is for 60% of people with HCV to be diagnosed and 50% of people diagnosed to have received treatment.[45] Currently, it is estimated that 26.8% of people who inject drugs in East and Southeast Asia have ever tested for HCV, and only 5% of people who inject drugs in South Asia have tested.[46] Testing rates vary substantially between countries, from 4.3% of people who inject drugs in Indonesia having ever tested for HCV compared to 57.3% in Malaysia. Asia has the lowest proportion of people who inject drugs who have ever received HCV treatment of any region in the world (1.9% in East and Southeast Asia, 2% in South Asia; no data is available from Central Asia).[47] Linked to its relative success with HCV testing, Malaysia has the highest proportion of people who inject drugs receiving HCV treatment in the region at 35.7%.[48.]

In Indonesia, scaling up HCV screening for people at increased risk of HIV, such as people who inject drugs and sex workers, and decentralising hepatitis services are major challenges that are hindering progress on eliminating hepatitis.[49] To improve hepatitis services in the country, the Ministry of Health has collaborated with a local NGO to prepare a national guideline on community-led monitoring of HBV and HCV services and plans for it to be included in the budget of the *National Action Plan for Viral Hepatitis 2025-2029*.[50,51,52]

In India, the country with the second biggest HCV epidemic in the world, the data gap is significant and is a major barrier to progress towards hepatitis elimination.[53] HCV prevalence estimates among people who inject drugs are not available in the majority of Indian states.[54,55] The coverage of harm reduction services is inadequate; NSP is only available in some states, while in most states OAT services reach fewer than 10% of people who inject drugs, and in the southern states coverage falls below 2%.[56,57] In Manipur, India a community-led organisation run by and for people who inject drugs, which provides HCV screening, diagnosis and treatment, implemented a same day test and treat programme. This enabled people who inject drugs to receive HCV screening, RNA testing, complete laboratory evaluation and to start antiviral treatment on the same day. HBV vaccination was also provided for those who were eligible. This programme shows that community-led, comprehensive viral hepatitis care is feasible to implement in resource-constrained settings and that it works. This non-stigmatizing, streamlined care was delivered within a supportive healthcare system and social environment and improved the treatment cascade for people who inject drugs, from HCV diagnosis to treatment.[58]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Bangladesh	33.2	7
Bhutan	nd	nd
Brunei Darussalam	nd	nd
Cambodia	30.4	nd
China	71.6	19.6
Hong Kong	nd	nd
India	44.71	19.2
Indonesia	89.2	nd
Japan	36.4	8.6
Laos	nd	nd
Macau	39	12
Malaysia	55.2	2.9
Maldives	nd	nd
Mongolia	nd	nd
Myanmar	56	7.7
Nepal	13.3	0.8
North Korea	nd	nd
Philippines	35.2	7.12
Singapore	47	nd
South Korea	39.7	4
Sri Lanka	6.2	0.1
Taiwan	93.1	20.8
Thailand	42.2	3.5
Vietnam	72.51	17.07

Eastern and Southern Africa; West and Central Africa

Although the 2023 *Lancet* review covered more countries in Eastern and Southern Africa and West and Central Africa than previous reviews, the data gap is still substantial. Out of the 47 countries included from the two regions, data on HCV prevalence among people who inject drugs is only available from 13 countries while HBV prevalence data is available from 10.[59] The latest estimate on HCV prevalence among people who inject drugs across both regions is 15.3%, indicating no substantial change since 2017 when prevalence was 16.3%. HBV prevalence across both regions is 6.9%.[60,61] Out of the countries with available data, Mauritius has the highest HCV prevalence among people who inject drugs at 67.5%.[62]

Across both regions, only 6.1% of people who inject drugs are estimated to have ever tested for HCV, but again the evidence is limited as this is only based on data from six countries (Burundi, Ethiopia, Ghana, Mauritius, Uganda and Tanzania).[63] The lack of data means the proportion of people who inject drugs who have received HCV treatment is unknown, something that seriously undermines efforts to assess progress towards HCV elimination. Comprehensive data on HCV testing and linkage to care among people who inject drugs is urgently needed so that strategies and interventions to enhance these vital services can be developed and evaluated.[64]

The consequences of data gaps and inadequate implementation of viral hepatitis-related services in the region is clearly demonstrated in Zimbabwe. The *Zimbabwe National Drug Master Plan (2020-2025)* includes harm reduction, but national laws and regulations are strongly punitive and harm reduction services for people who use drugs are unavailable in the country.[65,66,67] Research in Zimbabwe among people who use drugs found that 90% of study participants did not know what HCV is, and only half of those who were aware of HCV could identify transmission routes.[68,69]

The Egyptian government supports elimination efforts in the region. For example, in Ghana, testing and treatment for viral hepatitis have historically been very low due to the high service costs and limited access to treatment. But after receiving HCV treatment drugs from Egypt, the Ghanian government launched the STOP Hep C Ghana Project, which offers HCV treatment for free across the country at all levels of care and has reached 50,000 people.[70,71] But this does not mean the initiative has reached people who inject drugs as the proportion of people who inject drugs ever tested for HCV is estimated to be between 0.0-1.7%. This low testing rate is likely to be linked to extremely limited harm reduction programmes in Ghana, which means there are no community-based HCV testing and treatment services for people who use drugs.[72,73,74]

In South Africa, a non-profit primary healthcare facility has designed and evaluated a decentralised, simplified, complete point-of-service model to screen and link people who inject drugs to HIV and HCV care.[75] The programme provided harm reduction services (including OAT and harm reduction packs) alongside adherence support in the form of directly observed HCV therapy and peer support. Weekly financial allowances were offered to people receiving the service to reimburse transport costs and their time. Out of the 67% of people who tested

HCV-antibody positive, 81% were assessed as eligible for therapy, and 93% of those eligible initiated it.[76] This programme shows that a decentralised, person-centered harm reduction strategy can bridge gaps in treatment access for people who use drugs.[77] However, to ensure the effectiveness of such interventions, community- and peer-led outreach campaigns, with collaborative treatment support and referrals, are needed alongside sustained, unrestricted access to harm reduction services, such as OAT, to decrease the risk of reinfection.[78]

Eastern and Southern Africa

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Angola	nd	nd
Botswana	nd	nd
Comoros	nd	nd
Eritrea	nd	nd
Eswatini	nd	nd
Ethiopia	3.4	5.1
Kenya	20	3.9
Lesotho	nd	nd
Madagascar	5.6	5.3
Malawi	nd	nd
Mauritius	90	3.5
Mozambique	43.6	24.2
Namibia	nd	nd
Rwanda	nd	nd
Seychelles	79.1	0.3
South Africa	55	5
South Sudan	nd	nd
Uganda	2	8.4
United Republic of Tanzania	23.1	6.9
Zambia	nd	3.2
Zimbabwe	nd	nd

West and Central Africa

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Benin	nd	nd
Burkina Faso	nd	nd
Burundi	5.5	9.4
Cameroon	nd	nd
Cape Verde	nd	nd
Central African Republic	nd	nd
Chad	nd	nd
Congo	nd	nd
Côte d'Ivoire	1.8	10.5
Democratic Republic of the Congo	nd	nd
Equatorial Guinea	nd	nd
Gabon	nd	nd
Gambia	nd	nd
Ghana	2.3	nd
Guinea	nd	nd
Guinea-Bissau	nd	nd
Liberia	nd	nd
Mali	nd	nd
Mauritania	nd	nd
Niger	nd	nd
Nigeria	5.8	6.7
Sao Tome and Principe	nd	nd
Senegal	39.3	nd
Sierra Leone	nd	nd
Togo	nd	nd

Eurasia

Viral hepatitis prevalence among people who inject drugs remains steady in the region. It is estimated at 49.1% in Eastern Europe (48.6% in 2017) and 39.3% in Central Asia (40.5% in 2017).[79,80] HBV prevalence among people who inject drugs is 7.5% in Eastern Europe (7.9% in 2017) and 8.1% in Central Asia (9.3% in 2017). Romania has the highest HCV prevalence rate at 62.9%, although Russia has the largest number of people who inject drugs who are living with HCV (a 53.2% HCV prevalence rate among 1.3 million people who inject drugs).[81]

Data on the proportion of people who inject drugs who have ever tested for HCV is scarce in Central Asia. Data is only available in Tajikistan which reports a testing rate of 4%.[82] In Eastern Europe, the rate is 71.2%, the fourth largest across the WHO regions.[83] In Eastern Europe, there are considerable differences between countries. Two countries, Estonia and Lithuania, have reached HCV testing coverage of 90%, but in Romania only 38.2% of people who inject drugs have ever tested for HCV.[84] Treatment coverage among people who inject drugs who are living with HCV is estimated to be 21.3% in Eastern Europe, although this data only covers three countries (27.1% in Estonia, 24.8% in Georgia, 19.8% in Ukraine), amounting to 18% of people who inject drugs in Eastern Europe.[85] No data is available from Central Asia on the proportion of people who inject drugs who have received HCV treatment.

Russia has the 10th largest HCV epidemic in the world, and faces serious barriers to elimination. Although the government has approved a national action plan for eliminating HCV , the cost of treatment is prohibitively high (especially for marginalised populations like people who inject drugs), and this is restricting HCV treatment uptake.[86] Insufficient public awareness of the problem is another important barrier to reaching elimination goals.[87]

Ukraine is among the 20 countries in the world with the largest HCV epidemics. National hepatitis guidelines were updated in 2020, highlighting the importance of scale-up and decentralised care, and the number of treatment centres increased substantially resulting in HCV treatment demands being met for the first time. However, the ongoing war, which escalated in 2022, derailed elimination efforts. According to a recent report on HCV elimination, insufficient hepatitis care and imperfect epidemiological data are major barriers to Ukraine reaching elimination goals.[88]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Albania	56	18
Armenia	49.2	nd
Azerbaijan	59.3	7.9
Belarus	59	9.6
Bosnia and Herzegovina	30.8	2.5
Bulgaria	78.3	5.9
Croatia	30.7	3.1
Czechia	37.7	0
Estonia	73	5
Georgia	32.1	2.5
Hungary	35.9	1
Kazakhstan	58.6	8.3
Kosovo	23.8	5
Kyrgyzstan	64.5	11.3
Latvia	51.3	0.4
Lithuania	85.9	4.9
Moldova	42.7	5.4
Montenegro	62.8	1.4
North Macedonia	65.4	5.6
Poland	57.9	2.9
Romania	72.7	3.2
Russia	72.5	nd
Serbia	61.4	10.5
Slovakia	32.5	6.3
Slovenia	25	4.2
Tajikistan	61.3	2
Turkmenistan	nd	nd
Ukraine	67	46.7
Uzbekistan	20.9	5.1

Latin America and the Caribbean

HCV prevalence among people who inject drugs is estimated to be 43.7% in Latin America and 43.6% in the Caribbean. HBV prevalence among people who inject drugs is estimated to be 2.6% in Latin America; data is insufficient to calculate HBV prevalence in the Caribbean. Country-level HCV prevalence in the Caribbean is only available for Puerto Rico (58.7%).[89] In Latin America, Mexico is estimated to have the highest HCV prevalence among people who inject drugs not only in the region but in the world, at 71.6%.[90]

A recent systematic review in the region revealed significant gaps in data. HCV testing data is only available from Costa Rica, where 73% of people who inject drugs have ever tested for HCV.[91]

Although HBV and HCV treatment is free in Brazil, the number of people receiving direct-acting antiviral (DAA) treatment decreased during the COVID-19 pandemic (from 48,304 in 2019 to 19,496 in 2020). This has led to a fall in HCV diagnoses and referrals, endangering Brazil's plan to eliminate HCV by 2030.[92,93]

A recent study on the HCV care cascade among people who inject drugs in Puerto Rico revealed substantial barriers that are hindering access to testing and treatment, despite HCV treatment being available and free.[94,95] Common barriers reported among people who inject drugs include having a limited awareness of testing and treatment services, access issues such as a lack of transport to facilities, abstinence requirements to receive treatment, and stigma and discrimination (e.g., feeling unwelcome at medical facilities, fear of revealing HCV status).[96]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Antigua and Barbuda	nd	nd
Argentina	nd	nd
Bahamas	nd	nd
Barbados	nd	nd
Belize	nd	nd
Bolivia	nd	nd
Brazil	48.6	nd
Chile	nd	nd
Colombia	30.5	nd
Costa Rica	nd	nd
Cuba	nd	nd
Dominica	nd	nd
Domincan Republic	nd	nd
Ecuador	nd	nd
El Salvador	nd	nd
Grenada	nd	nd
Guatemala	nd	nd
Guyana	nd	nd
Haiti	nd	nd
Honduras	nd	nd
Jamaica	nd	nd
Mexico	nd	nd
Nicaragua	nd	nd
Panama	nd	nd
Paraguay	nd	nd
Peru	nd	nd
Puerto Rico	78.4	nd
Saint Kitts and Nevis	nd	nd
Saint Lucia	nd	nd
Saint Vincent and the Grenadines	nd	nd
Suriname	nd	nd
Trinidad and Tobago	nd	nd
Uruguay	nd	nd
Venezuela	nd	nd

Middle East and North Africa

HCV prevalence among people who inject drugs in the Middle East and North Africa (MENA) is estimated to be 30.5% and HBV prevalence is estimated at 7.5%.[97,98] HCV prevalence has decreased in the region since 2017 when it was 36.1%, which may be due to Egypt's elimination efforts.[99]

Similar to the situation in West and Central and Eastern and Southern Africa, the region has a significant data gap. Data on the proportion of people who inject drugs who have ever tested for HCV is only available in Morocco, where 52.1% have ever been tested.[100] The proportion of people who inject drugs in the region who have ever received HCV treatment is estimated to be 26.4%, but this is based on data from only two countries (Morocco and Türkiye).[101]

Egypt shows what can be achieved in a lower-middle-income country when a large-scale screening and treatment programme is implemented. Here, it is estimated that 96% of people living with HCV are diagnosed.[102]

However, criminalisation of drug use and insufficient access to harm reduction services like NSP still act as major barriers to reducing the burden of viral hepatitis in Egypt.[103]

HCV incidence is rising in Pakistan, which is home to 10% of people living with HCV.[104] It is estimated that a third of new HCV infections globally occur in the country.[105] The Pakistani government provides free hepatitis testing and treatment for people who use drugs and for those who cannot afford to pay for these services. Home delivery of medication is also available to ensure access to treatment.[106]

Nai Zindagi is a non-governmental organisation (NGO) which provides community-based services across 63 districts in Pakistan, serving 6,500-7,000 people who inject drugs daily.[107] In July 2023, the NGO began offering HCV screening and referrals through its established HIV services. This means Nai Zindagi is now able to offer HCV screening in all districts and HCV treatment services in 11 high-prevalence districts.[108] Nai Zindagi is now working on scaling up these services. Increasing services for marginalised populations is vital for the country, and people who inject drugs are highlighted as an especially important key population in HCV elimination progress reports.[109,110]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Afghanistan	23.08	2.77
Algeria	nd	nd
Bahrain	3.89	nd
Djibouti	nd	nd
Egypt	nd	nd
Iraq	nd	nd
Iran	36.8	3.04
Israel	nd	nd
Jordan	nd	nd
Kuwait	30.87	1.52
Lebanon	23.59	1.07
Libya	94.2	4.5
Morocco	63.13	nd
Oman	36.56	6.29
Pakistan	51.32	2.66
Palestine	41.48	6.15
Qatar	nd	nd
Saudi Arabia	62.61	7.7
Somalia	nd	nd
Sudan	nd	nd
Syria	3.3	0.5
Tunisia	28.32	4.3
United Arab Emirates	nd	nd
Yemen	nd	nd

North America

In Canada, estimated HCV prevalence among people who inject drugs is 20.6%, and HBV prevalence is 0%. In the USA, HCV prevalence among people who inject drugs is 43.7% and HBV prevalence is 4.8%. As the USA has the highest rate of injecting drug use in the world (1.5% of the general population or 3.1 million people), the country has the highest number of people who inject drugs living with HCV globally.[111,112] While HIV prevalence among people who inject drugs decreased in the region since the 2017 estimate (from 9% to 5.9%), HCV prevalence has increased, mostly due to increased opioid use in the USA.

HCV testing and treatment among people who inject drugs has been estimated based on combined data from Canada and the USA. Across the region, 77.2% of people who inject drugs are estimated to have ever tested for HCV, and 31.1% of those living with HCV have received treatment.

In the USA, acute HCV infection increased by 97% between 2015 and 2020, largely driven by increased opioid use.[113,114] The current administration has put forward a five-year programme to put the country on course to eliminate HCV. The proposal focuses on on-site quick tests, affordable treatment and comprehensive public health outreach. There are examples of HCV services integrated into harm reduction services. For example, all NSPs in Florida offer rapid HIV and HCV testing and treatment navigation, and there are NSPs and OAT clinics offering HCV treatment.[115,116] Serious barriers to treatment access persist. There are reports of people who use drugs, especially people who inject drugs, being denied HCV treatment. Typical restrictions on access to HCV treatment are abstinence requirements and concerns about reinfections.[117] Greater focus on reaching people who inject drugs and increasing access to harm reduction services is vital to reach WHO elimination targets.[118]

In the USA, national recommendations for HBV screening and testing were recently updated and now explicitly include injecting drug use as a risk factor. The Centers for Disease Control and Prevention now recommends HBV screening for all adults once in their lifetime and HBV vaccination for all adults aged 19-59 years. The recommendation also states that testing should be provided regardless of whether people disclose their risk level due to the understanding that many people might be reluctant to disclose risks that are stigmatised.[119]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Canada	64.2	nd
United States of America	53.5	4.8

Oceania

There are no recent estimates on HCV prevalence for Pacific Island countries and states. In the rest of the region, HCV prevalence among people who inject drugs is estimated to be 24.4% (17.8% in Australia, 53% in Aotearoa New Zealand), which is a considerable reduction since 2017, when it was 42.8%.[120,121] HBV prevalence is available for both parts of the region. It is estimated to be 8.5% among people who inject drugs in Pacific Island countries, 2.2% in Australia and 2.8% in Aotearoa New Zealand.[122]

Data on testing and treatment among people who inject drugs is not available in Pacific Island countries and states. However, the region has the highest HCV testing rate among people who inject drugs in the world at 86.3% (87.8% in Australia and 79.4% in Aotearoa New Zealand). Data on treatment among people who inject drugs living with HCV is only available in Australia, where 66.9% have received treatment. This is one of the highest rates in the world, second only to Spain.[123]

In Australia, the Surveillance and Treatment of Prisoners with hepatitis C (SToP-C) study implemented HCV treatment-as-prevention in four prisons in New South Wales.[f] Altogether, 3,691 people were enrolled in the programme and were at high risk regarding HCV infection: among those reporting recent injecting, 91% reported sharing injecting equipment while in prison.[124] The study demonstrates the effectiveness of HCV treatment-as-prevention in prisons and other closed settings as HCV incidence significantly reduced after DAA therapy was scaled up. The greatest reduction in HCV infections was among people who inject drugs, where HCV incidence more than halved (from 39 per 100 person-years to 14 per 100 person-years).[g][125] These findings provide important evidence to support increased HCV treatment access and coverage, including unrestricted access to DAA treatment, to improve elimination efforts in prisons and other closed settings and in the broader community.[126,127]

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Aotearoa New Zealand	53	2.8
Australia	32	2.2
Federated States of Micronesia	nd	nd
Fiji	nd	nd
Kiribati	nd	nd
Marshall Islands	nd	nd
Nauru	nd	nd
Palau	nd	nd
Papua New Guinea	nd	nd
Samoa	nd	nd
Solomon Islands	nd	nd
Timor Leste	nd	nd
Tonga	nd	nd
Tuvalu	nd	nd
Vanuatu	nd	nd

f Treatment-as-prevention is a method where treatment is used as a tool for limiting the spread of an infection.
g A person-year is a unit calculated by multiplying the number of people in a study by the time each person spends in the study.

Western Europe

In Western Europe, HCV prevalence among people who inject drugs is estimated to be 38.2% and has remained steady since 2017 (39.9%). HBV prevalence is estimated to be 2.7% (3.2% in 2017).[129] Greece has the highest HCV prevalence in the region (67.2%), while Italy has the highest number of people who inject drugs living with HCV (a 39.6% HCV prevalence rate among 320,500 people who inject drugs). [130]

In Europe, the latest estimate suggests 81.6% of people who inject drugs have ever tested for HCV. Out of the 15 countries with available HCV testing data, only 4 countries had a testing level below 70% (62.5% in Belgium, 66.2% in Ireland, 43.9% in Montenegro and 53.3% in Switzerland). Despite the high coverage of HCV testing in the region, only a quarter (25.6%) of people who inject drugs living with HCV received treatment.[131]

In Ireland, free HCV self-testing kits have been available since 2023. More than 5,500 home tests have been ordered since the start of the programme, indicating the feasibility of this new decentralized approach to HCV testing. The test requires someone to carry out a finger prick blood test, and then post the sample in a pre-paid envelope to a lab for analysis.[132] Although self-testing is a convenient solution for some, it may not be appropriate for others, such as people experiencing homelessness. In-person integrated testing services can deliver counselling, treatment referrals and accompaniment to other health services. These additional services can be crucial for people who inject drugs to decrease the barriers they face to accessing treatment, particularly those linked to stigma and discrimination and negative past experiences.

Country	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)
Andorra	nd	nd
Austria	16.7	4.4
Belgium	48.8	2
Cyprus	42.4	4.7
Denmark	65.6	1.3
Finland	73.7	nd
France	41.7	0.8
Germany	62.9	0.9
Greece	53.7- 69.6	2.1
Iceland	10	nd
Ireland	77.2	nd
Italy	63.8	nd
Liechtenstein	nd	nd
Luxembourg	71.1	nd
Malta	43.8	0
Monaco	nd	nd
Netherlands	61	0
Norway	38.8	1.5
Portugal	71.9	5.7
San Marino	nd	nd
Spain	45.9	5.3
Sweden	65.2	1.5
Switzerland	74.6	nd
Türkiye	37.5	3.9
United Kingdom	57	5.9

1 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
2 Ibid.
3 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
4 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
5 World Health Organization, (2024), *Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva.
6 Ibid.
7 Cui, F., et al., (2023), 'Global reporting of progress towards elimination of hepatitis B and hepatitis C', *The Lancet Gastroenterology* and *Hepatology*, vol. 8, no. 4, p.332–42.
8 Rockstroh, J., (2023), 'The path to hepatitis C elimination: who are we leaving behind and why?', *Journal of the International AIDS Society*, vol. 26, no, 7, e26136.
9 The CDA Foundation, 'Countries/Territories Achieving Relative or Absolute Impact and Programmatic Targets - HCV' [web page, accessed September 2024], CDA Lafayette, Colorado. Available from https://cdafound.org/polaris-countries-maps.
10 World Health Organization, (2024) *Implementing the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, 2022–2030: report on progress and gaps 2024, second edition*, WHO, Geneva.
11 World Health Organization, (2024), *Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva.
12 Cui, F., et al., (2023), 'Global reporting of progress towards elimination of hepatitis B and hepatitis C', *The Lancet Gastroenterology and Hepatology*, vol. 8, no. 4, p.332–42.
13 World Health Organization, (2024), *Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva.
14 Cui, F., et al., (2023), 'Global reporting of progress towards elimination of hepatitis B and hepatitis C', *The Lancet Gastroenterology and Hepatology*, vol. 8, no. 4, p.332–42.
15 World Health Organization, (2024), *Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva, 2024
16 Cui, F., et al., (2023), 'Global reporting of progress towards elimination of hepatitis B and hepatitis C', *The Lancet Gastroenterology* and *Hepatology*, vol. 8, no. 4, p.332–42.
17 Rockstroh, J., (2023), 'The path to hepatitis C elimination: who are we leaving behind and why?', *Journal of the International AIDS Society*, vol. 26, no, 7, e26136.
18 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
19 Ibid.
20 Khwairakpam, G., (2024) 'Global State of Harm Reduction 2024, amfAR reviewer response'.
21 World Health Organization, (2019), 'Hepatitis B vaccines: WHO position paper, July 2017 - Recommendations', *Vaccine*, vol. 37, no. 2, p.223–5.
22 World Health Organization, (2012), *Guidance on prevention of viral hepatitis B and C among people who inject drugs*, WHO, Geneva.
23 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
24 Rockstroh, J., (2023), 'The path to hepatitis C elimination: who are we leaving behind and why?', *Journal of the International AIDS Society*, vol. 26, no, 7, e26136.
25 Harris, M. and T. Rhodes, (2013), 'Hepatitis C treatment access and uptake for people who inject drugs: a review mapping the role of social factors', *Harm Reduction Journal*, vol. 10, no. 1, p.7.
26 Marshall A., et al., (2024), 'Direct-acting antiviral therapies for hepatitis C infection: global registration, reimbursement, and restrictions', *The Lancet Gastroenterology and Hepatology*, vol. 9. no. 4, p.366–82.
27 World Health Organization, (2024), *Consolidated guidelines on person-centred viral hepatitis strategic information*, WHO, Geneva.
28 Ibid.
29 UNAIDS, (2023), *The path that ends AIDS: UNAIDS Global AIDS Update 2023,* UNAIDS, Geneva.
30 World Health Organization, (2022), *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*, WHO, Geneva.
31 World Health Organization, (2022), *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030*, WHO, Geneva.
32 World Health Organization, (2024), *Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva, 2024.
33 World Health Organization, (2022), *Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030*, WHO, Geneva.
34 Cunningham, E., et al., (2023), 'Interventions to enhance testing and linkage to treatment for hepatitis C infection for people who inject drugs: A systematic review and meta-analysis', *International Journal of Drug Policy*, vol. 111, e103917.
35 Ibid.
36 Ibid.
37 World Health Organization, (2024),*Global hepatitis report 2024: action for access in low- and middle-income countries*, WHO, Geneva, 2024.
38 Ibid.
39 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
40 Ibid.
41 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
42 Ibid.
43 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
44 Fang, K., et al., (2023), 'Modeling the Impacts of Prevention and Treatment Interventions on Hepatitis C Among People Who Inject Drugs in China', *Infectious Disease Therapy*, vol. 12, no. 4. p.1043–55.
45 World Health Organization, (2023), *Guidance for country validation of viral hepatitis elimination and path to elimination: technical report,* WHO, Geneva.
46 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
47 Ibid.
48 Ibid.
49 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
50 Za, MT., (2024), 'Global State of Harm Reduction 2024 survey response, Indonesia'.
51 Yayasan Peduli Hati Bangsa, (22 April 2024), 'Pedoman pelaksanaan Community-led monitoring (CLM) layanan hepatitis B dan C di Indonesia' [web article, accessed August 2024], Yayasan Peduli Hati Bangsa, Jakarta. Available from https://pedulihatibangsa.id/2024/04/22/pedoman-pelaksanaan-community-led-monitoring-clm-layanan-hepatitis-b-dan-c-di-indonesia-2.
52 The Foundation for AIDS Research, (1 July 2024), 'Improving Viral Hepatitis Care in Indonesia' [web page, accessed September 2024], amfAR, New York. Available from www.amfar.org/news/improving-viral-hepatitis-care-in-indonesia/.
53 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
54 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
55 Shukla, L., P. Shivaprakash and M. Kumar, (2023), 'HIV, hepatitis B & C in people who inject drugs in India: A systematic review of regional heterogeneity & overview of opioid substitution treatment', *Indian Journal of Medical Research*, vol. 158, no. 5 and 6, p.522.
56 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
57 Shukla, L., P. Shivaprakash and M. Kumar, (2023), 'HIV, hepatitis B & C in people who inject drugs in India: A systematic review of regional heterogeneity & overview of opioid substitution treatment', *Indian Journal of Medical Research*, vol. 158, no. 5 and 6, p.522.
58 Rajkumar, N., et al., (2024), 'Decentralised same day test and treatment of hepatitis C levering existing peer support networks among men who inject drugs: feasibility and effectiveness', *Harm Reduction Journal*, vol. 21, no. 1, p.98.
59 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
60 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
61 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
62 Ibid.
63 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level

coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
64 Ibid.
65 Nyamucherera, O. and R. Rigoni, (2022), *Zimbabwe situational analysis of drug use in five provinces to inform HIV and TB programming for people who use drugs. Final Report*, Mainline, Amsterdam.
66 Wilson, (2024), 'Global State of Harm Reduction 2024 survey response, Zimbabwe'.
67 Dheka, VC., (2024), 'Global State of Harm Reduction 2024 survey response, Zimbabwe'.
68 Wilson, (2024), 'Global State of Harm Reduction 2024 survey response, Zimbabwe'.
69 Dheka, VC., (2024), 'Global State of Harm Reduction 2024 survey response, Zimbabwe'.
70 Coalition for Global Hepatitis Elimination, 'Ghana HEAT Project' [web page, accessed August 2024], CGHE, Decatur, Georgia. Available from www.globalhep.org/projects-research/hepatitis-evaluation-amplify-testing-project/ghana-heat-project.
71 World Health Organization, (28 July 2023), 'Renewed hope for all people living with viral hepatitis in Ghana', [online article, accessed August 2024], WHO, Geneva. Available from www.who.int/news-room/feature-stories/detail/renewed-hope-for-all-people-living-with-viral-hepatitis-in-ghana.
72 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
73 Hanu, SC., (2024), 'Global State of Harm Reduction 2024 survey response, Ghana'.
74 Nartey Y., et al., (2023), 'Hepatitis C virus seroprevalence, testing, and treatment capacity in public health facilities in Ghana, 2016–2021; A multi-centre cross-sectional study', *PLoS One*, vol. 8, no. 6, e0287580.
75 Saayman, E., V. Hechter, N. Kayuni and M. Sonderup, (2023), 'A simplified point-of-service model for hepatitis C in people who inject drugs in South Africa', *Harm Reduction Journal*, vol. 20. no. 1, p.27.
76 Ibid.
77 Ibid.
78 Ibid.
79 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
80 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review,' *The Lancet Global Health*, vol. 11, no.5, e659–72.
81 Ibid.
82 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
83 Ibid.
84 Ibid.
85 Ibid.
86 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
87 Ibid..
88 Ibid.
89 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
90 Ibid.
91 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
92 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
93 Coutinho, C., F., Bastos, E. da Fonseca and K. Shadlen, (2021), *Hepatitis C in Brazil: Overview and challenges in the light of the COVID-19 pandemic*, FGV and LSE, Sao Paulo.
94 Flores, A., (2024), 'Global State of Harm Reduction 2024 survey response, Puerto Rico'.
95 Aponte-Meléndez, Y., et al., (2023), 'Hepatitis C virus care cascade among people who inject drugs in Puerto Rico: Minimal HCV treatment and substantial barriers to HCV care', *Drug and Alcohol Dependence Reports,* vol. 8, e100178.
96 Ibid.
97 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
98 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
99 Cui, F., et al., (2023), 'Global reporting of progress towards elimination of hepatitis B and hepatitis C', *The Lancet Gastroenterology and Hepatology*, vol. 8, no. 4, p.332–42.
100 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
101 Ibid.
102 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update'. *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65
103 Ibid.
104 Ibid.
105 Ochani, S., et al., (2023), 'Hepatitis is still a major health concern in Pakistan: short communication', *Annals of Medicine and Surgery*, vol. 85, no. 11, e5820.
106 Ayyaz, Z., (2024), 'Global State of Harm Reduction 2024 survey response, MENANPUD, Pakistan'.
107 Khaqan, R., (2024), 'Global State of Harm Reduction 2024 survey response, Nai Zindagi, Pakistan'.
108 Ibid.
109 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update'. *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65
110 Qureshi, S., (2024), 'Global State of Harm Reduction 2024 survey response, Pakistan'.
111 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
112 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
113 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
114 Gezer, F., et al., (2024), 'Identification of factors associated with opioid-related and hepatitis C virus-related hospitalisations at the ZIP code area level in the USA: an ecological and modelling study', *The Lancet Public Health*, vol. 9, no. 6, e354–64.
115 Santamour, T., (2024), 'Global State of Harm Reduction 2024 survey response, USA'.
116 Cooper, RL., (2024), 'Global State of Harm Reduction 2024 survey response, USA'.
117 Santamour, T., (2024), 'Global State of Harm Reduction 2024 survey response, USA'.
118 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.
119 Conners, E. et al., (2023) 'Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States', *CDC Morbidity and Mortality Weekly Recommendation and Reports*, vol. 72, no. 1, p.1–25.
120 Degenhardt, L., et al., (2023), 'Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
121 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no.5, e659–72.
122 Ibid.
123 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.
124 Hajarizadeh, B., et al., (2021), 'Evaluation of hepatitis C treatment-as-prevention within Australian prisons (SToP-C): a prospective cohort study', *The Lancet Gastroenterology and Hepatology*, vol. 6, no. 7, p.533–46.
125 Ibid.
126 Ibid.
127 Lafferty, L., et al., (2021), 'Hepatitis C treatment as prevention in the prison setting: Assessments of acceptability of treatment scale up efforts by prison correctional and health personnel', *International Journal of Drug Policy*, vol. 98, e103379.
128 World Health Organization, (2023), Guidance for country validation of viral hepatitis elimination and path to elimination: technical report, WHO, Geneva.
129 Degenhardt, L., et al., (2023), 'Supplementary Appendix to: Epidemiology of injecting drug use, prevalence of injecting-related harm, and exposure to behavioural and environmental risks among people who inject drugs: a

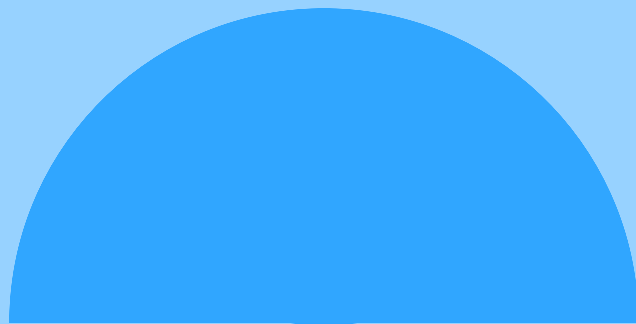
systematic review', The Lancet Global Health, vol. 11, no.5, e659–72.

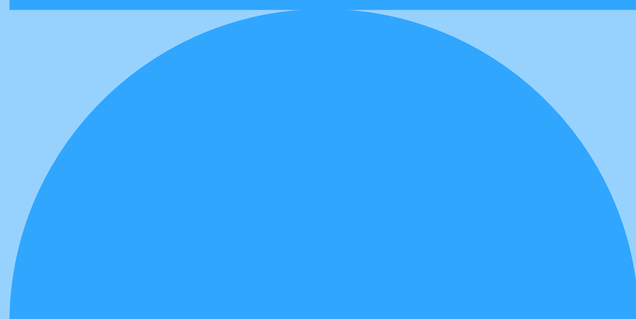
130 Cooke G., et al., (2024), 'Progress towards elimination of viral hepatitis: a Lancet Gastroenterology & Hepatology Commission update', *The Lancet Gastroenterology and Hepatology*, vol. 9, no. 4, p.346–65.

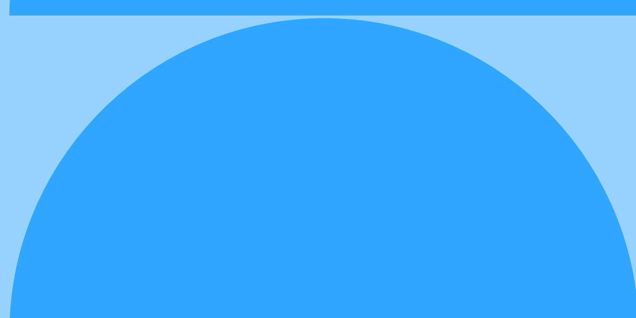
131 Hajarizadeh, B., et al., (2023), 'Global, regional, and country-level coverage of testing and treatment for HIV and hepatitis C infection among people who inject drugs: a systematic review', *The Lancet Global Health*, vol. 11, no. 12, e1885–98.

132 Health Service Executive Ireland, (29 April 2024), 'HSE on track to achieve Hep C elimination targets by 2030' [online article, accessed September 2024], HSE, Dublin. Available from https://about.hse.ie/news/hse-on-track-to-achieve-hep-c-elimination-targets-by-2030.

THEMATIC CHAPTER: INDIGENOUS PEOPLE







AUTHORS OF INDIGENOUS PEOPLE CHAPTER:
David Geraghty, Tuari Potiki, Shawnee Brausch and Tracey Potiki (National Māori Addiction Centre for Aotearoa)

David Geraghty has a PhD in Postcolonial Theory from Monash University (Melbourne) and is a Senior Research and Policy Analyst at the University of Otago.

Tuari Potiki is of Kāi Tahu, Kāti Mamoe and Waitaha descent. He has more than 30 years of experience in Māori alcohol and drug and mental health services, as both a clinician and manager. Tuari is a board member of Mental Health Wellbeing Commission. He is also Chair of the New Zealand Drug Foundation, a board member of Te Rau Ora (a Māori health workforce development organisation), and the Chair of Whare Tukutuku.

Shawnee Brausch of Ngāti Ruanui, Ngā Rauru Kītahi, Ngāti Tūwharetoa descent. Shawnee is the senior researcher for Whare Tukutuku.

Tracey Potiki of Kāi Tahu, Kāti Mamoe and Waitaha descent. She is Kaiwhakahaere/ Director of Whare Tukutuku, and is Deputy Chair of the International Drug Policy Alliance (IIDPA).

INDIGENOUS PEOPLE

In response to the *Global State of Harm Reduction 2024* thematic survey, 95% of Indigenous respondents indicated that drug use had been identified as a problem among Indigenous people in their countries. Methamphetamine, cannabis, tobacco and opioids were identified as the most commonly used drugs. The majority of respondents (77%) said drug-related harm was higher for Indigenous people than for non-Indigenous people.[1]

A 2017 evidence review by Anton Clifford-Motopi (Mosotho)[a] and Anthony Shakeshaft confirmed Indigenous people in Canada, the USA, Australia and Aotearoa New Zealand experience disproportionately high burdens of harm from substance use.[2] Among Indigenous contexts considered in this chapter, opioid toxicity deaths were seven times higher for Kainai people in Alberta, Canada than for the general population,[3] while in Minnesota, USA, opioid toxicity deaths were six times higher for Native Americans than for non-Hispanic whites.[4]

a Throughout this chapter, where source contributors are Indigenous people, the name of their community is given.

Note on our use of the term 'Indigenous'

The United Nations Declaration on the Rights of Indigenous Peoples purposefully does not include a formal definition of Indigenous peoples, noting that self-identification as Indigenous is considered a fundamental criterion of indigeneity, and that Indigenous peoples hold the right to determine their own identity or membership in accordance with their customs and traditions.[5]

The United Nations does, however, describe the following experiences and characteristics as commonly shared among Indigenous peoples: "Indigenous peoples have in common a historical continuity with a given region prior to colonization and a strong link to their lands. They maintain, at least in part, distinct social, economic and political systems. They have distinct languages, cultures, beliefs and knowledge systems. They are determined to maintain and develop their identity and distinct institutions and they form a non-dominant sector of society."[6]

Most survey respondents identified trauma from colonisation as a primary catalyst for drug-related harms experienced by Indigenous people.[7] This trauma is exacerbated by ongoing structural racism,

defined by Keith Lawrence and Terry Keleher as 'an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color'.[8] Structural racism might be manifested in ease of access to alcohol and drugs,[9] overprescription of opiate medications,[10] underfunding of Indigenous healthcare,[11] lack of recognition for Indigenous healthcare models (including at the level of multilateral organisations such as the World Health Organization),[12] policies that are unfavourable to the complexity, scale and urgency of drug-related harms experienced by Indigenous people,[13] intersectional stigma and discrimination (including in healthcare settings) and over-policing.

Intergenerational poverty directly relates to colonisation and structural racism, and it is another significant catalyst for drug use among Indigenous people. Poverty is compounded by unemployment, a lack of social services such as housing and limited access to ancestral land for traditional economic activities.[14] Josien Tokoe (Kari'na) describes the situation in Suriname as follows: 'Some communities are surrounded by third-party concessions, which prohibit them from entering the forest to hunt or fish for their daily family support. Young people and many [marginalised people] are on drugs, alcohol, etc., which means there are no development prospects for the future.'[15]

Increasingly, Indigenous harm reduction is turning away from mainstream Western frameworks towards self-determined approaches imbued with Indigenous identity, values and knowledge.

These responses vary in scale and relative complexity. The case studies presented below are selected to convey the range of harm reduction responses deployed within Indigenous settings, from urgent intervention via extrajudicial use of naloxone to longer term healing through the reintegration of Indigenous worldviews, languages and ways of life.

Work is currently being undertaken by Indigenous people around the world, including the Aboriginal Drug & Alcohol Council (South Australia), Drug Free World Fiji, Federación por la Autodeterminación de los Pueblos Indígenas (Paraguay), First Nations Health Authority (Canada), Indigenous Health Australia, Papa Ola Lokahi (Hawai'i), Te Hiku Hauora (Aotearoa New Zealand), Thunderbird Partnership Foundation (Canada) and many others.[b]

b For more on these organisations see: Aboriginal Drug & Alcohol Council: https://adac.org.au; Federación por la Autodeterminación de los Pueblos Indígenas: https://fapi.org.py; Indigenous Health Australia: https://iaha.com.au; Papa Ola Lokahi: www.papaolalokahi.org; Te Hiku Hauora: www.tehikuhauora.nz; Thunderbird Partnership Foundation: https://thunderbirdpf.org/.

ALBERTA, CANADA

Esther Tailfeathers (Kainai Nation), Medical Lead of the Indigenous Wellness Core at Alberta Health Services, has led the Kainai response to the fentanyl crisis, initiating a harm reduction response that is underpinned by 'kímmapiiyipitssini', a Blackfoot term meaning 'to give kindness to each other'.[16]

Tailfeathers identifies several social determinants that made the Kainai Nation vulnerable to fentanyl, including intergenerational poverty, unemployment and inadequate housing. The historic trauma of the Canadian Indian residential schooling system, and the adverse childhood events associated with it, is the number one cause.[c]

A more recent factor has been overprescription of opioids to First Nations people. Data from the Alberta First Nations Information Governance Centre shows opiates being prescribed to Indigenous people at twice the rate of non-Indigenous people.[17]

Tailfeathers' work follows a 'continuum of care' model, which moves from prevention to harm reduction, clinics, detoxification, treatment and aftercare to supportive housing, community care and, finally, to addressing the social determinants of challenges around drug use. A major part of her work to date has involved bringing naloxone kits onto the Kainai reserve and educating people about their use.

This work was initially outside the law, as naloxone could only be provided in metropolitan clinical settings. However, Dr Hakique Virani, a substance use specialist in Alberta, provided the programme with 50 naloxone kits. Dr Virani was subsequently fired by the federal government for providing naloxone to the community. However, the intervention proved so effective, the Kainai Chief successfully petitioned the federal government to reinstate Dr Virani, and naloxone was made more widely available in First Nations community settings across the country.

A further challenge for Tailfeathers' work was resistance from Kainai elders, who thought naloxone would enable drug use on the reserve. Tailfeathers' team provided information to community members which enabled them to see that the use of naloxone was about celebrating the lives of people without judgment. As Tailfeathers bluntly states in a speech given in 2023: "our [position] was you cannot enable a dead body to continue to use drugs".[18] The last two fentanyl overdose deaths on the Blood Reserve occurred on 20 March 2015, directly contrasting to the steady increase in overdose deaths across Alberta following the provincial government's cutbacks to harm reduction services.[d]

Carol Hopkins (Lenape Nation), CEO of Thunderbird Partnership Foundation, notes that First Nations harm reduction remains uneven: 'There are some programs, like national distribution of naloxone [and] some communities have access to resources that support mobile outreach and distribution of sterile drug use equipment. But this is not standard across all First Nations because of inequitable funding.'[19]

MINNESOTA, USA

Minnesotan Native American communities have similarly had to pursue their own responses to the opioid overdose epidemic into a headwind of federal underfunding and inadequate policy. Thaius Boyd (Ohkay Owingeh and San Felipe Pueblo) et al. note this has happened despite the USA government's obligation, rooted in Native American treaties, to provide healthcare services to Native Americans in exchange for land and resources.[20]

c From the 1880s until 1996, Indigenous children (some as young as four) were compulsorily removed from their homes and placed in residential schools, where many experienced physical, emotional and sexual abuse.

d Tailfeathers cites Alberta First Nations Information Governance Centre data which shows the rate of apparent accidental opioid poisoning deaths among Alberta First Nations people rising from 44.1 per 100,000 people in 2016 to 142.8 per 100,000 people in 2020.

Government attempts to improve Native American access to health services and Native American health outcomes have been negatively affected by consistent underfunding. In 2019, for example, the Indian Health Service per capita expenditure for healthcare services was USD 4,078, compared with a national average of USD 9,726 per person.[21]

These federal policy failures have been exacerbated by opioid prescribing and dispensing practices which include a lack of oversight of opioid prescription within the Indian Health Service.[22]

Opioid agonist therapy (OAT) is a critical public health tool for addressing increase in opioid use and related harms, including overdoses.[23] But the lack of culturally appropriate options, which explicitly integrate spirituality, holistic healing and wellness care into OAT, may exacerbate and prolong opioid-related harm within Native American communities. In 2017, only 22% of substance use treatment facilities offered OAT for Native Americans and Alaskan Natives, rising to only 40% in 2018.[24]

This low uptake of OAT among Native Americans is also due to an absence of specialised expertise and training, stigma towards substance use and treatment and misperceptions about treatment therapy.[25] This echoes Tailfeathers' observation about the cool reception to naloxone from Kainai elders.

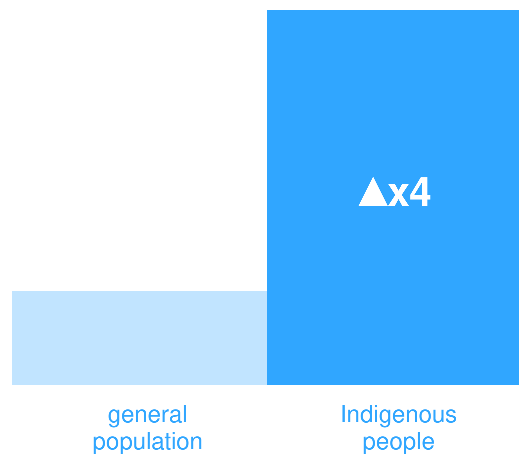
OAT with culturally-specific implementation approaches, integrated care, a focus on family and community wellness and accompanying psychosocial counselling would facilitate greater acceptance among Native Americans and better treatment outcomes.[26]

WISCONSIN, USA

While uptake of OAT has been uneven in Native American tribes and settings in the USA, there have been notable successes, including among the Bad River band of Lake Superior Chippewa, Wisconsin.

The 2022 rate of overdose deaths among Indigenous people in Wisconsin was four times that of the general population (97.8 per 100,000 people, against a statewide average of 24.8).[27] To counter this, and to avoid the potential stigma posed by in-clinic treatment, the Bad River band established a statewide mail-order service offering free naloxone in late 2022. Since then, the tribe, in partnership with the NEXT Distro online and mail-based harm reduction service,[28] has made 1,900 deliveries to people in at least 63 counties. Tribe members have also provided more than 2,000 in-person deliveries. Overall, around 14,800 doses of naloxone and 165,000 syringes have been distributed.[29]

Overdose deaths in Wisconsin



SYDNEY, AUSTRALIA

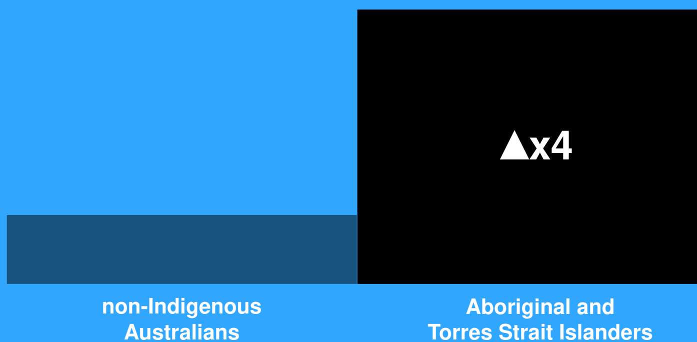
The Penington Institute's *Australia's Annual Overdose Report 2023* states there were 1,675 unintentional drug-induced deaths in Australia in 2021.[30] The report notes that Aboriginal and Torres Strait Islanders had a higher rate of unintentional drug-induced deaths (20 per 100,000 people) than non-Indigenous Australians (5.9 per 100,000 people).[e,31] While this number is significantly lower than the rates identified for Alberta First Nations people (142.8 per 100,000 people in 2020 – see footnote c) and Wisconsin Native Americans (97.8 per 100,000 people in 2022, as above), the disproportionality between Indigenous and non-Indigenous Australians is alarming.[f]

In 2023, Marguerite Tracy and Bradley Freeman (Bundjalung) et al. reviewed treatments for drug harm among Aboriginal and Torres Strait Islander people in Australia.[32] Cannabis is identified as the most common recently-used drug reported by Aboriginal and Torres Strait Islanders (16%), followed by strong pain relievers (not purchased over the counter) and opioids (5.9%).[33] The authors note the central, ongoing role of colonisation in placing Aboriginal and Torres Strait Islanders at increased risk of harms from drug use.[34] They endorse tailored holistic treatments which combine mainstream clinical practice with culturally secure care that promotes social and emotional wellbeing. This is a dual approach that is common among Australia's 140 Aboriginal and Torres Strait Islander Community Controlled Health Services.[35]

e The Pennington Institute's *Australia's Annual Overdose* Report 2023, p.45 clarifies that data on Indigenous status is only reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory (i.e., Victoria, Australian Capital Territory and Tasmania are absent) as these are the only states with an appropriate level of Indigenous identification and sufficient number of Indigenous deaths for the Australian Bureau of Statistics to include the data in its causes of death analysis

f Scott Wilson, board member of the Penington Institute and director of the Aboriginal Drug and Alcohol Council (South Australia), believes that the difference between the Indigenous Australian and Indigenous North American rates of unintentional drug-induced deaths is due to fentanyl not having taken as strong a hold in Australia as it has in North America.

Aboriginal and Torres Strait Islanders are four times more likely to die of an unintentional drug overdose as compared to non-Indigenous Australians



The Aboriginal Medical Service Cooperative (AMS) is a longstanding example of an Indigenous community-controlled health service. It was established in Redfern, a suburb of Sydney, in 1971 to counter the racism Aboriginal people experienced in mainstream health services and provide comprehensive and culturally secure primary healthcare for local Aboriginal people.[36]

The AMS founded a Drug and Alcohol Unit in 1999, following record numbers of people dying from heroin overdoses in Sydney and New South Wales.[37] The unit combines mainstream relapse prevention approaches with culturally-centred care led by Indigenous staff. Cultural aspects of care include connection to country through yarning, incorporation of family and observance of local cultural protocols.[38] The unit's coordinator (a Bundalung man) provides onsite counselling, aided by an Aboriginal drug and alcohol worker (of any gender, as required).[39]

The unit's mainstream medical care follows standard practice. When first established, the unit provided methadone prescribing and counselling. From 2001, it started prescribing and dispensing buprenorphine tablets. Later on, it began providing a branded medication called Suboxone (buprenorphine plus naloxone). At the outset of the COVID-19 pandemic, the unit offered slow-release injectable buprenorphine (Buvidal), meaning clients would not need daily or near-daily visits to the unit. The unit currently prescribes for around 150 clients, including onsite dispensing of Suboxone or Buvidal.[40] The unit's doctors also provide home detoxes, relapse prevention medicines and treatment for hepatitis C.[41]

AOTEAROA NEW ZEALAND

Andre McLachlan (Ngāti Apa /Ngāti Kauae, Muaūpoko/Ngāti Pāriri) and Waikareomoana Waitoki (Ngāti Hako, Ngāti Hako, Ngāti Māhanga, Ngāti Māhanga) describe similar combined approaches within Aotearoa New Zealand, where Western clinical practices have been reframed within an Indigenous understanding of harm reduction.[42]

McLachlan and Waitoki note that Māori, as with other Indigenous people, are disproportionately affected by mental health and challenges with substance use.[43] The authors see a tendency within Western approaches to drug-related harm to use reductionist models that focus on the individual outside of their relationship with family or community. Such top-down approaches utilise principles held by the practitioner and their organisation, rather than by the individual or their collective, and lack consideration of the needs, preferences and voices of those affected and their communities. This can lead to unintended consequences like criminalisation, inequitable law enforcement experiences, withdrawal-related harms and disconnection from treatment agencies and support services.[44]

Strategies focussed upon isolated health behaviours have limited efficacy if they do not also address the impact of systemic issues related to colonisation, interpersonal and structural racism, intergenerational trauma, poverty, homelessness or other determinants of ill health.[45]

Harm reduction responses developed by and from Indigenous perspectives can identify and articulate how colonisation and racism have created the systemic, biological and interpersonal factors leading to challenges with substance use. Extending beyond narrow clinical interventions, Indigenous responses to trauma can focus on cultural revitalisation and regeneration, providing space for language and the cultural dimensions of wellbeing to be centred.[46]

Indigenous harm reduction strategies have been successfully employed within Aotearoa New Zealand healthcare, including *Te Whare Tapa Whā* and *Pae Tata Pae Tawhiti: An Indigenous Framework for Brief and Early Intervention*.[47,48] The New Zealand Ministry of Health has funded and developed training based on these Indigenous strategies for Māori and non-Māori practitioners working within primary mental healthcare and harm reduction.[49]

There are four components viewed as critical for effective Indigenous harm reduction approaches:

1 **Whakapapa:** Harm reduction must consider the history and relationships between culture and community-specific harms, particularly colonisation and intergenerational trauma.

2 **Huanui oranga:** The strengths, preferences and strategies of Indigenous communities must be included to accurately and effectively respond to drug-related harms.

3 **Mauri ora, Whānau ora and Wai ora:** Harm reduction efforts must seek to increase quality of life as defined by Indigenous communities.

4 **Ngā take pū o te tangata:** Harm reduction must be guided by the values and principles of Indigenous peoples.[50]

Te Kāika (the village) in Otago, Aotearoa New Zealand is an example of this harm reduction approach.[g] Te Kāika was founded by Ōtākou Health Limited, a Ngāi Tahu[h] charity, with the vision of providing integrated health, social and educational services to Māori and other guests. Te Kāika prioritises affordability and takes a holistic, Māori-centred approach to improving and maintaining whānau (family) wellbeing; this reduces cultural and financial barriers to accessing health services.

Its services include the Te Kāika Community-Based Alcohol and Other Drug Addictions Service, which provides inclusive harm reduction within Māori-centred models of relational care for people with moderate to severe drug challenges and their families. The service incorporates a range of approaches, including safer use, managed use and abstinence, meeting people who use drugs 'where they're at', and addressing the conditions of substance use along with the use itself.

Te Kāika's operations parallel the dual approach recommended by the AMS unit in Redfern, Sydney and other Indigenous settings in Australia. Its clinical practice (delivered by Indigenous and non-Indigenous practitioners) is underpinned by the Te Whare Tapa Whā framework (outlined in the left hand column) and uses Indigenous delivery models, such as Ngāi Tahu's *Whānau as First Navigators*,[51] which champions the roles of family self-agency and received ancestral wisdom in achieving and maintaining wellbeing.

Despite the recent positive developments in reducing drug-related harm among Māori in Aotearoa New Zealand, a change of government in 2023 has seen nuanced Māori health policy abandoned in favour of a one-size-fits-all approach. This may stall some of the momentum that was building within Māori harm reduction. A respondent to the *Global State of Harm Reduction* survey observes: '[The] NZ government very recently dismantled the Māori health support organisation [authority], choosing instead to reduce its impact by cutting jobs and pushing it back into the mainstream health system, which instantly reduces services, increases waiting times and by design, de-prioritises Māori health.'[52] This policy shift, with its expected reduction in services, mirrors changes described by Tailfeathers and Boyd within First Nations and Native American contexts (above).

g For more on this, see www.tekaika.nz.
h Ngāi Tahu (people of Tahu) is the collective tribal name for a conglomerate of interrelated sub-tribes in Te Waipounamu (the South Island of Aotearoa New Zealand).

Increasingly, Indigenous people are taking the lead in their own healthcare relating to drugs, establishing harm reduction interventions and care programmes that are designed and implemented by and for themselves, with some notable successes. As described by Indigenous scholars, optimal Indigenous harm reduction will require approaches that merge leading clinical practice with Indigenous worldviews (identity, values and knowledge) and Indigenous leadership and agency, supported by stable policy and equitable funding. Achieving and maintaining this balance in the current volatile global political environment will require skill, resilience and tireless advocacy.

1 Various respondents, (2024), 'Global State of Harm Reduction 2024: Indigenous People and Harm Reduction Survey responses'.
2 Clifford--Motopi, A. and A. Shakeshaft, (2017) 'A bibliometric review of drug and alcohol research focused on Indigenous peoples of Australia, New Zealand, Canada and the United States', *Drug and Alcohol Review*, vol. 36, no. 4, p. 509.
3 Rotary 5360, (5 July 2023), 'Dr. Esther Tailfeathers Discusses the Opioid Crisis and Recovery Programs' [online video file, accessed September 2024]. Available from www.youtube.com/watch?v=TIIF1VXd9Io
4 Boyd, T., et al., (2021), 'Quantifying opioid use disorder Cascade of Care outcomes in an American Indian tribal nation in Minnesota', *Drug and Alcohol Dependence*, vol. 222, no. 108661, p. 1.
5 United Nations, Department of Economic and Social Affairs Social Inclusion, (13 September 2007), 'United Nations Declaration on the Rights of Indigenous Peoples' [webpage, accessed September 2024], UN, New York. Available from https://social.desa.un.org/issues/indigenous-peoples/united-nations-declaration-on-the-rights-of-indigenous-peoples
6 United Nations, 'Indigenous Peoples: Respect NOT Dehumanization' [webpage, accessed September 2024], UN, New York. Available from www.un.org/en/fight-racism/vulnerable-groups/indigenous-peoples
7 Various respondents, (2024), 'Global State of Harm Reduction 2024: Indigenous People and Harm Reduction Survey responses'.
8 Lawrence, K. and T. Keleher, (2004), *Structural Racism*, prepared for the 2004 Race and Public Policy Conference, Berkeley, CA.
9 Rotary 5360, (5 July 2023), 'Dr. Esther Tailfeathers Discusses the Opioid Crisis and Recovery Programs' [online video file, accessed September 2024]. Available from www.youtube.com/watch?v=TIIF1VXd9Io
10 Ibid.
11 Boyd, T., et al., (2021), 'Quantifying opioid use disorder Cascade of Care outcomes in an American Indian tribal nation in Minnesota', *Drug and Alcohol Dependence*, vol. 222, no. 108661, p. 1
12 Purcell-Khodr G., et al., (2022), 'The importance of culture in alcohol care: Listening to First Nations staff in Australian Aboriginal Community Controlled Health Services', *The International Indigenous Policy Journal*, vol. 13, no. 3, p. 21.
13 Rotary 5360, (5 July 2023), 'Dr. Esther Tailfeathers Discusses the Opioid Crisis and Recovery Programs' [online video file, accessed September 2024]. Available from www.youtube.com/watch?v=TIIF1VXd9Io Ibid.
14 Tokoe, J., (2024), 'Global State of Harm Reduction 2024: Indigenous People and Harm Reduction Survey response'.
15 Ibid.
16 Rotary 5360, (5 July 2023), 'Dr. Esther Tailfeathers Discusses the Opioid Crisis and Recovery Programs' [online video file, accessed September 2024]. Available from www.youtube.com/watch?v=TIIF1VXd9Io
17 Ibid.
18 Ibid.
19 Hopkins, C., (2024), 'Global State of Harm Reduction 2024: Indigenous People and Harm Reduction Survey response'.
20 Boyd, T. et al., (2021), citing Warne, D. and Frizzell. L., (2014), 'American Indian health policy: historical trends and contemporary issues', *American Journal of Public Health*, vol. 104, no. 3, S263–S267.
21 Indian Health Service, (2020), 'Indian Health Service fiscal year: Congressional justification, 2019', IHS, Rockville, Md.
22 U.S. Department of Health and Social Sciences, Office of Inspector General, (17 July 2019), 'IHS needs to improve oversight of its hospitals' opioid prescribing and dispensing practices and consider centralizing its information technology functions' [online article, accessed September 2024], HHS, Washington, DC. Available from: https://oig.hhs.gov/reports/all/2019/ihs-needs-to-improve-oversight-of-its-hospitals-opioid-prescribing-and-dispensing-practices-and-consider-centralizing-its-information-technology-functions/
23 Ibid.
24 Krawczyk, N., et al., (2021), 'Medications for Opioid Use Disorder among American Indians and Alaska Natives: Availability and Use Across a National Sample', *Drug and Alcohol Dependence*, vol. 220.
25 Venner, K., et al., (2018) 'Future directions for medication assisted treatment for opioid use disorder with American Indian/Alaska Natives', *Addictive Behaviors*, vol. 86, p.111–117.
26 Ibid.
27 Wisconsin Department of Health Services, 'Dose of Reality: Opioid Deaths by County Dashboard: 2022' [web page, accessed September 2024], DHS, Madison, WI. Available from www.dhs.wisconsin.gov/opioids/deaths-county.htm
28 NEXT Distro, 'What is NEXT Distro' [webpage, accessed September 2024], Next Harm Reduction, USA. Available from https://nextdistro.org/
29 Kaeding, D., (5 July 2024) 'Bad River tribe has provided thousands of doses of life-saving drug statewide' Wisconsin Public Radio [online article, accessed September 2024), University of Wisconsin, Madison, WI. Available from www.wpr.org/news/bad-river-tribe-has-provided-thousands-of-doses-of-life-saving-drug-statewide
30 Penington Institute, (2023), *Australia's Annual Overdose Report 2023*, Penington Institute, Melbourne, p. 139.
31 Ibid., p. 45.
32 Tracy, M. et al., (2023), 'Review of alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples', *Journal of the Australian Indigenous HealthInfoNet*, vol. 4, no. 1, article 1.
33 Ibid., p. 5.
34 Ibid., p. 4.
35 Ibid., p. 17.
36 Freeburn, B., S. Loggins, K. Lee and K. Conigrave, (2022), 'Coming of age: 21 years of providing opioid substitution treatment within an Aboriginal community-controlled primary health service', *Drug and Alcohol Review*, vol. 41, no. 262.
37 Ibid., p. 261.
38 Tracy, M. et al., (2023), 'Review of alcohol and drug treatment for Aboriginal and Torres Strait Islander peoples', *Journal of the Australian Indigenous HealthInfoNet*, vol. 4, no. 1, p. 6-8.
39 Freeburn, B., S. Loggins, K. Lee and K. Conigrave, (2022), 'Coming of age: 21 years of providing opioid substitution treatment within an Aboriginal community-controlled primary health service', *Drug and Alcohol Review*, vol. 41, no. 262, p. 261.
40 Ibid., p. 261.
41 Ibid., p. 262.
42 McLachlan, A. and W. Waitoki, (2024), 'Tawhiti: An Indigenous Trauma Informed Harm Reduction Approach to Alcohol and Other Drug Use', *Journal of Indigenous Wellbeing*, vol. 7, no. 1, p. 21-36.
43 Ibid., p. 24.
44 Ibid., p. 22.
45 Ibid., p. 23.
46 Ibid., p. 24.
47 Ibid., p. 26.
48 Ibid., p.26.
49 Ibid., p. 33.
50 Ibid., p. 33.
51 Ngāi Tahu, 'Whānau as First Navigators' [web page, accessed September 2024], Addington, Christchurch. Available from: https://ngaitahu.iwi.nz/opportunities-and-resources/programmes-2/whanau-as-first-navigators/
52 Name not given, 'Global State of Harm Reduction 2024: Indigenous People and Harm Reduction Survey response'.

THEMATIC CHAPTER: PRISONS

AUTHOR OF PRISONS CHAPTER: Tríona Lenihan

Tríona Lenihan is a human rights advocate with 12 years of experience, mostly in the justice sector. She holds a BCL (Law) and LLM in International Human Rights Law and Public Policy from University College Cork. Based in London, she previously led Penal Reform International's policy and international advocacy programme, where she supported implementation of human rights standards in prisons. She is currently an international policy adviser on rule of law and human rights at the Law Society of England and Wales.

PRISONS

The term ‘prisons’ is used to describe places of criminal legal detention, where individuals are held either pre-trial or under sentence. It does not include other places of deprivation of liberty where harm reduction services are also needed, including immigration or police detention or mental health institutions.

PLACES OF HIGH NEED AND OPPORTUNITIES FOR HARM REDUCTION

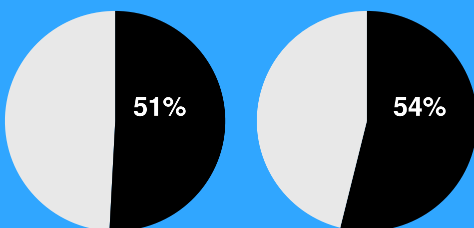
An estimated 11.5 million people were in prison globally in 2022.[1] While at least 66 jurisdictions in 40 countries have in some way decriminalised personal use and possession of drugs,[2] punitive drug policies remain a key driver of imprisonment worldwide.[3]

In 2022, 51% of global prosecutions (1.4 million people) and 54% of convictions (900,000 people) for drug-related offences were for drug use or possession.[4] Punitive drug policies have also led to the overrepresentation of racialised and marginalised groups in the criminal legal system.[5] Over one in three women in prison globally are incarcerated for drug offences, rising to 60-80% in some Latin American and Asian countries.[6]

The criminalisation of drug use means people who use drugs are over-represented in prisons: an estimated one third to half of all people entering prison have a history of drug use.[7] The likelihood of injecting drug use decreases with incarceration, however, some people continue or start injecting drugs while in prison.[8] This is linked to poor prison environments that lack purposeful activity and where drug use is acceptable or even pressurised by peers.[9] High-risk behaviours, such as sharing syringes, also increase in prisons. In Australia, for example, data from 2022 shows 73% of people entering prison had used drugs in the past year.[10] On release, 37% had used illicit drugs in prison; 14% injected drugs in prison and 13% shared injecting equipment.[11]

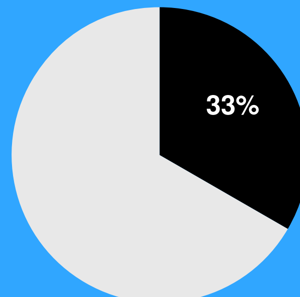
The situation is compounded by the fact that people in prison are likely to have a poorer health status

51% of global prosecutions and 54% of convictions for drug-related offences were for drug use or possession



people incarcerated for drug use or possession

1/3rd of all women in prison globally are incarcerated for drug offences



women incarcerated for drug offences
women in prison

than the general population[12] and unfavourable environmental factors in prison, such as overcrowding and inadequate access to healthcare and harm reduction services. As a result, people in prison have an alarmingly high risk of contracting infectious diseases and experiencing other negative health outcomes compared to the general population. The latest figures from UNAIDS show

the global median of HIV prevalence reported among people in prison in 2023 was almost double that of the general population.[13]

HIV prevalence in prisons is highest in Eastern and Southern Africa (12% regionally), and was estimated to be as high as 21% in Zambia and 35% in Zimbabwe in 2022.[14] Over 15% of people in prisons globally are living with hepatitis C virus (HCV) and 5% have chronic hepatitis B virus.[15] In the USA, HCV is nearly nine times more prevalent in prisons than in the community.[16]

The increased risk of negative health outcomes from infectious diseases and unsafe drug use in prisons means that harm reduction interventions are critically needed and can have a significant, positive impact.[17] For some, prisons may provide an opportunity for improved adherence to treatment and increased use of harm reduction services. The UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) require that, when people enter prison, they are assessed for symptoms or risk of drug withdrawal and any treatment that is needed is provided (Rule 30c). Failure to provide such treatment may amount to ill-treatment and is thus prohibited under the Convention Against Torture.[18]

As closed settings, prisons provide an opportunity for universal screening and 'micro-elimination' of communicable diseases among a high-risk population.

For example, in France, where HCV is 10 times more prevalent in prisons than outside, one remand prison has succeeded in eliminating the virus for the past seven years, attributed to a proactive screening policy. The prison, which has also set up a syringe exchange programme and an exchange for stimulant smoking kits, has had no overdose deaths for 10 years.[19a] In Virginia, USA, where HCV prevalence is 10 times higher among people in prison than the general population, a pharmacist-led telemedicine HCV clinic achieved a 97% cure rate among 1,040 people in prison with chronic HCV who were treated between 2020 and 2022.[20]

AVAILABILITY OF HARM REDUCTION IN PRISONS

International human rights norms and standards, including the Nelson Mandela Rules, state that people in prison are entitled to the same standard of healthcare as people in the community (the principle of equivalence).[21] This is interpreted to apply to harm reduction services, meaning that services in prison should be as available and accessible, and of the same quality and voluntary nature, as those that exist for the general population. Moreover, experts have questioned whether the aim, instead of equivalence of care, should be equivalence of objectives and results, which would involve a higher standard of care for people in prison.[b]

The United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO)

a This is an unsanctioned NSP operating without formal approval from the government.
b This opinion is supported by the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment, and the former UN Special Rapporteur on the right to health. See Harm Reduction International, (2016), *HIV, HCV, TB and Harm Reduction*, HRI, London.

include needle and syringe programmes (NSP), opioid agonist therapy (OAT), naloxone distribution and other services in their latest recommended interventions for people in prisons.[22] UN human rights bodies have called for harm reduction to protect the right to health in prisons,[23] and 108 countries recognise harm reduction in their national laws or policies.[24] Yet, implementation in prisons remains far behind implementation in the community and wholly inadequate, with little improvement since the last *Global State of Harm Reduction* report.

OPIOID AGONIST THERAPY

OAT is available in at least one prison in 60 countries (compared to 93 in the community). This is only one more country than in 2022 when 59 countries offered OAT in prison. OAT is now known to be available in at least one prison in Algeria, Puerto Rico and Türkiye, but we can no longer confirm availability in Bulgaria and Palestine.

Availability of OAT in prisons varies widely between regions. Most countries that provide at least one prison-based OAT programme are in Western Europe (21 countries) and Eurasia (19 countries). In contrast, fewer countries offer OAT in prisons in the Middle East and North Africa (six countries)[c], Asia (five countries)[d], Eastern and Southern Africa (four countries)[e] or Oceania (two countries)[f]. Puerto Rico offers the only prison-based OAT programme in Latin America and the Caribbean, and there are no known OAT in prisons in West and Central Africa.

In countries where OAT is available in at least one prison, coverage across the prison estate varies significantly. OAT is available in all prisons in Austria, Kosovo and France.[25] In Romania, OAT is functional in 15 prison units out of 45.[26,27] Similarly, in Mauritius there are four methadone dispensing sites among 11 prison facilities,[28] including one at the women's prison.[29] Outpatient OAT clinics were initiated in prisons in Punjab in India in 2022 (in 9 out of 24 prisons). However, there have been reports of staffing issues and a lack of testing kits,[30] and nationwide data on people who inject drugs in prisons and coverage of OAT is largely unavailable.[31]

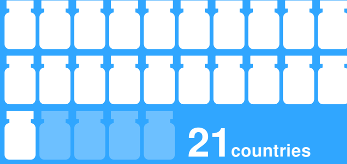
NEEDLE AND SYRINGE PROGRAMMES

An NSP is available in at least one prison in 11 countries (compared to 93 in the community). This is two more than in 2022 when nine countries provided NSP in prison. France[g], Iran, North Macedonia and Ukraine now provide at least an NSP in at least one prison, but prison-based NSP is no longer available in Armenia.[32] Apart from Canada[33] and Iran,[34] all identified NSPs in prisons are in Eurasia (Kyrgyzstan,[35] Moldova, North Macedonia, Tajikistan, Ukraine[36]) and Western Europe (Spain,[37] Luxembourg,[38] Germany,[39] Switzerland,[40] France[41g]). Ukraine's first prison NSP opened in Odesa prison in 2023, in collaboration with the NGO FREE ZONE. Based on a prison survey that revealed 50% of respondents had used drugs and 40% were interested in participating in an NSP,[42] a comprehensive service package was developed. This included training for people in prison and prison staff, and technical support for peer consultants who FREE ZONE later employed. By July 2024, 592 people had received around 19,500 services from the NSP, and 13 people in prison became peer workers to support social reintegration once people were released. Following the success of this model, another prison facility in Ukraine has recently proposed a similar programme.[43] In contrast, the

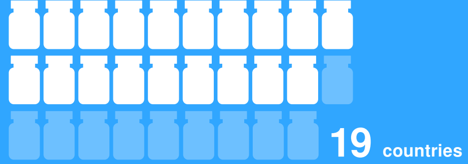
c Afghanistan, Algeria, Iran, Israel, Lebanon and Morocco.
d India, Indonesia, Macau, Malaysia and Vietnam.
e Kenya, Mauritius, Seychelles and Tanzania.
f Aotearoa New Zealand and Australia.
g This is an unsanctioned NSP operating without formal approval from the government.

AVAILABILITY OF OPIOID AGONIST THERAPY IN PRISONS BY REGIONS

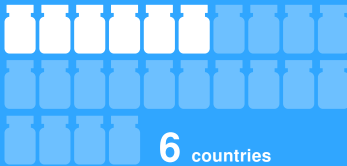
WESTERN EUROPE



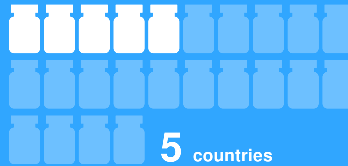
EURASIA



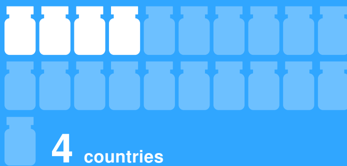
MIDDLE EAST
AND NORTH AFRICA



ASIA



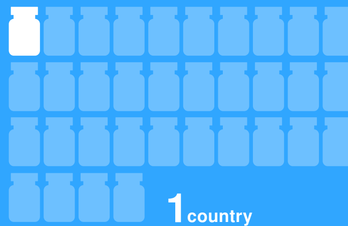
EASTERN AND
SOUTHERN AFRICA



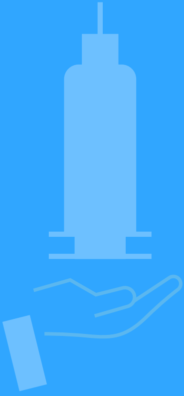
NORTH AMERICA

OCEANIA

LATIN AMERICA
AND THE CARIBBEAN



NUMBER OF COUNTRIES WITH NEEDLE AND SYRINGE PROGRAMMES (NSP) IN PRISON



2022

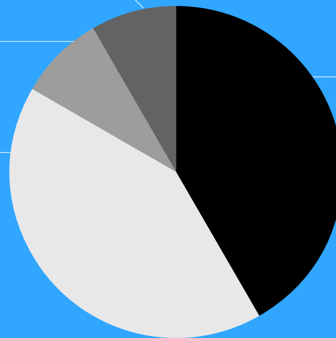
2024
(2 + from 2022,
+ Iran, North Macedonia
and Ukraine, - Armenia)

AN NSP IS AVAILABLE IN AT LEAST ONE PRISON IN 11 COUNTRIES IN 2024

MIDDLE EAST AND NORTH AFRICA
Iran

NORTH AMERICA
Canada

WESTERN EUROPE
Spain
Luxembourg
Germany
Switzerland



EURASIA
Kyrgyzstan
Moldova
North Macedonia
Tajikistan
Ukraine

TAKE-HOME NALOXONE AVAILABLE ON RELEASE IN AT LEAST ONE PRISON

AVALIABLE IN 11 COUNTRIES

France
Germany
Italy
Ireland
Norway
Estonia
Lithuania
Ukraine
Canada
USA
Australia

Austrian government has said it does not envisage implementing NSP in prisons, stating that the country's prisons' substitution programme offers numerous ways to stabilise substance use in line with external OAT guidelines.[44]

NALOXONE

Take-home naloxone is available on release in at least one prison in 11 countries, mostly in Europe (France,[45] Germany,[46] Italy,[47] Ireland,[48] Norway,[49] Estonia,[50] Lithuania,[51] Ukraine[52]) and North America (Canada[53] and the USA[54]), plus one scheme in Oceania (Australia[55]). However, the level of coverage varies significantly. Naloxone-on-release is only available in 3 out of 190 prisons in Italy, for example.[56] It is available in most prisons in British Columbia, Canada[57] and Victoria, Australia,[58] but in both countries it varies by state. In some places, such as France, it requires a prescription,[59] and in others it is delivered through civil society partnerships. In Ireland, for example, the Irish Red Cross provides peer-to-peer programmes on overdose prevention and naloxone training to equip people with knowledge of and access to naloxone on release from prison.[60]

Within prisons, naloxone tends to only be administered by staff. This limits its effectiveness, since staff will not always be immediately available in overdose situations, and the time they take to respond could be the difference between life and death.

In the Australian Capital Territory, following discussions with labour unions and training for staff, naloxone has been included in prison officers' first aid kits.[61] In Ireland, it can only be administered in an emergency by a nurse, and in Canada, it is only accessible to prison healthcare or security staff; people in prison cannot have naloxone kits in their cells in case their cellmate experiences an overdose.[62] Evidence relating to this staff-only approach points to its failings. For example, the U.S. Department of Justice Office of the Inspector General (OIG) found that, despite at least 70 people dying from a drug overdose in federal prisons between 2014 to 2021, staff were hesitant to administer naloxone in a timely manner; medical staff told the OIG that guards trained to use naloxone were "uncomfortable" doing so.[63]

DRUG CONSUMPTION ROOMS

Canada opened its first prison-based overdose prevention site (OPS), referred to elsewhere as a drug consumption room (DCR), in Drumheller Institution in Alberta in 2019. Here, people in prison can access sterile syringes, consume drugs in private rooms, and medical staff (not correctional officers) are on hand in case of overdose. Following criticism for delays, two more OPSs opened in 2023 at the Springhill Institution in Nova Scotia and Collins Bay Institution in Ontario. The Drumheller OPS received its first visit from a client after three weeks of opening, but it has now logged nearly 2,000 visits. The first visit from a client to the Springhill OPS took three months.[64] The experience in Canada shows there is a period after an OPS opens when awareness must be raised and trust must be built among people in the prison so they feel confident to use the service. In federal prisons in Canada, 46 people died from suspected drug overdoses and another 728 people nonfatally overdosed between 2011 to 2022.[65] To date, there have been no overdose deaths at any facility with an OPS since the service has been active.[66]

BARRIERS TO ACCESS

Making a harm reduction service available in a prison does not necessarily make it fully accessible. In some countries, OAT in prisons is

limited to people who were prescribed OAT before incarceration. This is the case in some Eurasian countries, including Albania, Bulgaria, Latvia, Montenegro and Serbia.[67] Similar restrictions apply in Lebanon,[68] Macao (China)[69] and Mauritius.[70] Even when OAT is available to everyone, regardless of whether someone has been on OAT before prison, there can be increased barriers for those who start OAT while incarcerated, such as treatment waitlists and extensive wait times of up to multiple months, leading to withdrawal and other negative health outcomes.[71] In Victoria, Australia some people have reported commencing OAT post-release to ensure continuity of care if reincarcerated.[72]

Among the countries surveyed for this report,

the most reported barrier that prevents people in prison from accessing harm reduction, apart from a lack of services, is people's fear of punishment for drug use or possession (in 7 of the 10 countries that provided information)[h], followed by the fear of losing other rights or privileges, privacy concerns, restrictive eligibility criteria and stigmatisation or ill-treatment by staff or peers.

RISK OR PERCEIVED RISK OF SANCTIONS OR LOSS OF RIGHTS OR PRIVILEGES

In Romania, once someone enters a drug treatment programme, they are reportedly declared unfit to work while in prison, which means they will lose their income and cannot participate in a meaningful activity.[73] The HIV organisation Asociația Română Anti-SIDA has found the lack of demand for NSP is linked to the fact that people who request syringes are not given a guarantee that they will not face sanctions.[74] In Indonesia, research has found people participating in OAT programmes in prison were perceived by both prison staff and peers to be engaged in illicit drug use. They were heavily stigmatised; they were seen as lazy, poor, dirty and unproductive people and were presumed to have HIV.[75] This multi-layered, intersectional stigma affected not only the OAT clients' quality of life and mental health but also their access to parole, and therefore the possibility of early release. Similarly, in England and Scotland, service users have reported that while people who disclose use of heroin on admission to prison are offered help, those who disclose later are met primarily with a punitive response and are often suspected of selling drugs or other activities which violate prison rules. This leads people in prison to fear that disclosing opioid use will damage their prospects of accessing home detention, curfew, release on temporary licence or parole.

In Canada, only 20% of people approved for an NSP were utilising the service (as of June 2022).[76] Canada's Correctional Investigator has attributed this poor uptake to various factors, including the prison service's zero-tolerance drug strategy, which conflicts with harm reduction principles, and active opposition to harm reduction among frontline prison staff.[77] Similarly, a study in Western Canada found women in prison perceived NSP as being incompatible with a prison system that continues to criminalise drugs.[78]

LACK OF CONFIDENTIALITY AND ANONYMITY

In Moldova, uptake of OAT is believed to be limited by confidentiality breaches as well as stigma and a prison subculture that informally regulates access. Those who accept methadone treatment are frequently subject to bullying and isolation, directed by leaders among the prison population.[79] Despite

h Romania, Ukraine, Morocco, Moldova, Australia, Canada and Spain.

an NSP being available in most Moldovan prisons (34 sites, across 15 out of 17 prisons), a survey in 2020 found 22% of people who inject drugs in prison shared injecting equipment, suggesting the lack of anonymity in accessing the service due to the conduct of peers and medical staff may be a deterrent.[80] Perceived negative consequences of disclosing drug dependence reported by people in prison in England and Scotland include being looked down on by prison staff and peers, being considered weak and a target for bullying by other people in prison and increased attention from prison security, including more frequent body and cell searches.[81]

SPECIFIC BARRIERS FOR WOMEN IN PRISON

Women who go to prison often have complex circumstances. Many have histories of trauma, and they have higher levels of mental health issues and needs, including drug dependence, than men. All these issues are exacerbated in prison.[82] The UN Rules on the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) require specialised treatment programmes in prisons that are designed for women with substance dependence, 'taking into account prior victimization, the special needs of pregnant women and women with children, as well as their diverse cultural backgrounds' (Rule 15).[83] The Bangkok Rules also state that women in prison should receive medical screening on entry and healthcare while incarcerated, including mental healthcare, HIV treatment, care and support, support in relation to suicide and self-harm and preventive healthcare services which are responsive to the specific needs of women.

Yet, harm reduction is particularly limited for women in prison. The prison-based harm reduction services that exist are concentrated in men's facilities.

For example, the only therapeutic community in Moldovan prisons is in a male facility.[84] The two prisons in Ireland that have consultant-led, 'in-reach' drug dependence services only accommodate men.[85] The impact of such a gap in services can be fatal. For example, successive coronial inquests in Australia have identified service provision issues in women's prisons as contributing factors in women's deaths.[86]

Where harm reduction services are available in prisons, they are rarely tailored to women's specific needs and, as in the community, women who use drugs face particular stigma and discrimination when accessing services in many countries.[87]

In Eastern and Southern Africa, civil society has documented widespread barriers to accessing HIV testing and treatment in prison for women who use drugs, including humiliating and punitive treatment by prison staff and services only being available in a limited number of facilities.[88]

In Georgia, OAT (for detoxification) is not available in the women's prison. Instead, women in need of OAT are temporarily transferred to a treatment facility in a male prison where they share a psychiatric ward with men.[89] As a result, uptake is low among women who accounted for only 2 of the 754 people that benefited from prison-based OAT in 2021.[90] Discriminatory attitudes from staff and feelings of shame that lead some women to hide their drug use or dependency means it is likely that many women in prison do not access the services available in the system and deal with withdrawal on their own.[91]

Researchers have noted the dearth of research on OAT for women in Southeast Asian prisons. This fuels the continued invisibility of women in prison and possible systemic failures to safeguard and uphold their rights, in violation of the Bangkok Rules.[92]

OTHER MARGINALISED PEOPLE IN PRISON

Other groups that face particular barriers accessing harm reduction in prisons are foreign nationals (partly linked to language barriers, which have been reported in Armenia[93] and Ireland[94]), LGBTQI+ people, children, Black, Brown, ethnic minority and Indigenous people and people engaged in sex work (reported in Indonesia[95] and Armenia[96]).

The challenges these marginalised populations face in prisons are often similar to the issues they experience in the community, including services that are not responsive to their needs. In Morocco and Armenia, for example, standard services are generally provided to all individuals without consideration of the specific needs of women, LGBTQI+ people or other groups.[97] The lack of tailored services can have significant consequences for people's health and life. Research has exposed a much higher rate of opioid overdose deaths among Black people in prison in Ontario, Canada. The risk is even higher for Black women due to multiple layers of marginalisation based on race, gender and incarceration. The researchers found an urgent need for interventions to address factors including sexism and systemic and structural racism, and for culturally appropriate harm reduction and treatment services in custody and post-release. These services should be comprehensive, multisectoral, community-based and developed in partnership with Black communities.[98]

Sex workers who use drugs face barriers accessing services due to the layered stigma surrounding drug use, sex work and sexual orientation, which in many countries are all criminalised to varying degrees. In Indonesia, trans and gender diverse sex workers who use drugs who are incarcerated are failed by existing harm reduction structures. In Bali, this has led the Women and Harm Reduction International Network (WHRIN) and YAKEBA to launch Project GAP to identify and address data, service provision and stakeholder accountability gaps for sex workers who use drugs.[99] As part of the project, focal points for sex workers who use drugs have been trained on harm reduction, and harm reduction providers have been trained on sexual orientation and gender identity rights, sex worker rights and gender responsive services.

In some countries, trans and gender diverse people in prison are held in long periods of lock-up and solitary confinement, often on grounds of protection. This limits their access to all services in prison, including harm reduction. This has been reported in Ireland,[100] Zambia and the USA.[101]

“ The challenges these marginalised populations face in prisons are often similar to the issues they experience in the community, including services that are not responsive to their needs. The lack of tailored services can have significant consequences for people’s health and life.”

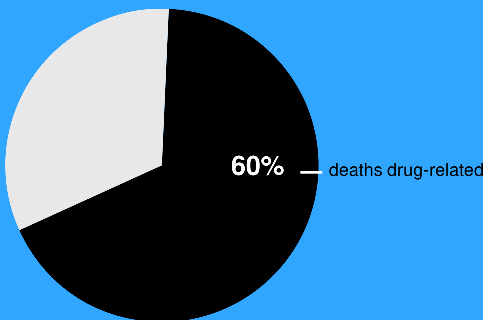
CONTINUITY OF CARE ON RELEASE FROM PRISON

The period following release from prison is one of heightened vulnerability as people experience multiple challenges re-entering society and face higher risks of relapsing to substance use as well as overdose and death.[102] In England and Wales, over 60% of deaths among people in the first two weeks after prison release since 2021 have been drug-related.[103] The risk of dying from an opioid overdose among men and women who had been in prison in Ontario, Canada between 2015 and 2022 was 28 times and 78 times higher, respectively, than in the general population.[104] The risk of injecting-related infections is higher in the first two weeks after release in Australia, with factors such as poor access to health and harm reduction services, poverty, experience of homelessness and reduced opioid tolerance after incarceration likely to be contributing factors.[105]

Receiving OAT while in prison is crucial for reducing deaths among people who use drugs for six months after release (both all-cause deaths and overdose deaths).[106]

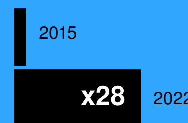
Post-release OAT retention is associated with lower rates of contact with emergency healthcare after release [107] and higher rates of contact with broader primary healthcare.[108] Higher doses of methadone (at least 80 mg per day) before release have been shown to increase the likelihood of retention in post-release OAT. In Malaysia, for example, 46% of people in prison who received a higher methadone dose stayed on OAT after release compared to 28% of those on lower doses.[109] A review of three Southeast Asian countries found family support and reducing societal stigma were key enablers to staying on OAT post-release, while barriers to retention included a lack of trained prison staff and high turnover, poor coordination between prison and community and limited availability of treatment.[110] The researchers noted that, despite the growing

In England and Wales, over 60% of deaths among people in the first two weeks after prison release since 2021 have been drug-related.



The risk of dying from an opioid overdose among men and women who had been in prison in Ontario, Canada between 2015 and 2022 was 28 times and 78 times higher than the general population.

WOMEN



MEN

availability of OAT in the community in the region, the challenge remains to support continuity of care both in and out of prison.

In most of the countries surveyed for this report,[i] some form of support is available to people accessing harm reduction in prisons so they can continue accessing services after release and is often provided by civil society organisations (CSOs). However, significant challenges remain. In Victoria, Australia, for example, if people have a significant mental health disorder or are on HCV treatment there are policies for active referral to community-based treatment, but most other healthcare continuity is simply a paper-based health discharge summary provided to people on release to take to their healthcare providers.[111]

In a positive move, Community Transition Teams have been expanded in British Columbia, Canada, from covering 5 correctional centres in the pilot launched in 2019 to province-wide coverage (10 centres), with support extended from 30 to 90 days following release.[112] This initiative of BC Mental Health and Substance Use Services (part of the Provincial Health Services Authority) aims to reduce overdose deaths, enhance health outcomes and reduce the harms associated with repeat involvement with the criminal legal system.[113] The teams are made up of social workers, peer support workers, Indigenous patient navigators and nurse prescribers who provide short-term clinical intervention and link clients to mental health and substance use services in the community.[114]

MANAGEMENT OF HARM REDUCTION IN PRISONS

Prison healthcare should be organised in close relationship with the national health system in a way that ensures continuity of treatment and care, including for HIV, tuberculosis, other infectious diseases and drug dependence, as required by the Nelson Mandela Rules.[115] Both the WHO and the UNODC recommend that the most effective way of doing this is to assign responsibility for prison healthcare to the national health authority, rather than the prison administration.[116] In Germany, for example, prison healthcare is under the ministries of justice in the 16 *Länder* (states), and care for people with opioid dependency is fragmented; some Länder have almost no waiting list for prison-based OAT and others provide hardly any treatment at all, meaning people on OAT will not be able to continue in prison.[117] In Armenia, while the Penitentiary Medical Centre collaborates with healthcare institutions that provide harm reduction, significant issues in continuity of care mean people face interruptions in the services they have initiated both upon entering and leaving prison.[118] The failure to transfer responsibility for prison health to the regional health services in Spain is seen as a barrier to the expansion of harm reduction in prisons.[119]
Countries that have transferred responsibility for prison health to the health ministry include Norway, Finland, Italy, England and Wales and Kazakhstan.[120] In April 2024, Portugal proposed a gradual transfer, with the aim of ensuring people have uninterrupted access to healthcare during incarceration and upon release by 2030.[121]

DELIVERY OF HARM REDUCTION IN PRISONS

In almost all the countries surveyed, harm reduction in prisons is delivered by a range of providers. In Ukraine, for example, healthcare staff with specialised training manage testing, treatment and the coordination of OAT, while counselling, information and educational activities are conducted by social workers or peer volunteers from the prison, and non-governmental organisations are involved with NSP.[122] Services are most commonly delivered by healthcare staff that are trained for this purpose

i Respondents of the prisons thematic survey in 11 out of 14 countries indicated that some form of support is available to people accessing harm reduction in prisons to continue access upon release.

(in 10 of the 11 countries where information was available)[j] and outside organisations like CSOs (9 countries).[k] Prison staff deliver some harm reduction in more than half of the countries,[l] often but not always with dedicated training.

Peer programmes exist in 7 out of the 11 countries.[m] In Morocco and Ireland, these focus on training peer educators in prisons. The Irish Red Cross (IRC) provides peer programmes on overdose prevention and naloxone training to prepare people for release (in prison, naloxone may only be administered by a nurse in an emergency). IRC peers also run HCV and HIV awareness and anti-stigma campaigns, with voluntary screening.[123]

QUALITY OF SERVICES IN PRISONS

The quality of information and services provided is often lower in prisons than in the community, resulting in poorer experiences and outcomes for clients. A recent study found 80% of people receiving OAT in Estonian prisons reported not receiving the guidelines or rules at the beginning (compared to 20% in the community), and no one had attended peer-led support groups, suggesting these services are likely not offered in prisons.[124] About half said there was no designated person within the prison for the services, implying inadequate oversight and support for people undergoing OAT in prisons.[125]

Research has also shown about half of people receiving OAT in prisons in England were pleased with the service they received, while the other half were disappointed, suggesting that good practice is reliant on the culture and commitment of healthcare and prison staff in individual establishments.[126]

Participants emphasised that, in almost every case, a peer or staff member treating them with compassion, as a human being, was key to their engagement and commitment to treatment or recovery.

SCALE UP AND SUSTAINABILITY OF SERVICES IN PRISONS

Most harm reduction programmes in prisons, including OAT and NSP, are small with limited coverage and unevenly distributed across prison systems, with many relying heavily on donor funding and support.[127] National scale up and linkage to national HIV and public health programmes is crucial to ensure equity across prisons and between prisons and the community, while incorporation into state budgets ensures sustainability by protecting services from fluctuations in external funding. In Romania, for example, NSP, OAT and prevention programmes for groups at increased risk of HIV were dramatically reduced once funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) ended, and the government was not able to take over and sustain the financing of services.[128]

In contrast, some prisons in Moldova started offering harm reduction services in 2000 through international funding and technical assistance. Over the years, the country developed a supportive regulatory environment and started funding services from the state budget[129] and has also expanded services.[130] Harm reduction programmes in prisons in Mauritius are funded by the government, mainly through the ministry of health and other ministries' budgets, with contribution from the Global Fund for specific items.[131]

j Pakistan, Mauritius, Romania, Ukraine, Moldova, Morocco, Australia, Canada, Ireland and Spain.
k Pakistan, Romania, Ukraine, Moldova, Morocco, Australia, Canada, Ireland and Spain.
l Mauritius, Romania, Ukraine, Morocco, Australia, Canada and Spain.
m Mauritius, Ukraine, Moldova, Morocco, Australia, Canada and Ireland.

Among the countries surveyed for this report, the biggest barriers to the introduction or expansion of harm reduction in prisons were laws prohibiting drug consumption and sexual relations in prisons, stakeholder support for the ideological principles of abstinence and drug-free prisons, and a lack of support from staff and the general population. In Australia, unions for prison staff are strongly against prison-based NSP and wield considerable power over aspects of prison policies which they believe (despite a lack of evidence) could compromise their health.

In a workshop held by the International Network on Health and Hepatitis in Substance Users – Prisons Network in October 2023, critical barriers preventing the scale up of prison-based hepatitis services were identified as the lack of political will, poor knowledge, attitudes and awareness among prison leadership and staff of viral hepatitis and harm reduction, a lack of education and information on safe injecting practices, stigma around people who use drugs in prison, a lack of sustainable financing and shortages of medical staff.[132]

Importantly, researchers have noted that while every effort should be made to expand and improve harm reduction services in prisons, for many people in prison with histories of drug use, imprisonment offers little rehabilitative value.

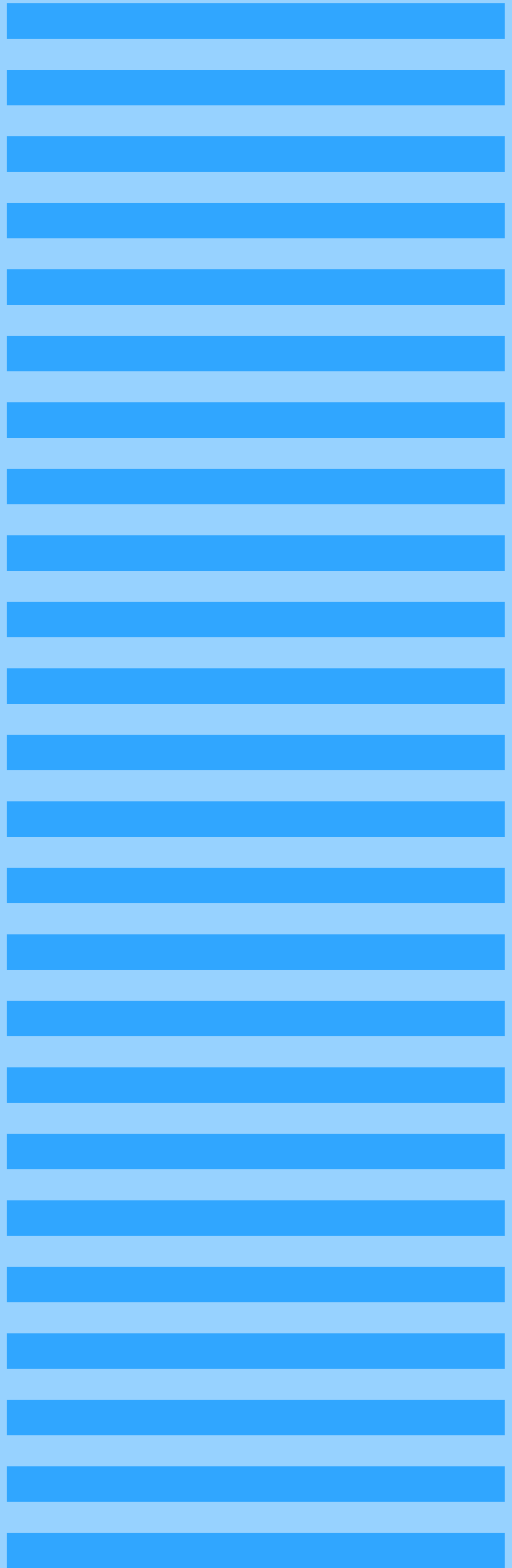
People with drug dependency would be better served by community-based responses which address the root causes of criminal behaviour, are more successful in reducing reoffending, cheaper than imprisonment and do not increase health risks.[133] Both the UN System Common Positions on drugs and on incarceration recognise the need to reduce the use of imprisonment, and more UN human rights experts and treaty bodies are urging countries to adopt decriminalisation and alternatives to prison to protect the human rights of people who use drugs.[134]

1 United Nations Office on Drugs and Crime, (2024), *Prison Matters 2024: Global Prison Population and Trends; A Focus on Rehabilitation*, UNODC, Vienna, p. 11.
2 International Drug Policy Consortium, (2023), *Off Track: Shadow Report for the Midterm Review of the 2019 Ministerial Declaration on Drugs*, IDPC, London, p. 11.
3 UN General Assembly, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem: Report of the Office of the United Nations High Commissioner for Human Rights*, A/HRC/54/53, para. 24, UNGA, New York.
4 United Nations Office on Drugs and Crime, (2024), *World Drug Report 2024, Special Points of Interest*, p. 9, UNODC, Vienna.
5 International Drug Policy Consortium, (2023), *Off Track: Shadow Report for the Midterm Review of the 2019 Ministerial Declaration on Drugs*, p. 48, IDPC, London.
6 Ibid., p. 53.
7 Fazel, S., I.A. Yoon and A. Hayes, (2017), 'Substance use disorders in prisoners: an updated systematic review and metaregression analysis in recently incarcerated men and women', *Addiction*, vol. 112, p.1725–1739.
8 Among others, see Favril, A., (2023), 'Drug use before and during imprisonment: Drivers of continuation', *International Journal of Drug Policy*, vol. 115, e104027 and Norman, C. (2022), 'A global review of prison drug smuggling routes and trends in the usage of drugs in prisons', *WIREs Forensic Science*, vol. 5, no. 2, e1473. In Mauritius, 20% of the prison population report drug dependence: National Audit Office, (2023), *Performance Audit Report: Enhancing the Effectiveness of the Interventions Related to Drug Demand and Harm Reduction*, NAO, London, p. 16.
9 Austin, A., et al., (2023), 'Factors associated with drug use in prison: A systematic review of quantitative and qualitative evidence', *International Journal of Drug Policy*, vol. 112, e104248.
10 Australian Institute of Health and Welfare, (2023), *The health of people in Australia's prisons 2022*, p. 99, AIHW, Canberra.
11 Ibid., p. 102-103.
12 See, for example, Penal Reform International, 'Key facts', [web page, accessed August 2024], PRI, London. Available from www.penalreform.org/issues/healthcare/key-facts/.
13 UNAIDS, (2024), *The urgency of now: AIDS at a crossroads*, p. 47, UNAIDS, Geneva.
14 United Nations Office on Drugs and Crime, (2023), *Prisons and HIV: Situation and Response Analysis in High-Priority Countries 2021/2022*, p. 5, p. 26, p. 28, UNODC, Vienna.
15 United Nations Office on Drugs and Crime, 'Prisons and HIV' [web page, accessed August 2024], UNODC, Vienna. Available from www.unodc.org/unodc/es/hiv-aids/new/prison_settings_HIV.html.
16 See, for example, Spaulding, A.C., et al., (2023), 'Estimates of Hepatitis C Seroprevalence and Viremia in State Prison Populations in the United States', *Journal of Infectious Diseases*, vol. 228, no. 3, p.160-167.
17 Harm Reduction International, (2022), *Availability, accessibility, acceptability and quality of harm reduction services in Moldovan prisons*, p. 5, HRI, London.
18 See, for example, UN General Assembly, (2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, A/HRC/22/53, para. 73, UNGA, New York.
19 Hamdaoui, S., (7 May 2024) 'Visite parlementaire à la maison d'arrêt de Villeneuve-lès-Maguelone, unique en France pour la réduction des risques' [online article, accessed August 2024], ICI, Paris. Available from www.francebleu.fr/infos/societe/visite-parlementaire-a-la-maison-d-arret-de-villeneuve-les-maguelone-unique-en-france-pour-la-reduction-des-risques-9379104; World Health Organization, (18 July 2023), 'The independence of doctors is essential: the work of a Montpellier prison towards eliminating hepatitis C' [online article, accessed August 2024], WHO, Geneva. Available from www.who.int/azerbaijan/news/item/18-07-2023-the-independence-of-doctors-is-essential--the-work-of-a-montpellier-prison-towards-eliminating-hepatitis-c.
20 Masuda Q.N., et al., (2023), 'Outcomes of Pharmacist-Led Treatment of Hepatitis C in the Virginia Department of Corrections', *Journal of Correctional Health Care*, vol. 29, no. 6.
21 United Nations General Assembly, (2015), *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution 70/175, annex, adopted on 17 December 2015, Rule 24(1)*, UNGA, New York.
22 United Nations Office on Drugs and Crime and the World Health Organization, (2023), *Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for people in prisons and other closed settings, Policy brief*, UNODC/WHO, Vienna and Geneva.
23 UN General Assembly, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem: Report of the Office of the United Nations High Commissioner for Human Rights*, A/HRC/54/53, para. 12, UNGA, New York; UN General Assembly, (2024), *Drug use, harm reduction and the right to health: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng*, A/HRC/56/52, para. 21, UNGA, New York.
24 International Drug Policy Consortium, (2023), *Off Track: Shadow Report for the Midterm Review of the 2019 Ministerial Declaration on Drugs*, p. 33, IDPC, London.
25 Pont, J., A. Muriqi and F. Meroueh, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
26 Asociația Română Anti-SIDA, (2023), *Human Rights for All Humans: Report of the Analysis of Harm Reduction Services for Persons Deprived of Liberty, Romania*, p. 2, ARAS, Bucharest.
27 World Prison Brief, 'Romania' [web page, accessed August 2024], Birkbeck, University of London, London. Available from www.prisonstudies.org/country/romania.
28 World Prison Brief, 'Mauritius' [web page, accessed August 2024], Birkbeck, University of London, London. Available from www.prisonstudies.org/country/mauritius.
29 National Audit Office, (2023), *Performance Audit Report: Enhancing the Effectiveness of the Interventions Related to Drug Demand and Harm Reduction*, p. 29, NAO, London.
30 Commonwealth Human Rights Initiative, (2022), *Inside Punjab Prisons: A study on prison conditions, Part A*, p. 87-88, 123-124. CHRI, New Delhi, London and Accra.
31 Parmar, A., R. Chakraborty and Y.P.S. Balhara, (2024), 'Current status of harm reduction in India: Are we doing enough?', *Indian Journal of Psychiatry*, vol. 66, no.4, p.388–391.
32 Eurasian Harm Reduction Association, (2023), 'Armenia' [web page, accessed September 2024], EHRA, Vilnius. Available from https://harmreductioneurasia.org/drug-policy/criminalization-costs/armenia.
33 Correctional Services Canada, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey, response'.
34 Saberi Zafarghandi, M.B., et al., (2024), 'Addiction treatment and harm reduction programs in prisons: lessons from Iran' [pre-print, available online], Research Square, Eindhoven. Available from https://doi.org/10.21203/rs.3.rs-3931219/v1.
35 Communication with UNDP in Kyrgyzstan as part of the Global State of Harm Reduction 2024 survey follow up.
36 Clark, S., (9 July 2024), 'Compassion in Conflict: Harm Reduction for Prisoners in Ukraine' [online article, accessed August 2024], Hot Press, Dublin. Available from www.hotpress.com/opinion/compassion-in-conflict-harm-reduction-for-prisoners-in-ukraine-23037744.
37 European Union Drugs Agency, (2024), *Statistical Bulletin 2024 — health and social responses* [web resource, accessed August 2024], EUDA, Lisbon. Available from www.euda.europa.eu/data/stats2024/hsr_en#displayTable:HSR-4-1.
38 Ibid.
39 Schäffer, D., (2024), 'Global State of Harm Reduction 2024 survey response'.
40 Marthaler, M., (2024), 'Global State of Harm Reduction 2024 survey response'.
41 Communication with Meroueh, F. as part of Global State of Harm Reduction 2024 survey follow up.
42 Clark, S., (9 July 2024), 'Compassion in Conflict: Harm Reduction for Prisoners in Ukraine' [online article, accessed August 2024], Hot Press, Dublin. Available from www.hotpress.com/opinion/compassion-in-conflict-harm-reduction-for-prisoners-in-ukraine-23037744.
43 Ibid.
44 European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment, (2023), *Response of the Austrian Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its periodic visit to Austria from 23 November to 3 December 2021 (CPT/Inf (2023) 04),* p. 16 CPT, Strasbourg.
45 Communication with Meroueh, F. as part of the Global State of Harm Reduction 2024 survey follow up.
46 European Union Drugs Agency, (2024), *Harm reduction – the current situation in Europe (European Drug Report 2024)*, p. 12-13, EUDA, Lisbon.
47 Ronconi, S., (2024), 'Global State of Harm Reduction 2024 survey response'.
48 Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
49 European Union Drugs Agency (2024), *Harm reduction – the current situation in Europe (European Drug Report 2024)*, p. 12-13, EUDA, Lisbon.
50 Abel-Ollo K. and M. Oja, (2024), 'Global State of Harm Reduction 2024 survey response'.
51 European Union Drugs Agency (2024), *Harm reduction – the current situation in Europe (European Drug Report 2024)*, pp. 12-13, EUDA, Lisbon.
52 Vlasenko, L., (2024), 'Global State of Harm Reduction 2024 survey response'.
53 Ka Hon Chu, S. and A. Juristia, (2024), 'Global State of Harm Reduction 2024 survey response'.
54 Santamour, T et al., (2024), 'Global State of Harm Reduction 2024 survey response'.
55 Hiley, S., P. Dietze and G. Davey, (2024), 'Global State of Harm Reduction 2024 survey response'.
56 Ronconi, S., (2024), 'Global State of Harm Reduction 2024 survey response'.

57 Juristia, A., (2024), 'Global State of Harm Reduction 2024 survey response'.
58 Dietze, P., (2024), 'Global State of Harm Reduction 2024 survey response'.
59 Communication with Meroueh, F. (2024) as part of Global State of Harm Reduction 2024: Prisons and Harm Reduction survey follow up.
60 Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
61 Gough, C., (2024), 'Global State of Harm Reduction 2024 survey response'.
62 HIV Legal Network & Centre on Drug Policy Evaluation, (2023), *Joint Submission to the Office of the UN High Commissioner for Human Rights pursuant to Human Rights Council resolution 52/24 entitled "Contribution of the Human Rights Council with regard to the human rights implications of drug policy"*, p. 3, CDPE, Toronto.
63 Department of Justice Office of the Inspector General, (2024), *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, OIG, Washington DC. See also: Levin, S. (15 February 2024), 'Hundreds of deaths in US prisons linked to policy violations and failures – report' [online article, accessed August 2024], The Guardian, London. Available from www.theguardian.com/us-news/2024/feb/15/prison-death-causes-preventable-justice-department.
64 Taekema, D., (6 February 2024), 'Overdose prevention site opens at Kingston prison, but inmates remain wary' [online article, accessed August 2024], CBD News, Toronto. Available from www.cbc.ca/news/canada/ottawa/overdose-prevention-service-opens-collins-bay-1.7105518.
65 Smith, A., (13 February 2023), 'Prison watchdog calls for more harm-reduction services to prevent drug overdoses and deaths' [online article, accessed August 2024], The Globe and Mail, Toronto. Available from www.theglobeandmail.com/canada/article-prison-watchdog-harm-reduction-overdose-crisis/.
66 Taekema, D., (6 February 2024), 'Overdose prevention site opens at Kingston prison, but inmates remain wary' [online article, accessed August 2024], CBD, Toronto. Available from www.cbc.ca/news/canada/ottawa/overdose-prevention-service-opens-collins-bay-1.7105518.
67 Harm Reduction International, Unmode and European Prison Litigation Network, (2024), *Joint Submission to the Special Rapporteur on Health's report on Harm Reduction for peace and development*, HRI, London.
68 MENAHRA, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
69 Social Welfare Bureau of the Macao SAR Government, (2022), *Report on Drug Control in Macao 2022*, p. 56, Macao.
70 National Audit Office, (2023), *Performance Audit Report: Enhancing the Effectiveness of the Interventions Related to Drug Demand and Harm Reduction*, p. 78, NAO, London.
71 Russell, C., et al., (2022), 'Opioid agonist treatment (OAT) experiences and release plans among federally incarcerated individuals with opioid use disorder (OUD) in Ontario, Canada: a mixed-methods study', *BMC Public Health*, vol. 22, no. 436. See also Harm Reduction International, (2022), *The Global State of Harm Reduction 2022*, p. 147, HRI. London.
72 Marshall, A.D., et al., (2023), 'Perceived access to opioid agonist treatment in prison among people with a history of injection drug use: A qualitative study', *Journal of Substance Use and Addiction Treatment*, vol. 150, e209066.
73 Lăutaru, A., (9 November 2018), 'Deținuți din România mi-au povestit cum luptă cu dependența de droguri' [online article, accessed August 2024], Vice, New York. Available from www.vice.com/ro/article/detinuti-din-romania-dependenti-de-droguri/.
74 Asociația Română Anti-SIDA, (2023), *Report of the Analysis of Harm Reduction Services for Persons Deprived of Liberty, Romania, December 2023*, p. 11, ARAS, Bucharest.
75 Komalasari R., et al., (2020), 'Multiple burdens of stigma for prisoners participating in opioid antagonist treatment (OAT) programmes in Indonesian prisons: a qualitative study', *International Journal of Prisoner Health*, vol. 17, no. 2, p.156-170.
76 Smith, A., (13 February 2023), 'Prison watchdog calls for more harm-reduction services to prevent drug overdoses and deaths' [online article, accessed August 2024], The Globe and Mail, Toronto. Available from www.theglobeandmail.com/canada/article-prison-watchdog-harm-reduction-overdose-crisis/.
77 Office of the Correctional Investigator, (2022), *Annual Report 2021-2022*, Canadian Government, Ontario.
78 Giffin, L., et al., (2023), 'Sticking points: Incarcerated women's views on barriers to a prison needle exchange program', *Incarceration*, vol. 4.
79 Harm Reduction International, (2022), *Availability, accessibility, acceptability and quality of harm reduction services in Moldovan prisons*, HRI, London.
80 Ibid.
81 Webster R., et al., (2024), 'Accessing opioid agonist treatment in prison in England and Scotland remains problematic – the views of people with lived experience', *International Journal of Prison Health*, vol. 20, no. 2. See also Webster, R., (9 January 2024), 'The lived experience of opioid users in prison' [online article, accessed August 2024], Russell Webster, Rainham, UK. Available from www.russellwebster.com/the-lived-experience-of-opioid-users-in-prison/.
82 United Nations Office on Drugs and Crime, (2024), *Prison Matters 2024: Global Prison Population and Trends; A Focus on Rehabilitation*, p. 29, UNODC, Vienna.
83 UN General Assembly, (2011), *Resolution adopted by the General Assembly on 21 December 2010*, A/RES/65/22, UNGA, New York.
84 Doltu, S., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
85 Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
86 Stoove, M., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
87 UN General Assembly, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem: Report of the Office of the United Nations High Commissioner for Human Rights*, A/HRC/54/53, paras. 47, 49, UNGA, New York. See also Vienna and New York NGO Committees on Drugs, (2024), *Global Civil Society Report for the 2024 mid-term review of the Commission on Narcotic Drugs*, p. 16, VNGOC and NYNGOC, Vienna and New York.
88 Harm Reduction International, Unmode and European Prison Litigation Network, (2024), *Joint Submission to the Special Rapporteur on Health's report on Harm Reduction for peace and development*, HRI, London.
89 Harm Reduction International and GeNPUD, (2023), *A survey of the availability, accessibility and quality of harm reduction services in prisons in Georgia*, p. 7, 15, HRI. London.
90 National Center for Monitoring the Drug Situation, (2022), *Annual Report on the Drug Situation 2021*, Ministry of Justice of Georgia, Tbilisi.
91 Harm Reduction International and GeNPUD, (2023), *A survey of the availability, accessibility and quality of harm reduction services in prisons in Georgia*, p. 14, HRI, London.
92 Loh, D.A., Plugge E and M.C. van Hout, (2023), 'Continuity of opioid substitution treatment between prison and community in Southeast Asia: A scoping review', *International Journal of Drug Policy*, vol. 112, e103957.
93 Hovhannisyan, N., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
94 Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
95 Yayasan Karisma (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
96 Hovhannisyan, N., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
97 ALCS (Association de Lutte Contre le Sida) (Morocco) and Hovhannisyan N (Armenia), (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
98 Owusu-Bempah A., et al., (2023), 'Opioid toxicity deaths in Black persons who experienced provincial incarceration in Ontario, Canada 2015–2020: A population-based study', *Preventive Medicine*, vol. 177, e107778.
99 CND Blog, (19 March 2024), 'Side event: Breaking Barriers and Building Bridges: Navigating Justice for Womxn who Use Drugs', [online blog, accessed August 2024], IDPC, London. Available from https://cndblog.org/2024/03/side-event-breaking-barriers-and-building-bridges-navigating-justice-for-womxn-who-use-drugs/.
100 Office of the Inspector of Prisons, (2021), *COVID-19 Thematic Inspection of Limerick Prison 6 - 7 April 2021*, OIP, Co. Tipperary, Ireland.
101 Penal Reform International and Trans Europe and Central Asia, (2024), *Placement of trans and non-binary people: A guide for prisons*, p. 9. PRI, London.
102 Cooper J.A., et al., (2023), 'Record linkage studies of drug-related deaths among adults who were released from prison to the community: a scoping review', *BMC Public Health,* vol. 23, no. 826; Binswanger I.A., et al., (2012), 'Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors', *Addiction Science & Clinical Practice*, vol. 7, no.1. p. 3.
103 Prisons and Probation Ombudsman, (2024), *Learning lessons bulletin: Fatal incident investigations. Issue 19*, PPO, London.
104 Butler A., et al., (2023), 'Burden of opioid toxicity death in the fentanyl-dominant era for people who experience incarceration in Ontario, Canada, 2015–2020: A whole population retrospective cohort study', *BMJ Open*, vol. 13, e071867.
105 Brothers, T.D., et al., (2023), 'Effect of incarceration and opioid agonist treatment transitions on risk of hospitalisation with injection drug use-associated bacterial infections: A self-controlled case series in New South Wales, Australia', *International Journal of Drug Policy*, vol. 122, e104218.
106 Bukten, A. and M.R. Stavset, (2024), 'Estimated effects of opioid agonist treatment in prison on all-cause mortality and overdose mortality in people released from prison in Norway: a prospective analysis of data from the Norwegian Prison Release Study (nPRIS)', *Lancet Public Health*, vol. 9: e421–3.
107 Brothers, T.D., et al., (2023), 'Effect of incarceration and opioid agonist treatment transitions on risk of hospitalisation with injection drug use-associated bacterial infections: A self-controlled case series in New South Wales, Australia', *International Journal of Drug Policy*, vol. 122, e104218.

108 Curtis, M. et al., (2023), 'Is use of opioid agonist treatment associated with broader primary healthcare use among men with recent injecting drug use histories following release from prison? A prospective cohort study', *Harm Reduction Journal*, vol. 20, no. 42.
109 Ahmad, A., et al., (2024), 'Higher methadone dose at time of release from prison predicts linkage to maintenance treatment for people with HIV and opioid use disorder transitioning to the community in Malaysia', *International Journal of Drug Policy*, vol. 126, e104369.
110 Loh, D.A. et al.,(2023), 'Continuity of opioid substitution treatment between prison and community in Southeast Asia: A scoping review', *International Journal of Drug Policy*, vol. 112, e103957.
111 Curtis, M., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
112 British Columbia Government (3 October 2022), 'Vital supports expanded for people leaving correctional centres' [online article, accessed August 2024], BC Gov News, Victoria. Available from https://news.gov.bc.ca/releases/2022MMHA0063-001465.
113 BC Mental Health & Substance Use Services, 'Community Transition Teams' [web page, accessed August 2024], BCHSUS, Vancouver. Available from www.bcmhsus.ca/correctional-health-services/community-transition-teams.
114 For more details, see: British Columbia Centre on Substance Use, (2023), *An evaluation of the use of Community Transition Teams to improve health outcomes for individuals with an opioid use disorder following release from British Columbia Corrections (The OPAC Corrections Study)*, BCCSU, Vancouver.
115 UN General Assembly, (2015), *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution 70/175, annex, adopted on 17 December 2015, Rule 24(2),* UNGA, New York.
116 United Nations Office on Drugs and Crime and the WHO Regional Office for Europe, (2013), *Good governance for prison health in the 21st century*, UNODC and WHO, Vienna and Geneva.
117 Stöver, H., et al., (2022), 'Discontinuation of Adequate Opioid Agonist Treatment in Prison: A Violation of Human Rights', in *Human Rights Behind Bars* edited by C. Burbano Herrera and Y. Haeck Y, Springer, The Hague.
118 Hovhannisyan, N., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
119 Etxebarria, X., (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
120 Penal Reform International and Thailand Institute of Justice, *Global Prison Trends 2023*, p. 26, PRI, London.
121 World Health Organization, (18 April 2024), 'Portugal proposes integration of prison health into its National Health Service' [online article, accessed August 2024], WHO, Geneva. Available from www.who.int/europe/news/item/18-04-2024-portugal-proposes-integration-of-prison-health-into-its-national-health-service.
122 FREE ZONE, Ukraine, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
123 Irish Penal Reform Trust, (2024), 'Global State of Harm Reduction 2024: Prisons and Harm Reduction survey response'.
124 Eurasian Harm Reduction Association, (2024), *Client satisfaction with opioid agonist treatment in Estonia (Summary)*, p. 12, EHRA, Vilnius.
125 Ibid., p. 17.
126 Webster, R., et al., (2024), 'Accessing opioid agonist treatment in prison in England and Scotland remains problematic – the views of people with lived experience', *International Journal of Prison Health*, vol. 20, no. 2. See also Webster, R., (9 January 2024), 'The lived experience of opioid users in prison' [online article, accessed August 2024], Russell Webster, Rainham, UK. Available from www.russellwebster.com/the-lived-experience-of-opioid-users-in-prison/
127 UNAIDS, (2023), *Submission to the Office of the High Commissioner for Human Rights Report on human rights challenges in addressing and countering all aspects of the world drug problem, pursuant to HRC resolution 52/24,* UNAIDS, Geneva.
128 Asociația Română Anti-SIDA, (2023), *Report of the Analysis of Harm Reduction Services for Persons Deprived of Liberty, Romania, December 2023*, p. 2, ARAS, Bucharest.
129 UNAIDS, (5 May 2023), 'Moldova expands harm reduction services to all prisons' [online article, accessed August 2024], UNAIDS, Geneva. Available from www.unaids.org/en/resources/presscentre/featurestories/2023/may/20230505_moldova-expands-harm-reduction-services-prisons.
130 Harm Reduction International, (2022), *Availability, accessibility, acceptability and quality of harm reduction services in Moldovan prisons*, HRI, London.
131 National Audit Office, (2023), *Performance Audit Report: Enhancing the Effectiveness of the Interventions Related to Drug Demand and Harm Reduction*, p. 27, NAO, London.
132 International Network on Health and Hepatitis in Substance Users, (2024), *INHSU Prisons Third Annual Workshop*, INHSU Prisons, Zürich.
133 Curtis, M., et al., (2022), 'Switching of opioid agonist treatment modality during imprisonment: a novel marker for increased support need during and following release from prison', *International Journal of Drug Policy*, vol. 100, e103572.
134 International Drug Policy Consortium, (2023), *Off Track: Shadow Report for the Midterm Review of the 2019 Ministerial Declaration on Drugs*, p. 53, IDPC, London.

THEMATIC CHAPTER: YOUTH



THE GLOBAL STATE
OF HARM REDUCTION 2024

AUTHORS OF YOUTH CHAPTER: Charity Monareng and Ruby Rose Lawlor

Charity Monareng is the Executive Director of Students for Sensible Drug Policy International. She has previously worked with TB HIV Care in South Africa, where she passionately advocated for drug policy reform at national, regional and international levels. She serves on the Board of the South African Network of People Who Use Drugs (SANPUD), Digital Girl Africa and Stand Action. Charity is also pursuing her PhD in the Department of Public Law at the University of Cape Town, reflecting her deep commitment to law and public policy.

Ruby Rose Lawlor is the Executive Director of Youth RISE. She is a drug policy reform and harm reduction activist, with a background in grassroots youth activism. Ruby has worked with Students for Sensible Drug Policy, provided festival harm reduction through Chill Welfare in the UK, and while living in Uganda, she worked with the Human Rights Centre Uganda, and the Uganda Harm Reduction Network, implementing projects tailored to youth harm reduction and advocacy.

YOUTH

For the first time, the *Global State of Harm Reduction* includes a chapter dedicated to young people and harm reduction. This chapter, based on data from a newly conducted survey, provides valuable insights into the experiences and challenges faced by young people who use drugs, and offers a comprehensive overview of the current state of harm reduction services available to this age group.

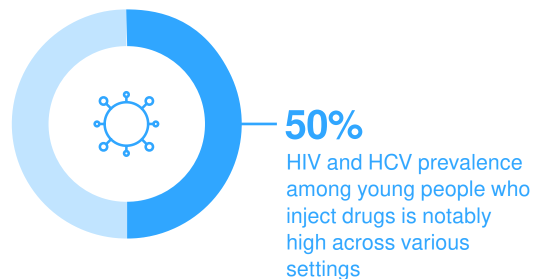
The past two years have seen some recognition that harm reduction services are crucial for protecting the health and human rights of people who use drugs. However, young people who use drugs remain underserved, as most harm reduction services have been designed for adults who use drugs (30 years and older).[1] This has created a gap in addressing the unique needs of adolescents (10-15 years old) and young people (15-24 years old).[2] Interventions for adolescents and young people continue to focus primarily on prevention and abstinence-based treatment, making harm reduction for this group a controversial subject.[3]

Young people represent one of the largest demographic groups that uses drugs and have distinct substance use patterns that require specific, evidence-based and tailored harm reduction services.[4]

Young people who inject drugs are 50% more likely to acquire HIV and hepatitis C (HCV) than their adult counterparts.[5] HIV and HCV prevalence among young people who inject drugs is notably high across various settings.[6] For example, in North America, young people are disproportionately affected by overdoses[7] and drug poisonings, and overdose is now the third leading cause of death among this age group.[8]

Adolescents and young people are often subject to different ethical and legal frameworks than older people who use drugs, which dictate the extent to which young people can access harm reduction services. These frameworks are often based on paternalistic paradigms, which prioritise young people's 'protection' against drug use over their autonomy.[9] This results in restrictive policies that do not fully address the realities of adolescent's and young people's lives and their drug use. The legal status of certain harm reduction interventions varies widely across regions and countries, leading to inconsistencies in the availability and accessibility of these services for adolescents and young people.[10]

Young people who inject drugs are 50% more likely to acquire HIV and hepatitis C than their adult counterparts.



“Young people and adolescents need services that are welcoming and inclusive, free of stigma and discrimination, without age-of-consent policies, which integrate innovative or creative services and provide young people with a safe and comfortable environment where their privacy is respected and protected.”

Youth-friendly harm reduction services: issues and challenges

Despite growing support for harm reduction services such as needle and syringe programmes (NSP), opioid agonist therapy (OAT) and HIV testing for people who use drugs across different populations, many countries provide little or no services specifically for young people who use drugs.[11] One of the biggest barriers highlighted by our research is the absence of youth-friendly harm reduction services. Young people and adolescents need services that are welcoming and inclusive, free of stigma and discrimination, without age-of-consent policies, which integrate innovative or creative services and provide young people with a safe and comfortable environment where their privacy is respected and protected. To be effective, youth-friendly harm reduction services should meaningfully involve young people who use drugs as peers in their activities and decision-making processes.[12] Unfortunately, these kinds of services are lacking in most places.

Other significant barriers that prevent young people from accessing harm reduction services include stigma and discrimination within existing harm reduction services, and young people's fear of negative repercussions if they come forward, such as getting a criminal record or their career or studies being affected. Another major issue is that young people who use drugs are often unaware of harm reduction services even when they are available.

Barriers to access to harm reduction services: survey responses

	Eastern and Southern Africa	West and Central Africa	Asia	Latin America	North America	Oceania	Western Europe	Eurasia	Middle East & North Africa
ID requirements	○	○	○	○	○	○	○	nd	nd
Fear of breaches of privacy	○	●	○	○	○	○	●	nd	nd
Limited opening hours of services	●	○	○	○	●	●	○	nd	nd
Stigma and discrimination	●	●	●	●	●	●	●	nd	nd
Fear of legal repercussions	●	●	○	●	●	●	●	nd	nd
Lack of comprehensive youth-friendly services	●	○	○	●	●	○	●	nd	nd
Age restrictions	●	●	○	●	○	○	○	nd	nd
Parent/guardian consent requirement	○	○	●	○	○	○	○	nd	nd
Fear of academic repercussions	●	●	○	●	○	●	●	nd	nd
Limited awareness of services among young people who use drugs	○	●	●	●	●	●	○	nd	nd
Inaccessible location of services	●	●	○	○	●	●	○	nd	nd

● Yes ○ No nd = No Data

Stigma and discrimination

Stigma and discrimination significantly hinder young people's access to harm reduction services. If young people belong to other marginalised groups, for instance if they are female, LGBTQI+, a migrant, a sex worker or neurodiverse, this stigma is compounded, making it difficult for them to seek help without fear of judgement or exclusion.

In Burundi[13] and Uganda, stigma continues to impede young people's access to harm reduction services, despite the presence of youth-friendly service initiatives, workshops and peer involvement.[14] In South Africa, the absence of youth-specific services worsens stigma, particularly for young women, many of whom end up in rehabilitation facilities where they may face additional discrimination.[15]

Similarly, in Nigeria, although youth-friendly harm reduction services exist, stigma and discrimination, especially towards young women and young LGBTQI+ people, along with concerns about privacy and legal repercussions, hinder access.[16] In Canada, stigma within healthcare settings, particularly if young people are female, LGBTQI+ and/or neurodiverse, discourages young people from getting the help and support they need, despite the presence of comprehensive harm reduction services.[17]

In Malaysia, government-provided harm reduction services are similarly hindered by stigma and discrimination, particularly against LGBTQI+ people, making it difficult for young people who use drugs to access vital services.[18] Across Mexico, Peru, Brazil, Argentina[19] and Costa Rica, stigma and discrimination against young women, neurodiverse people, people with disabilities and other marginalised groups prevents many young people from accessing harm reduction services, putting their health at risk.[20]

Legal restrictions and fear of repercussions

Legal environments that impose strict penalties for drug-related offences also stop many young people from engaging in harm reduction services. Fear of legal consequences, parental notification and academic repercussions often deter young people from seeking support.

In Uganda, age restrictions, such as no access to services for people under 18 years old, combined with fears of academic and legal repercussions, significantly hinder young people's ability to access harm reduction services like NSP, OAT and HIV testing. Similarly, in Malaysia, the country's strict legal environment, creates a climate of fear among young people, deterring them from seeking harm reduction services, even when they are available.[21] In countries such as Austria and the UK, young people face the risk of parental notification and judgmental attitudes when seeking harm reduction services like NSPs and OAT.[22,23] Concerns about privacy breaches and potential academic consequences further discourage young people from accessing these essential services.[24]

People with intersecting criminalised identities, such as young sex workers who use drugs, often face multiple, compounded stigma and criminalisation, meaning that these populations are even more cautious and wary of available services due to concerns of legal repercussions.[25]

'They threaten to notify parents of use (even when above 18 years), withholding diagnosis and prescriptions due to suspected drug use, being told religious-based drug services are the only option, being told I'm not serious about my health.'

– Survey response from Austria (Students for Sensible Drug Policy International).

Lack of services, lack of awareness

In many regions, harm reduction services are either non-existent or inadequate. Where they do exist, financial constraints and a lack of awareness about what services are available present further barriers for young people. These challenges are often exacerbated in rural areas where service provision is limited and young people may be unaware of their options. This urban-rural divide leaves many young people who use drugs and live in rural areas without access to the necessary support, which makes them more vulnerable to drug-related harms. In several countries a lack of employment and financial opportunities, particularly in rural areas, leaves young people without essential support,[26] something that is often exacerbated by a lack of free health services.[27]

In Liberia, the complete absence of harm reduction services is especially concerning.[28] Similarly, in Costa Rica, financial constraints and the absence of dedicated harm reduction services for young people who use drugs in rural areas are particularly pronounced, and this is in a context where awareness and availability of harm reduction services in general are already low.[29] Australia also struggles with limited services in rural regions, where financial barriers further restrict access.[30] Even in Australian cities, young women, young Indigenous people, young migrants and young LGBTQI+ people face additional barriers arising from treatment-related costs and limited awareness of services.[31] In Indonesia, the situation is dire. For example, in the city of Bandung only around a quarter of young people who inject drugs access NSP services, and rural areas face even more severe shortages.[32] In Mexico, the urban-rural divide means that, while harm reduction services are available in city nighttime venues like bars and clubs, young people in rural regions often go without adequate support.[33] In Aotearoa New Zealand, harm reduction services are concentrated in urban areas, leaving rural regions with minimal access to essential services like NSP, which are primarily available through pharmacies.

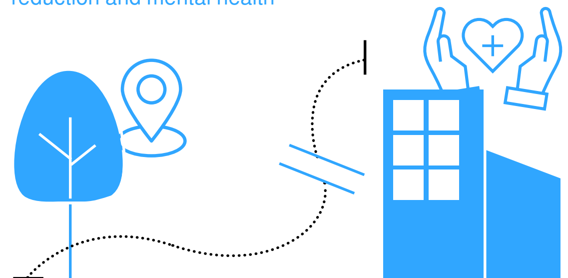
Barriers that are unique to young people

The lack of youth-specific harm reduction services, coupled with the absence of youth-friendly approaches, significantly limits young people's ability to access the care they need. Services that fail to cater specifically to young people's needs often result in low engagement and poor outcomes. In South Africa, the lack of youth-specific harm reduction services means that young people, particularly young women, often end up in facilities not designed to meet their needs, such as general rehabilitation centres. This often leaves young women vulnerable to violence and abuse, not only from partners but also from law enforcement officers who coerce young women to provide sex in order to avoid arrest.

In Ireland, the scarcity of youth-specific services further exacerbates the challenges young people face, while stigma and legal fears hinder young people's access to the limited support on offer. This is especially the case in rural Irish areas where young people who use drugs often struggle to find the support they need.[34] When it comes to good practice, a strong example can be seen in Vietnam where Lighthouse Social Enterprise's High Fun initiative works to create youth-friendly environments by involving young peers in the process. However, this is a small-scale project, leaving many young people who use drugs in Vietnam without adequate support.[35]

The urban-rural divide

Many young people who use drugs and live in rural areas lack access to essential services including harm reduction and mental health



PROVIDING SERVICES FOR YOUNG PEOPLE IN RURAL AND UNDERSERVED AREAS

Expanding health and social services to rural and underserved areas is vital for young people, who are often the most vulnerable and underserved group in these places. In many countries, urban centres receive the majority of resources, leaving rural youth with limited access to essential services, including those related to mental health, substance use and harm reduction.

In Eastern and Southern Africa, the disparity between urban and rural healthcare services is stark. Rural areas often lack the necessary infrastructure, trained personnel and youth-focused services, leaving young people who use drugs particularly vulnerable to drug-related harms. This limited access heightens health risks and restricts opportunities for lifesaving care. Similarly, in India, where a significant portion of the population lives in rural regions with inadequate healthcare, young people face considerable challenges in obtaining health services.[36] The concentration of harm reduction programmes in urban centres leaves rural youth, especially in northeastern states like Manipur and Nagaland, without sufficient support.[37] This service gap further complicates efforts to address substance use issues. In the USA, the overdose crisis has severely impacted rural communities, including young people, who often face difficulties in accessing harm reduction services. The scarcity of youth-friendly services in these areas has contributed to rising overdose rates, underscoring the urgent need to expand these services in underserved regions.[38]

ADDRESSING STIGMA AND DISCRIMINATION AGAINST YOUNG WOMEN, YOUNG LGBTQI+ PEOPLE AND YOUNG MIGRANTS

Young people face stigma surrounding drug use which can be particularly harsh. In conservative societies, such as those in the Middle East and North Africa, young women who use drugs are often stigmatised and excluded, and face both social ostracism and harsh legal penalties like corporal punishment.[39] This stigma discourages them from accessing harm reduction services or seeking support, increasing their vulnerability to health risks such as HIV and other sexually transmitted infections (STIs).

Young migrants also face significant challenges in accessing harm reduction services. With the current state of harm reduction provision already being limited to legal citizens in many countries across the world, young migrants and refugees have little to no access to harm reduction services. In Europe, for example, young migrants often encounter language barriers, cultural differences and legal restrictions that prevent them from receiving appropriate care. Countries like Greece and Italy, which serve as entry points into Europe for many migrants, struggle to provide adequate health services to migrant populations, and when healthcare is received it is often inadequate or insufficient. Migrants in irregular situations are often unaware of the services they are entitled to due to a lack of targeted information regarding their rights which results in many people not being able to access healthcare services even when they are available. This leaves young migrants at increased risk of HIV, STIs and other blood-borne diseases.[40]

LGBTQI+ youth, particularly young transgender people, often experience discrimination and violence both within their communities and from healthcare providers. In countries like Russia[41] and Uganda[42], where anti-LGBTQI+ sentiments and laws are widespread, young LGBTQI+ people face severe difficulties in accessing harm reduction services. The fear of discrimination and legal repercussions

can lead young LGBTQI+ people to avoid healthcare services altogether, which further compounds their marginalisation.[43] Addressing stigma and discrimination is crucial to improving access to harm reduction services for young people. This includes comprehensive education, training for healthcare providers and the implementation of non-discriminatory policies. Ensuring that young people, regardless of their gender, sexual orientation or migration status, can receive the care they need without fear of judgement or exclusion is essential to their wellbeing.

WAYS TO IMPROVE HARM REDUCTION SERVICES FOR YOUNG PEOPLE AND ADOLESCENTS

UN agencies have not yet formally outlined the elements that are needed for effective youth-friendly harm reduction services, but research from youth-led organisations highlights crucial components. For example, Youth Lead, Youth RISE and Y+'s *Harm Reduction Services for Young People Who Use Drugs: Case studies report*, which details specific examples of how programmes and initiatives around the world tailor their services to young people, lays out recommendations to ensure harm reduction services truly meet the needs of this population.[44] Key to effective services is the meaningful engagement of young people who use drugs in all aspects of service planning, implementation and evaluation. Including young people who use drugs as peer workers in harm reduction initiatives can make other young people more likely to relate to those services and trust them. Organisations such as CORE in Oregon, USA,[45] Trip! in Toronto, Canada[46] and Juana Banga in Lithuania[47] ensure this meaningful engagement by including young people who use drugs in decision making relating to services and including them in governance structures. These organisations also include young people who use drugs as peer workers in outreach activities and provide services like peer-to-peer counselling.[48] They do this because young people may find it easier to discuss sensitive issues with their peers who have been through similar experiences.

Specialised programmes should address the unique needs of young people, offering comprehensive, evidence-based education on substance use, harm reduction and sexual health. Utilising digital platforms and social media can make these programmes more engaging and relevant to young people. Lighthouse Social Enterprises, which runs the youth-friendly High Fun initiative in Vietnam, offers online platforms such as GTown to provide online outreach and a virtual community space covering topics like chemsex and risk reduction.[49]

Creating a non-judgmental, supportive environment within harm reduction services is crucial. Key to achieving this is creating physical safe spaces and drop-in centres that are tailored to young people; DrogArt in Slovenia is a good example of this.[50] To create such an environment, staff should be trained to address the specific concerns of young people, including issues related to mental health, gender, sexuality and cultural background. It is also important to provide trainings and education to existing healthcare service providers (such as healthcare professionals in family planning clinics) to make these spaces more youth-friendly and the staff less judgmental.[51] This approach can reduce stigma and encourage young people to seek help without fear of discrimination or legal consequences. Services should be offered without age restrictions or parental consent requirements, ensuring confidentiality to increase accessibility.

Improving accessibility also involves expanding services to rural and underserved areas, offering flexible hours and integrating harm reduction into existing youth-focused health and social services. Mobile units and pop-up clinics at events that young people attend can help reach those less likely to visit traditional healthcare settings. To support this, targeted outreach and public information campaigns should be designed to raise young people's awareness about available services in ways that young people will engage with and trust.

“Key to effective services is the meaningful engagement of young people who use drugs in all aspects of service planning, implementation and evaluation.”

Policy developments

Adolescents and young people are disproportionately affected by drug laws and policies, yet progress in youth-friendly harm reduction services has been slow.[52] Globally, there is a growing recognition of the need to address the unique challenges faced by young people who use drugs. A 2023 report by Dr. Tlaleng Mofokeng, the Special Rapporteur on the right to health for the UN, highlighted the need for tailored interventions for young people, noting the negative impact of punitive policies on their access to healthcare.[53]

National efforts have seen some improvements. In Canada, recent policy changes have expanded youth-friendly services like drug consumption rooms and naloxone distribution. Portugal has integrated harm reduction services into its broader healthcare system, including drug checking at youth-centric events like festivals.

Despite these advancements, significant challenges remain. Many policies still fail to fully address the needs of young people who use drugs, especially in regions where punitive measures overshadow harm reduction, such as Southeast Asia where countries like the Philippines have harsh anti-drug policies. This is also the case in parts of Eastern Europe and the Middle East where criminalisation continues to take precedence over health-focused approaches. This is despite the global community, including organisations like UNAIDS and OHCHR, advocating for more inclusive drug policies that prioritise health over punishment.

Recommendations for designing services

Ensure programming is engaging and relevant for young people who use drugs

Engage young people in developing the spaces where harm reduction services are provided

Create a non-judgemental and supportive environment

Integrate harm reduction into existing youth-focused health and social services

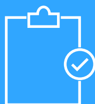
Acknowledge poly-drug use, addressing different drugs and drug combinations

Sensitise and educate youth service providers and parents, while always respecting the rights of young people and prioritising their wellbeing

Provide staff with necessary support and training so they are sensitive to young people's specific concerns and experiences, including those related to mental health, gender, sexuality and cultural background

Pay attention to intersectionality – some young people may belong to more than one marginalised group

Recommendations for monitoring and evaluating services



Involve young people in monitoring and evaluating services

Involve young people in recommending changes and adapting approaches to service provision

Recommendations for creating enabling and supportive legal environments

Advocate for non-prohibitionist drug policies, and policies that do not criminalise conduct associated with sex, reproduction, HIV, homelessness and poverty

Advocate for the removal of legal barriers to assist underage people who use drugs

Advocate for the collection of disaggregated data on young people who use drugs

Recommendations for providing services

Provide comprehensive, evidence-based education on substance use, harm reduction practices and sexual health

Provide a comprehensive package of services in one location

Use digital platforms and social media

Hire young people who use drugs as staff members

Prioritise youth-led peer initiatives

Do not require parental consent for young people to use services

Remove age-related barriers to access

Guarantee privacy and confidentiality

Provide youth-specific services

Reach young people who use drugs where they are by employing youth peers and expanding outreach to areas where young people who use drugs gather

Expand services to rural and underserved areas

Have flexible opening hours

Recommendations for providing services

Provide mobile units and pop-up clinics at events that young people go to, such as festivals and community gatherings

Provide evidence-based, judgement-free information, presented in ways that will appeal to young people

Provide fun and recreational activities

Increase young people's awareness of available services through targeted outreach and public information campaigns

Foster autonomy and decision making among adolescents and young people who use drugs

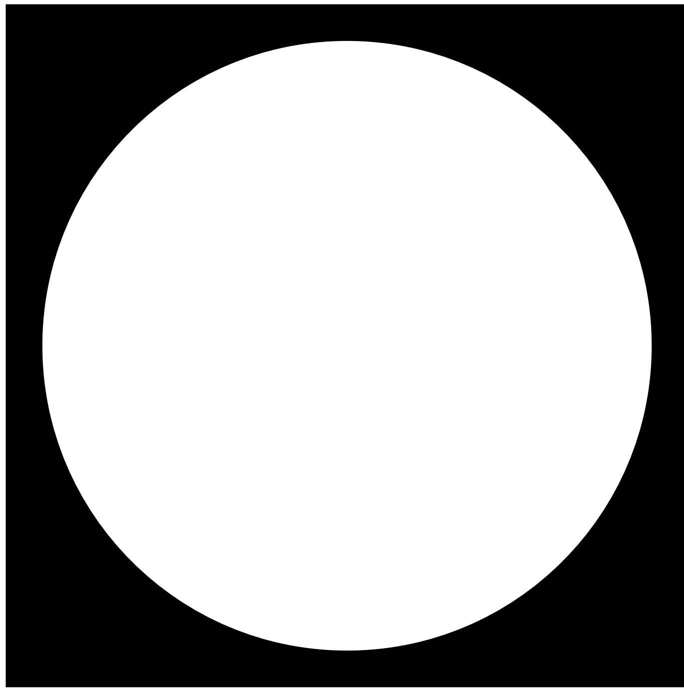
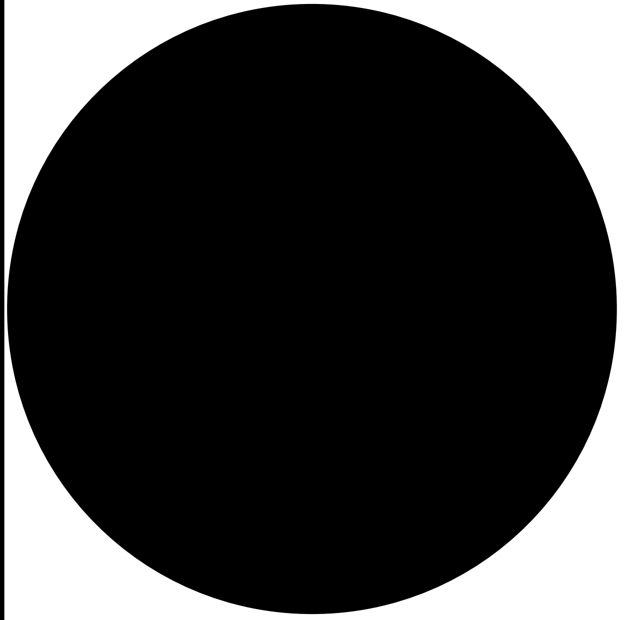
Inform young people about other youth-friendly services and provide referrals

Invest in building a relevant network of non-stigmatising and youth-friendly healthcare providers for referrals and support

Enable capacity building and knowledge sharing among harm reduction, health and social services providers

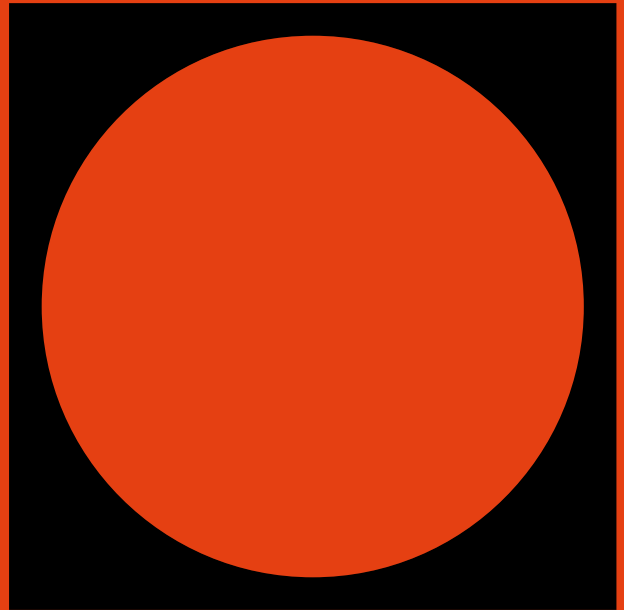
Document and share information about your activities with young people who use drugs

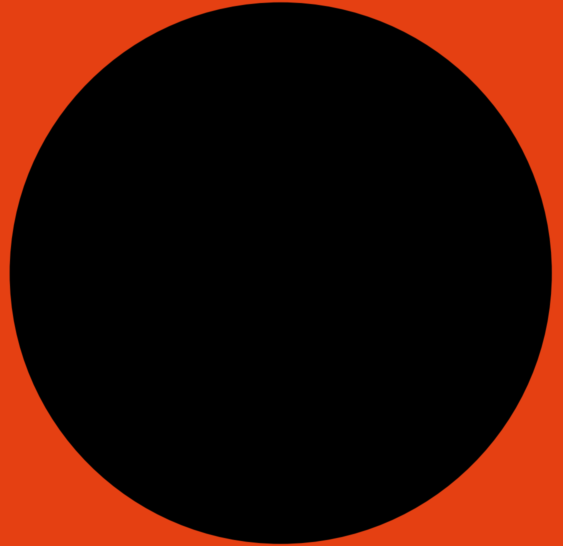
1 United Nations Human Rights Office of the High Commissioner, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem,* OHCHR, Geneva.
2 Barret, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
3 United Nations Human Rights Office of the High Commissioner, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem,* OHCHR, Geneva.
4 United Nations Office on Drugs and Crime (2024), *World Drug Report: Contemporary Issues*, UNODC, Vienna.
5 Artenie, A., et al., (2023), 'Incidence of HIV and hepatitis C virus among people who inject drugs, and associations with age and sex or gender: a global systematic review and meta-analysis', *Lancet Gastroenterology and Hepatology,* vol. 8, no. 6, p.533-552.
6 Ibid.
7 Canêdo, J., et al., (2022), 'Harm reduction call to action from young people who use drugs on the streets of Vancouver and Lisbon', *Harm Reduction Journal*, vol. 19, no. 43.
8 Barret, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
9 Ibid.
10 Ibid.
11 Stowe M., et al., (2022), 'The challenges, opportunities and strategies of engaging young people who use drugs in harm reduction: insights from young people with lived and living experiences', *Harm Reduction Journal,* vol. 19, no. 83.
12 Youth LEAD, Youth RISE and Y+, (2021), *Harm Reduction Services for Young People Who Use Drugs: Case studies report*, YL, YR and Y+, Bangkok, Dublin, Amsterdam and Cape Town.
13 Nduwayezu, L., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Burundi'.
14 UNAIDS (7 May 2021) 'Pioneers of the harm reduction response in Uganda' [online article, accessed September 2024], UNAIDS, Geneva. Available from www.unaids.org/en/resources/presscentre/featurestories/2021/may/20210507_pioneers-harm-reduction-uganda.
15 Monareng, C., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, South Africa'.
16 Bashorun, O., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Nigeria.'
17 Delair, L., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Canada'.
18 Tham, J., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Malaysia'.
19 Ahumada, C., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Argentina'.
20 Grill, F.B., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Peru'; Marques, R., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Brazil'.
21 Darshan, S. and S. Narayanan, (2022), 'Mandatory corporal punishment and its consequences on repeat drug offenders in Malaysia: Call to action', *International Journal of Drug Policy*, vol. 99.
22 Head, H., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, UK'.
23 Chagnon, J., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, USA'.
24 Anonymous, (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Austria'.
25 Youth RISE, (2022), *Young Sex Workers Who Use Drugs: Issues and Recommendations Narrative Research,* YR, Dublin and Amsterdam.
26 Williams, E., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Liberia'.
27 Kehinde, O. and E.I. Effiong for Youth RISE, (2021), *UHC Issues for Young People Who Use Drugs and Other Young Inadequately Served Populations*, YR, Dublin, Amsterdam.
28 Ibid.
29 Abrams, M., (2024) 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Costa Rica'.
30 Reiki, N., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Australia'.
31 Wind, K. R., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Australia'; Scott, E., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Australia'.
32 UNAIDS, (2022), *HIV and young people from key populations in the Asia-Pacific region*, UNAIDS, Geneva.
33 Calzada, R., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response Mexico'.
34 Lawlor, R., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Ireland'.
35 Barret, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
36 Chatterjee, S., A. Singh and S. Kar, (2022), 'Rural healthcare services in India: Challenges and the way forward', *The Lancet Regional Health Southeast Asia,* vol. 6, e100060.
37 Parmar. A., R. Chakraborty and Y. Balhara, (2024), 'Current status of harm reduction in India: Are we doing enough?', *Indian Journal of Psychiatry*, vol. 66, no. 4.
38 Mun, C., H. Schuler and R. Baker, et al., (2023), 'Rural communities face more than an opioid crisis: Reimagining funding assistance to address polysubstance use, associated health problems, and limited rural service capacity', *The Journal of Rural Health,* vol. 39, no. 4.
39 Karbasi, A., et al., (2023), 'An evolving HIV epidemic in the Middle East and North Africa (MENA) region: A scoping review', *International Journal of Environmental Research and Public Health,* vol. 20, no. 5.
40 de Kock, C., (2022), *Responding to drug-related problems among migrants, refugees and ethnic minorities in Europe,* EUDA. Lisbon.
41 Lopatto, L., (14 August 2023), 'Russia's war on the LGBTQI+ community continues' [online article, accessed September 2024], Wilson Centrer, Kennan Institute, Washington DC. Available from www.wilsoncenter.org/blog-post/russias-war-lgbtq-community-continues.
42 OutRight Action International, (2023), *Challenges faced by LGBTQI+ youth activist for their full participation in public life*, ORI, New York.
43 Asylum Research Centre, (2023), *Uganda: Query response on the situation and treatment of the LGBTQI+ community*, ARC, London.
44 Nduwayezu, L., (2024), 'Global State of Harm Reduction 2024: Youth and Harm Reduction survey response, Burundi'.
45 Community Outreach Through Radical Empowerment, 'These are our programs' [web page, accessed September 2024], CORE, Eugene, OR. Available from https://coreeugene.org/.
46 Trip! Project, 'About us' [web page, accessed September 2024], TP, Toronto. Available from https://tripproject.ca/about-us/.
47 Juana Banga, 'Apie mus', [web page, accessed September 2024], JB, Vilnius. Available from https://youngwave.lt/apie-mus/
48 de Kock, C., (2022), *Responding to drug-related problems among migrants, refugees and ethnic minorities in Europe,* EUDA. Lisbon.
49 Barret, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
50 Eurasian Harm Reduction Association, 'Stigma and Drogart Drop-In Centres In Ljubljana, Slovenia' [web page, accessed September 2024], EHRA, Vilnius. Available from https://harmreductioneurasia.org/harm-reduction/needle-and-syringe/stigma-and-drogart.
51 Barret, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
52 United Nations Human Rights Office of the High Commissioner, (2024), *Drug use, harm reduction and the right to health,* OHCHR, Geneva.
53 United Nations Human Rights Office of the High Commissioner, (2023), *Human rights challenges in addressing and countering all aspects of the world drug problem,* OHCHR, Geneva.

REGIONAL CHAPTERS

REGIONAL OVERVIEW: ASIA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHOR OF ASIA REGIONAL OVERVIEW: **Gideon Lasco**

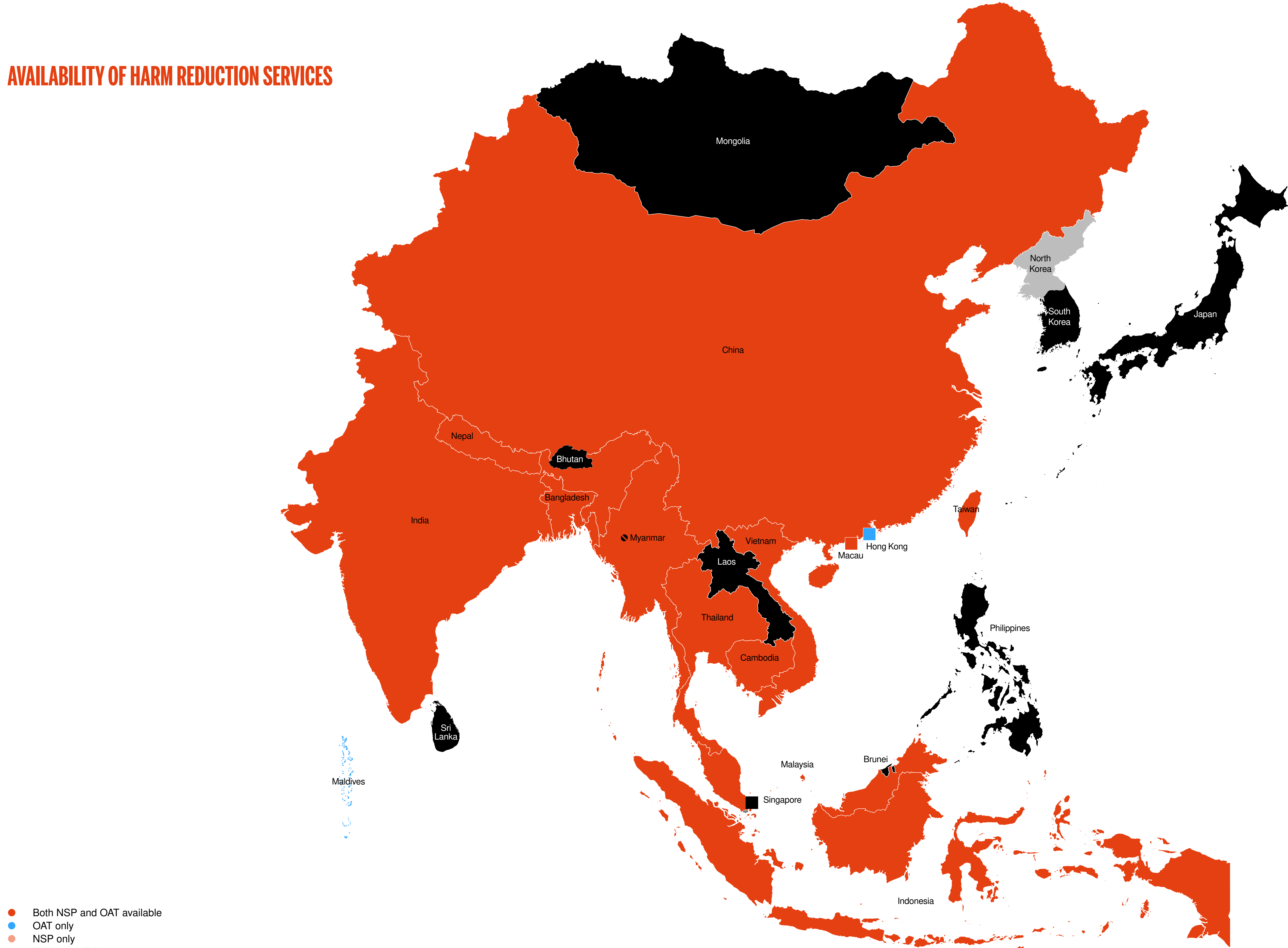
Gideon Lasco is senior lecturer at the University of the Philippines, Diliman Department of Anthropology, research fellow at Ateneo de Manila University, Department of Development Studies, and honorary fellow at Hong Kong University's Centre for Criminology. Gideon is a trustee of the International Society for the Study of Drug Policy (ISSDP). He holds advanced social science degrees from the University of the Philippines (MSc Medical Anthropology), University of Amsterdam (PhD) and Harvard University (MA History of Science).

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN ASIA

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Bangladesh	34,370	4.1	33.2	7	✓ 44	✓ M	×	×	×
Bhutan	nd[f]	nd	nd	nd	×	×	×	×	×
Brunei Darussalam	nd	nd	nd	nd	×	×	×	×	×
Cambodia	4,136	15.2	30.4	nd	✓ 5	✓ M	×	×	×
China	nd	5	71.6	19.6	✓ 578	✓ M	×	×	×
Hong Kong	738	nd	nd	nd	×	✓ M	×	×	×
India	288,717	9.03	44.71	19.2	✓ 266	✓ B M	nd	×	×
Indonesia	34,517	39.1	89.2	nd	✓ 194	✓ M	×	×	✓
Japan	nd	0.02	36.4	8.6	×	×	×	×	×
Laos	1,661	7.4	nd	nd	×	×	×	×	×
Macau	<100	2.7	39	12	✓ 1	✓ M B	×	×	×
Malaysia	60,000	7.5	55.2	2.9	✓ 477	✓ M	×	×	×
Maldives	nd	nd	nd	nd	×	✓ M B	×	×	×
Mongolia	nd	nd	nd	nd	×	×	×	×	×
Myanmar	92,798	34.9	56	7.7	✓ 51	✓ M	✓	×	×
Nepal	37,822	2.8	13.3	0.8	✓ 60	✓ M	×	×	×
North Korea	nd	nd	nd	nd	nd	nd	nd	nd	nd
Philippines	7,700	29	35.2	7.12	×	×	×	×	×
Singapore	3,470	nd	47	nd	×	×	×	×	×
South Korea	nd	1.9	39.7	4	×	×	×	×	×
Sri Lanka	2,672	0	6.2	0.1	×	×	×	×	×
Taiwan	60,000	16	93.1	20.8	✓ 1,252	✓ M B	×	×	×
Thailand	57,640	8.2	42.2	3.5	✓ 30	✓ M	×	×	×
Vietnam	189,000	12.1	72.51	17.07	✓ 56	✓ M	×	×	×

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data

AVAILABILITY OF HARM REDUCTION SERVICES



- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone

NSP, OAT, DCRs AND SAFER SMOKING KITS

12 countries (50%) in Asia provide **needle and syringe programmes** (no change from 2022)

14 countries (58%) in Asia provide **opioid agonist therapy** (no change from 2022)

No country in Asia provides **drug consumptions rooms** (no change from 2022)

Indonesia is the only country in Asia which provides **safer smoking kits** (no change from 2022)

KEY ISSUE

PUNITIVE DRUG LAWS HOLD BACK HARM REDUCTION

From marginalisation and incarceration of people who use drugs, to executions and extrajudicial killings, Asia's punitive drug laws continue to hold back efforts to promote harm reduction. However,

there is growing recognition within the region, including from some government officials,[1,2] that a zero-tolerance approach to drugs has had staggering humanitarian, social and economic costs and a different strategy is needed.[3,4]

In December 2023, Sri Lanka's government launched Operation Yukthiya, which led to tens of thousands of people being arrested over four months. From the beginning, the campaign was marked by an intensification of public humiliation, arbitrary arrests, detention in inhumane conditions and other human rights violations which have long characterised the Sri Lankan government's approach to drugs.[5,6] In Indonesia, the election of Prabowo Subianto in March 2024 has raised concerns of a further escalation of the country's punitive approach to drugs, given Subianto's vocal support for the death penalty for drug offences.[7]

In the Philippines, there have been some welcome developments, like the dropping of trumped-up charges against staunch drug war critic Leila de Lima as well as government participation in a recently-held Drug Policy and Law Reform Summit.[8,9,10,11] Despite this, 700 drug-related killings have been documented since former President Duterte left office,[12] and neither the former President nor his high-ranking officials have been held accountable for their actions.[13,14] Crucially, the government has yet to go beyond rhetoric in pursuing a scientific, evidence-based and health-centred approach that fully respects human rights.[15,16]

Anti-drug campaigns in the region are initiated by leaders like Duterte, Sri Lanka's Ranil Wickremesinghe and Bangladesh's Sheikh Hasina, who use drugs and 'drug wars' as populist tropes.[17] They are ultimately sustained by broader political attitudes towards drugs and enabled by punitive (and often longstanding) laws that conflate drug use with criminality and curtail harm reduction approaches.[18] These laws often single out drug-related offences. For instance, all of the at least 15 executions that Singapore carried out in 2022 and 2023 were for drug-related offences.[19,20] Even in affluent countries in the region, laws that criminalise and harshly punish any kind of involvement with drugs harms individuals and entire communities. This is illustrated by the suicide of South Korean actor Lee Sun-kyun following allegations of drug use and the trauma and stigmatisation experienced by LGBTQI+ people in Singapore.[21,22]

Civil society organisations (CSOs) in the region are valiantly challenging these laws and engaging with their respective governments to find ways forward.[23,24] Lawmakers are also exploring legislative reforms, such as the Japanese parliamentarians who recently formed a harm reduction group.[25] Developments like Malaysia's apparent commitment to decriminalising drugs[26] and Nepal's strong support for harm reduction in its new *National Master Plan on Drugs*[27,25] may make neighbouring countries rethink their own laws and policies. As Thailand's indecision on the legal status of cannabis shows, these moves can be illusory and highly contingent on political currents,[28] but they can nonetheless pave the way for more humane, evidence-based and cost-effective drug policies in the region.

“Many harm reduction programmes are designed for injecting drug use, even as drug use in the region has continued to shift to methamphetamine and amphetamine-type stimulants.”

KEY ISSUE

DISPARITIES IN DISTRIBUTION OF SERVICES

As *Global State of Harm Reduction* reports indicate, several countries in Asia have many harm reduction services. While these are welcome developments, there lies a more complicated picture of geographic and socio-economic disparities in the distribution of harm reduction programmes.

In 12 Indian states and Union territories, for instance, at least 95% of people who inject drugs are covered by a package of harm reduction services, but coverage figures are only 22% for the state of Assam, 31% for Haryana and 39% for Delhi.[29,30] Opioid agonist therapy (OAT) coverage in Thailand overall is dismally low at 5.2%; it is even lower in Bangkok at 1.8%,[31] despite non-governmental organisations and CSOs in the capital attracting clients from the provinces due to their perceived non-judgmental attitudes.[32,33]

Socioeconomic marginality comes with additional barriers to accessing harm reduction services, including being singled out by law enforcement and facing further stigma and discrimination. For instance, the Rohingya refugees in Bangladesh are simultaneously exploited by drug traffickers and blamed by the government for bringing drugs into the country; they have been disproportionately targeted by the drug war along with the country's urban poor.[34,35] Crucially, marginalised communities are also on the receiving end of the structural drivers of harms related to drug policies.[36,37,38]

Many harm reduction programmes are designed for injecting drug use,[39] even as drug use in the region has continued to shift to methamphetamine and amphetamine-type stimulants.[40,41] Governments in the region have also disproportionately targeted these drugs in their punitive campaigns.[42,43] These disparities are further complicated by continued dependence on international support for harm reduction in countries like Myanmar, Nepal and Thailand, making services, as well as the CSOs that provide them, financially and politically precarious.[44,45,46]

Encouragingly, there are also some positive developments. In Myanmar, harm reduction services have continued despite the country's political situation, even in conflict-affected areas like Sagaing, Kachin and Shan State.[47] In Vietnam, community health workers are enabling the provision of OAT in rural areas as far as 55 kilometres away from clinics. In Bangkok, Thailand a new facility specifically catering to LGBTQI+ people who inject drugs opened in November 2022, integrating health and harm reduction services.[48,49] In Kaohsiung, Taiwan, a health centre specifically for chemsex adopted a new community- and person-centered social enterprise model in 2022, and received 1,576 clients in its first 10 months.[44] Meanwhile, the incorporation of harm reduction services in Malaysia's healthcare system through One Stop Crisis Centres is increasing access and improving trust.[50]

Scaling up these initiatives and engendering people-centered drug policies in the process[51,52] will require greater and more tailored investments from international and national sources, meaningful involvement of people who use drugs, and broader recognition of the economic, health and social benefits of harm reduction.

NEGATIVE DEVELOPMENTS IN ASIA

Sri Lanka's government launched Operation Yukthiya, which led to tens of thousands of people being arrested over four months, public humiliation, arbitrary arrests, detention in inhumane conditions and other human rights violations

Indonesia's President Prabawo Subianto expressed support for the death penalty for drug offences

Drug-related killings in the Phillippines have continued since former President Duterte left office

Countries like Singapore continue to execute people for drug offences. All of the at least 15 executions that Singapore carried out in 2022 and 2023 were for drug-related offences

POSITIVE DEVELOPMENTS IN ASIA

Japanese parliamentarians formed a harm reduction group

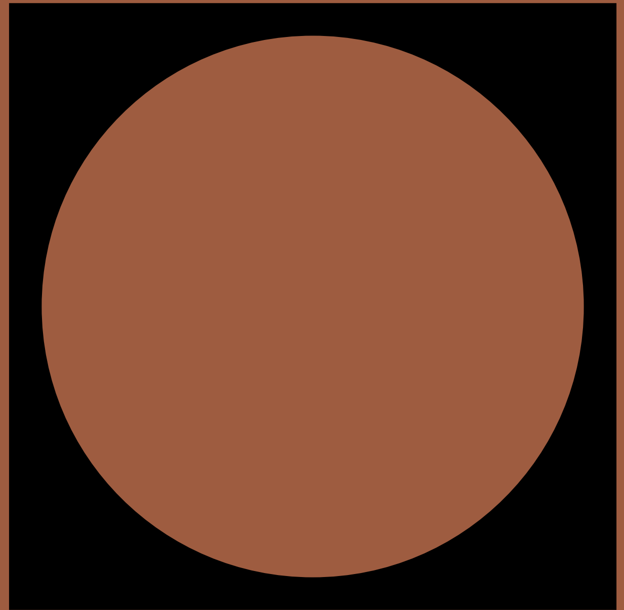
Malaysia committed to decriminalising drugs

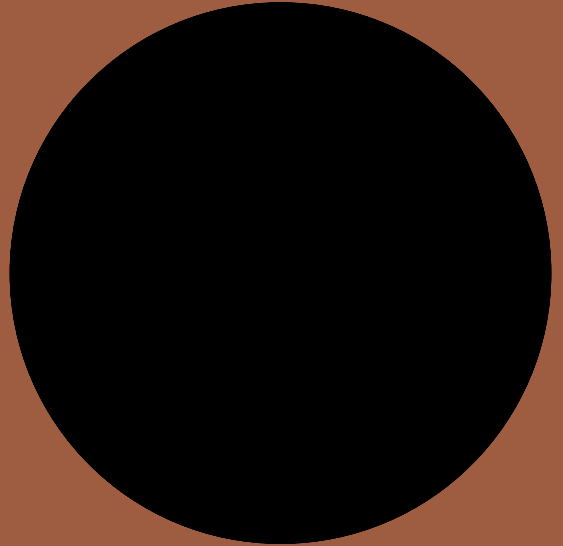
Nepal supported harm reduction in its new National Master Plan on Drugs

1 Muslim, N., (28 June 2024), 'Taking The Next Step In The Nation's Drug Strategy' [online article, accessed September 2024] Bernama Fokus, Kuala Lumpur. Available from www.bernama.com/en/bfokus/news.php?id=2312127.
2 Yarcia, L., (2024), Personal correspondence from Makati City, Philippines.
3 Fransiska, A., (5 September 2022), 'Indonesia's zero tolerance drug laws leave hundreds on death row - 360' [online article, accessed September 2024], 360 Info, Monash University, Melbourne. Available from https://360info.org/indonesias-zero-tolerance-drug-laws-leave-hundreds-on-death-row.
4 Lai, G., (13 June 2024), 'Thailand risks reversing successful reforms, repeating drug policy failures' [online article, accessed September 2024] IDPC, London. Available from https://idpc.net/blog/2024/06/thailand-risks-reversing-successful-reforms-repeating-drug-policy-failures.
5 Harm Reduction International et al., (2024), *Joint Statement: Stop abusive anti-drug operation and release those arbitrarily detained*, HRI, London.
6 Office of the United Nations High Commissioner for Human Rights, (22 January 2024), 'UN experts call on Sri Lanka to immediately suspend and review 'Yukthiya' anti-drug operation' [online media statement, accessed September 2024] OHCHR, Geneva. Available from www.ohchr.org/en/press-releases/2024/01/un-experts-call-sri-lanka-immediately-suspend-and-review-yukthiya-anti-drug.
7 Lekhtman, A., (22 February 2024), 'Fears for Drug Users and Many Others After Indonesia's Presidential Election' [online article, accessed September 2024] Filter Magazine, New York. Available from https://filtermag.org/indonesia-presidential-election-drug-war.
8 UN Office on Drugs and Crime Regional Office for Southeast Asia and the Pacific, (16 April 2024), 'Philippines embarks on drug policy reform: multi-stakeholder summit launched in Manila' [online article, accessed September 2024] UNODC, Quezon City, Philippines. Available from www.unodc.org/roseap/en/philippines/2024/04/drug-policy-summit/story.html.
9 Naguit, R., (23 August 2024), 'Philippines Drug Policy and Law Summit: Is Harm Reduction Genuine Reform or Co-optation?' [online article, accessed September 2024] TalkingDrugs, London. Available from www.talkingdrugs.org/philippines-drug-policy-and-law-summit-is-harm-reduction-genuine-reform-or-co-optation.
10 The Red Whistle, (2024), 'Global State of Harm Reduction 2024 survey response, Philippines'.
11 University of Philippines College of Law, (14 August 2024), 'Philippine Drug Policy and Law Reform Summit' [online article, accessed September 2024] UP College of Law, Quezon City. Available from https://law.upd.edu.ph/philippine-drug-policy-and-law-reform-summit
12 Dahas, 'The Latest Numbers' web page, accessed September 2024, Third World Studies Center, Quezon City. Available from https://dahas.upd.edu.ph/sources.
13 Morales, N. and M. Flores, (23 January 2024), 'Philippines will not 'lift a finger' to assist ICC's drug war probe' [online article, accessed September 2024] Reuters, Manila. Available from http://www.reuters.com/world/asia-pacific/philippines-will-not-cooperate-with-icc-probe-into-drugs-war-president-2024-01-23.
14 Philippine Daily Inquirer, (14 June 2024), 'Editorial: Still no EJK accountability' [online article, accessed September 2024] PDI, Manila. Available from https://opinion.inquirer.net/174424/still-no-ejk-accountability.
15 UN Office on Drugs and Crime Regional Office for Southeast Asia and the Pacific, (16 April 2024), 'Philippines embarks on drug policy reform: multi-stakeholder summit launched in Manila' [online article, accessed September 2024] UNODC, Quezon City, Philippines. Available from www.unodc.org/roseap/en/philippines/2024/04/drug-policy-summit/story.html
16 Naguit, R., (23 August 2024), 'Philippines Drug Policy and Law Summit: Is Harm Reduction Genuine Reform or Co-optation?' [online article, accessed September 2024] TalkingDrugs, London. Available from www.talkingdrugs.org/philippines-drug-policy-and-law-summit-is-harm-reduction-genuine-reform-or-co-optation.
17 Lasco, G., (2020), 'Drugs and drug wars as populist tropes in Asia: Illustrative examples and implications for drug policy', *International Journal of Drug Policy*, vol. 77, e102668.
18 Lai, G. and C. Stoicescu, (2020), 'Drug policy in Asia: the origins and extremities of prohibition', *Research Handbook on International Drug Policy*, edited by D. Bewley-Taylor and K. Tinasti, Edward Elgar Publishing, Northampton, MA.
19 Amnesty International, (28 June 2023), 'Singapore: Unlawful and shameful drug executions continue, including of first known woman in 20 years' [online article, accessed September 2024] Amnesty International, London. Available from www.amnesty.org/en/latest/news/2023/07/singapore-unlawful-and-shameful-drug-executions-continue-including-of-first-known-woman-in-20-years.
20 Han, K., (24 July 2023), 'The first woman to be executed in Singapore in about 20 years' [online article, accessed September 2024] We, The Citizens, Singapore. Available from www.wethecitizens.net/the-first-woman-to-be-executed-in-singapore-in-about-20-years.
21 Tan, R., et al., (2021), 'Exploring the role of trauma in underpinning sexualised drug use ('chemsex') among gay, bisexual and other men who have sex with men in Singapore', *International Journal of Drug Policy*, vol. 97, e103333.
22 Yoon, J., (28 December 2023), 'Death of 'Parasite' Star Highlights South Korea's Crackdown on Drugs' [online article, accessed September 2024] The New York Times, New York. Available from www.nytimes.com/2023/12/28/world/asia/lee-sun-kyun-korea-drug-policy.html.
23 Feria, I., (2024), Personal correspondence from Quezon City, Philippines.
24 Raks Thai Foundation, (2024), 'Global State of Harm Reduction 2024 survey response, Thailand'.
25 Sato, A., (2024), 'Global State of Harm Reduction 2022 survey response, Japan'.
26 Zainuddin, A., (3 July 2024), ''Punitive' Drug Dependants Bill Isn't 'Decriminalisation', Experts Demand Dangerous Drugs Act Amendment' [online article, accessed September 2024] CodeBlue2024, Kuala Lumpur. Available from https://codeblue.galencentre.org/2024/07/03/punitive-drug-dependants-bill-isnt-decriminalisation-experts-demand-dangerous-drugs-act-amendment.
27 Sharma, B., (2024), 'Global State of Harm Reduction 2024 survey response, Recovering Nepal'.
28 Nolan, B., (19 February 2024), 'Inside Thailand's U-Turn on Cannabis Decriminalization' [online article, accessed September 2024] TalkingDrugs, London. Available from www.talkingdrugs.org/inside-thailands-u-turn-on-cannabis-decriminalization.
29 National AIDS Control Organisation, (2023), S*ankalak: Status of National AIDS & STD Response*, *fifth edition*, NACO, Ministry of Health and Family Welfare, Government of India New Delhi.
30 Parmar, A., R. Chakraborty and Y. Balhara, (2024), 'Current status of harm reduction in India: Are we doing enough?', *Indian Journal of Psychiatry*, vol. 66, p.388–91.
31 Ministry of Public Health Thailand, (2022), *Thai National AIDS Program Review 2022*, MOPH, Nonthaburi, Thailand.
32 Dickinson, D., (25 June 2023), 'Thailand: Moving from punishment to treatment of people who use drugs' [online article, accessed September 2024] UN News, New York. Available from https://news.un.org/en/story/2023/06/1137927.
33 Poonkasetwattana, M., (2024) Personal correspondence from Bangkok, Thailand.
34 Human Rights Watch, (13 July 2023), 'Bangladesh: Spiraling Violence Against Rohingya Refugees' [online article, accessed September 2024] HRW, Bangkok. Available from www.hrw.org/news/2023/07/13/bangladesh-spiraling-violence-against-rohingya-refugees.
35 Hoque, R. and S. Shamin, (14 November 2018), 'Cracking down on the disadvantaged' [online article, accessed September 2024] D+C - Development + Cooperation, Bonn. Available from www.dandc.eu/en/article/alcohol-and-drugs-are-prohibited-bangladesh-enforcement-biased-against-poor.
36 Hla, S. and S. Phu, (2023), 'Drug harms amongst youth in Shan State, Myanmar: Community responses and increased vulnerabilities', *Journal of Southeast Asian Studies*, vol. 54, p.570–89.
37 Rhodes, T., K. Kyaw and M. Harris, (2023) 'Precarious Lives, Precarious Treatments: Making Drug Treatment Work in Northern Myanmar', *Medical Anthropology*, vol. 42, p.4–20.
38 Warburg, A. and S. Jensen, (2020), 'Policing the war on drugs and the transformation of urban space in Manila', *Environment and Planning Design*, vol. 38, p.399–416.
39 Nolan, B., (19 February 2024), 'Inside Thailand's U-Turn on Cannabis Decriminalization' [online article, accessed September 2024] TalkingDrugs, London. Available from www.talkingdrugs.org/inside-thailands-u-turn-on-cannabis-decriminalization.
40 UNODC Regional Office for Southeast Asia and the Pacific, (2023), *Synthetic Drugs in East and Southeast Asia: Latest developments and challenges*, UNODC, Bangkok.
41 Sadar Hati Foundation, (2024), 'Global State of Harm Reduction 2024 survey response, Indonesia'.
42 Bangladesh Awami League, (7 May 2017), 'Yaba peddlers will not be spared: HPM Sheikh Hasina' [online article, accessed September 2024. Available from http://www.albd.org/articles/news/28912/Yaba-peddlers-will-not-be-spared:-HPM-Sheikh-Hasina.
43 Lasco G. and V. Yu, (2021), '"Shabu is different": Extrajudicial killings, death penalty, and 'methamphetamine exceptionalism' in the Philippines', *International Journal of Drug Policy*, vol. 92, e103168.
44 Sharma, B., (2024), 'Global State of Harm Reduction 2024 survey response, Recovering Nepal'.
45 Anonymous, (2024), 'Global State of Harm Reduction 2024 survey response, Myanmar'.
46 Raks Thai Foundation, (2024), 'Global State of Harm Reduction 2024 survey response, Thailand'.
47 Anonymous, (2024), 'Global State of Harm Reduction 2024 survey response, Myanmar'.
48 Bangkok Post, (4 November 2022), 'New clinic a haven for LGBT users' [online article, accessed September 2024] Bangkok Post, Bangkok. Available from www.bangkokpost.com/thailand/general/2429450/new-clinic-a-haven-for-lgbt-users.
49 Lin, C. et al., (2023) 'An intervention pilot to facilitate harm reduction service decentralization in Vietnam', *Journal of Substance Abuse Treatment*, vol. 144, e108927.
50 Southeast Asia Harm Reduction Association, (8 November 2023), 'Visit to the One Stop Crisis Centre (OSCC), Kuala Lumpur, Malaysia', AHRA,

Yangon. Available from www.harmreductionsea.org/visit-to-the-one-stop-crisis-centre-oscc-kuala-lumpur-malaysia.
51 Daniels, C., et al., (2021), 'Decolonizing drug policy', *Harm Reduction Journal*, vol. 18, no. 120.
52 Lasco, G., (2022), 'Decolonizing harm reduction', *Harm Reduction Journal*, vol. 19, no. 8.

REGIONAL OVERVIEW: EASTERN AND SOUTHERN AFRICA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

AUTHOR OF EASTERN AND SOUTHERN AFRICA REGIONAL OVERVIEW: **Wangari Kimemia**

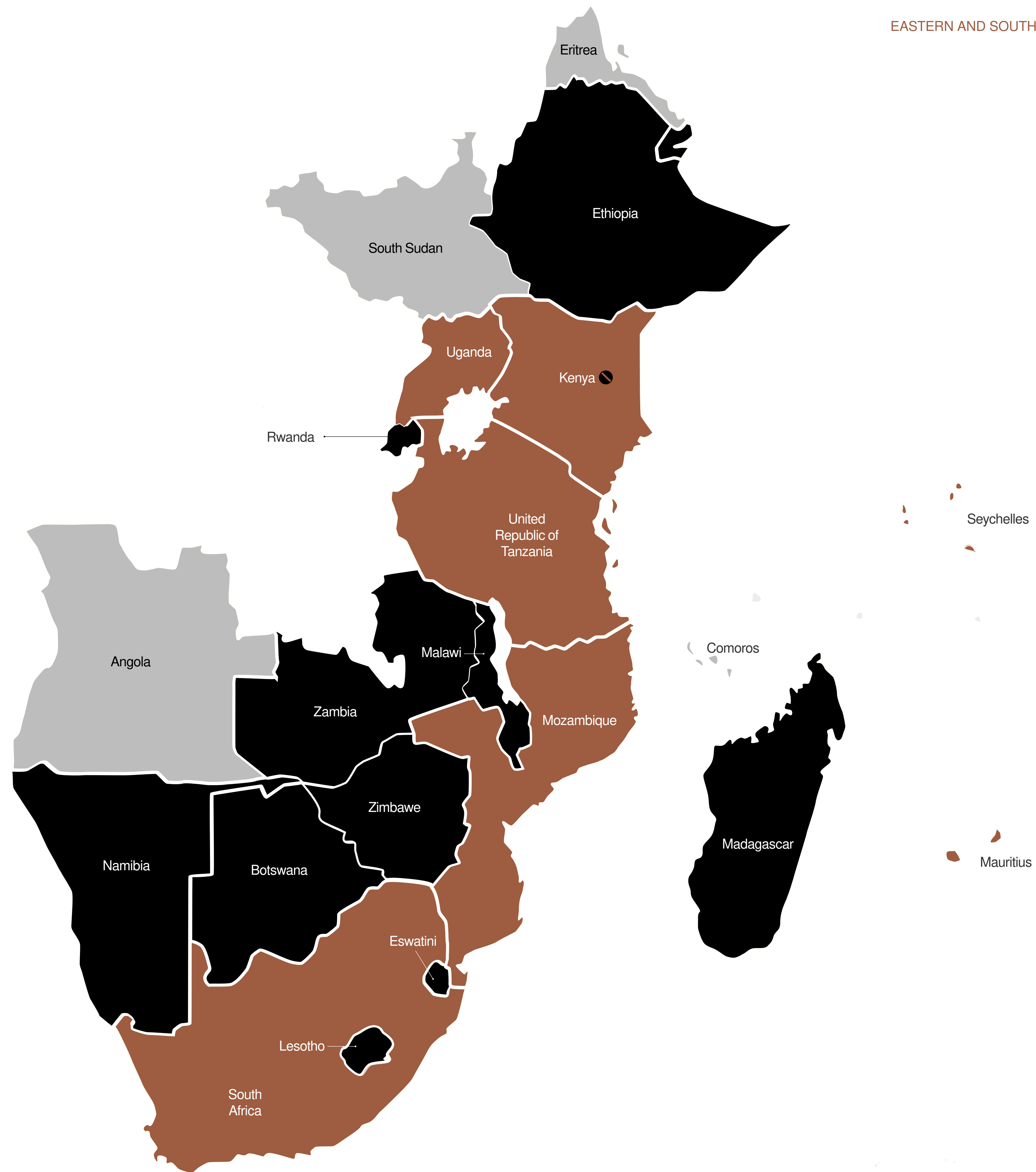
Wangari Kimemia is a Kenyan harm reduction consultant. Wangari's work focuses on capacity building, training, advocacy and research. She is currently pursuing her PhD in Sociology at Kenyatta University in Kenya.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EASTERN AND SOUTHERN AFRICA

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Angola	nd[f]	nd	nd	nd	nd	nd	nd	nd	nd
Botswana	nd	nd	nd	nd	✗	✗	✗	✗	✗
Comoros	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eritrea	nd	nd	nd	nd	nd	nd	nd	nd	nd
Eswatini	1,279	nd	nd	nd	✗	✗	✗	✗	✗
Ethiopia	4,068	39.5	3.4	5.1	✗	✗	✗	✗	✗
Kenya	27,056	11.3	20	3.9	✓ 10	✓ M B	✓	✗	✗
Lesotho	2,600	nd	nd	nd	✗	✗	nd	nd	nd
Madagascar	18,500	35.5	5.6	5.3	✗	✗	nd	nd	nd
Malawi	nd	nd	nd	nd	✗	✗	✗	✗	✗
Mauritius	12,000	32.3	90	3.5	✓ 1	✓ M B N	✗	✗	✗
Mozambique	33,000	35.5	43.6	24.2	✓ 1	✓ M	✗	✗	✗
Namibia	930	nd	nd	nd	✗	✗	✗	✗	✗
Rwanda	2,000	9.5	nd	nd	✗	✗	✗	✗	✗
Seychelles	2,000	12.6	79.1	0.3	✓ 2	✓ M	✗	✗	✗
South Africa	75,701	21	55	5	✓ 11	✓ M B N	✗	✗	✓
South Sudan	nd	nd	nd	nd	nd	nd	nd	nd	nd
Uganda	9,500	17	2	8.4	✓ 1	✓ M B N	✗	✗	✗
United Republic of Tanzania	30,000	14	23.1	6.9	✓ 9	✓ M	✗	✗	✗
Zambia	26,840	24	nd	3.2	✗	✗	✗	✗	✗
Zimbabwe	nd	nd	nd	nd	✗	✗	✗	✗	✗

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data

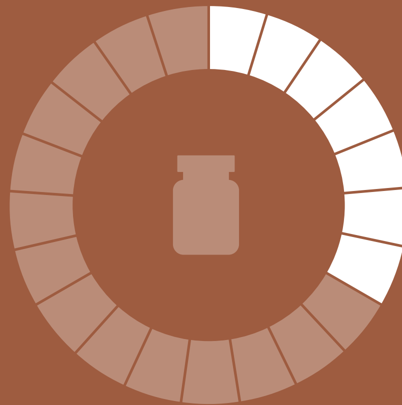
AVAILABILITY OF HARM REDUCTION SERVICES



- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone

NSP, OAT, DCRs AND SAFER SMOKING KITS

7 countries (33%) in Eastern and Southern Africa provide **needle and syringe programmes** (no change from 2022)

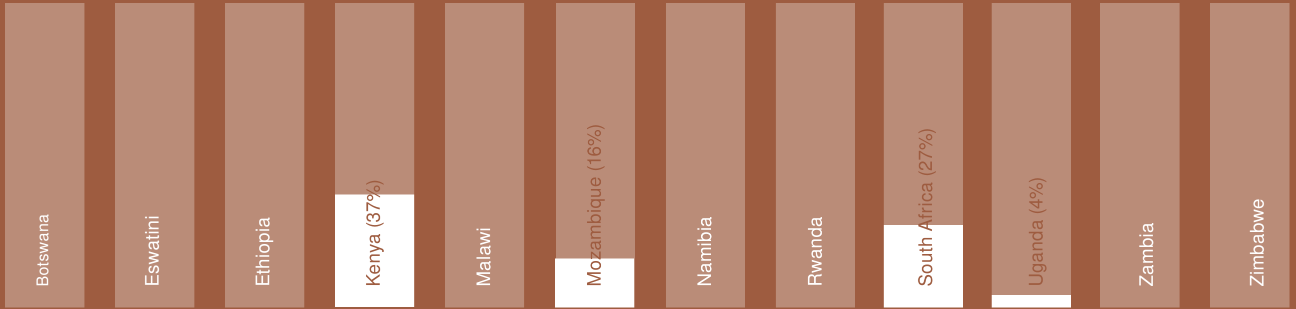


7 countries (33%) in Eastern and Southern Africa provide **opioid agonist therapy** (no change from 2022)

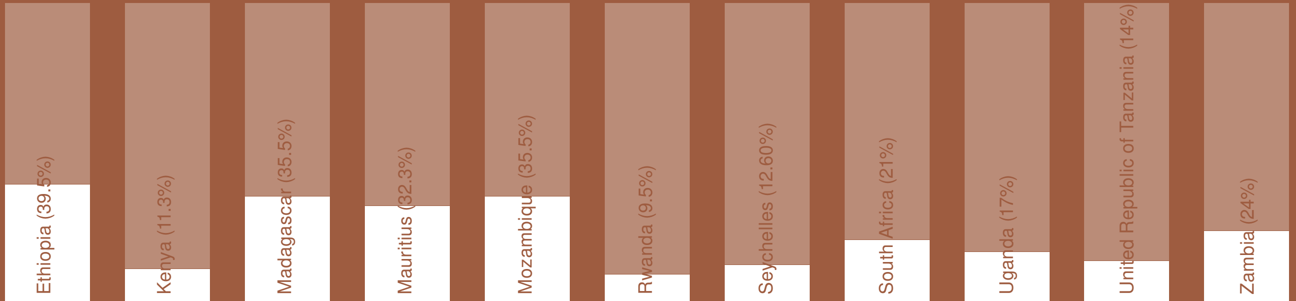
No country in Eastern and Southern Africa provides **drug consumptions rooms** (no change from 2022)

South Africa is the only country in Eastern and Southern Africa to provide **safer smoking kits** (+1 from 2022)

AVERAGE HARM REDUCTION COVERAGE



HIV PREVALENCE AMONG PEOPLE WHO INJECT DRUGS



AVERAGE HARM REDUCTION COVERAGE

KEY ISSUE

SUPPORTIVE POLICIES, PUNITIVE PRACTICES

Eastern and Southern Africa has the highest HIV prevalence in the world with more than 20 million (5.9%) people living with HIV.[1] HIV prevalence among people who inject drugs in the region stands at a high of 21.8% – almost four times that of the general population – yet all Eastern and Southern African countries continue to criminalise drug use. This prevents people who use drugs from receiving equitable HIV services compared to the general population.[2] Repressive drug law enforcement contributes to the barriers people who use drugs face when accessing health services, heightening their HIV risk.[3,4,5] But progress is being made in the region as there continues to be a shift towards the implementation of some harm reduction services.

Since 2022, three more countries (Botswana, Mozambique and Namibia) produced national policy documents that explicitly support harm reduction. Botswana's *HIV Prevention Road Map 2023-2025* refers to the need to introduce harm reduction interventions, although this is yet to be actualised.[6] Namibia has included harm reduction, specifically opioid agonist therapy (OAT), in its HIV strategic framework.[7] Mozambique has included harm reduction in its national HIV plan.[8] Only two countries in the region are now without supportive policies (Eswatini and Rwanda).

However, there is a lag between policy and practice, as no additional country has initiated OAT or a needle and syringe programme (NSP) since 2022. Although Zimbabwe's *National Drug Master Plan (2020-2025)* outlines harm reduction interventions, including NSP, OAT and naloxone, these are yet to be implemented despite funds being available through a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria.[9] In 2022, Mauritius legalised medical cannabis and decriminalised possession of small amounts for personal consumption. Yet, medical cannabis is still not accessible, and people are still being arrested for possessing small amounts of the drug.[10,11,12] In Rwanda, the non-governmental organisation (NGO) Health Development Initiative Rwanda is implementing an advocacy and health service project for people who use drugs. However, this does not include NSP, OAT or naloxone.[13,14]

Despite notable efforts towards a harm reduction approach, law enforcement and the 'war on drugs' still dominates the region's approach to drug use. In South Africa, in spite of a recent scaling up of harm reduction, punitive responses to drugs continue.[15,16,17]

According to the Networking HIV and AIDS Community of Southern Africa, in just three months in 2023, programme data revealed 600 human rights violations against people who use drugs, including confiscation of syringes, assaults and unlawful arrests by law enforcement.[18]

The NGOs TB/HIV Care and the South African Network of People Who Use Drugs reported that, due to resistance towards harm reduction, there was a three-month shutdown of the NSP in Wynberg,

Cape Town. In Zimbabwe, law enforcement is reported to be running active anti-drug campaigns, including arresting and publicly parading people arrested for drug use.[19,20,21,22] In Uganda, there were around 4,800 people, including 137 young people, arrested for drug use in 2022.[23] In Botswana, a presidential commission of inquiry on constitutional reforms has recommended that the death penalty be imposed for drug trafficking.[24]

Although harm reduction has grown in the region, primarily due to advocacy from community and civil society organisations, the prevailing contradiction between policy and practice poses a major barrier to progress. The Eastern and Southern African Commission on Drugs has underscored the need to review the current strategic and policy responses to drug trafficking and drug use in the region to ensure people who use drugs can access healthcare and other vital services.[25]

KEY ISSUE

DIMINISHING HARM REDUCTION FUNDING

Eastern and Southern Africa has a high rate of poverty, with 45% of people in Southern Africa and 34% in Eastern Africa living below the poverty line.[26] Low domestic investment in health is common, with most governments spending less than USD 100 per person annually on healthcare.[27] The Joint United Nations Programme on HIV and AIDS (UNAIDS) notes that high national debts are a major threat to the HIV response in low-income countries, which can spend up to four times more on debt repayments than on health.[28] While some countries in the region have made investments in their national HIV responses, there remains a marked reliance on international donor funding, which undermines the sustainability of a domestic HIV response. For example, Madagascar has seen a 151% increase in new HIV infections and a 279% increase in AIDS-related deaths since 2010.[29] In South Sudan, only half of people living with HIV know their status and less than half (47%) are on treatment.[30]

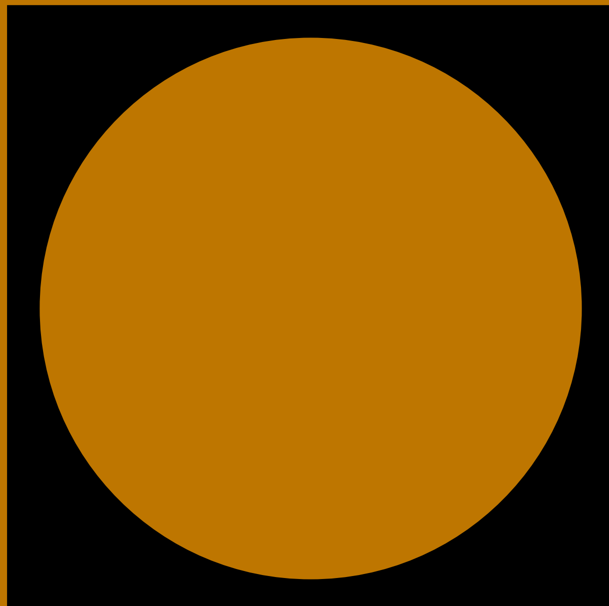
The South African government funds 70% of its HIV response domestically, but no national funds are allocated to harm reduction; instead, the government allocates resources to ineffective abstinence-based programmes. However, the City of Tshwane funds the Community-Oriented Substance Use Programme, which takes a harm reduction approach, through social contracting.[a,31] In Uganda, the government has not committed any budget to fund harm reduction.[32,33] Kenya's HIV response, under which harm reduction falls, remains heavily donor-funded, with only 36.5% of the funding coming from domestic sources.[34] In the financial years 2019-2022, the country's harm reduction programme, which included methadone, buprenorphine, naloxone and hepatitis B and C management, experienced a funding gap of USD 29,398,721.[35] Mauritius funds around 80% (approximately USD 1,271,483) of its national HIV programme and partially funds harm reduction in accordance with the *National HIV and AIDS Action Plan 2023-2027*.[36] Nevertheless, domestic harm reduction funding decreased from USD 261,198 in 2018 to a predicted USD 228,000 in 2023.[37]

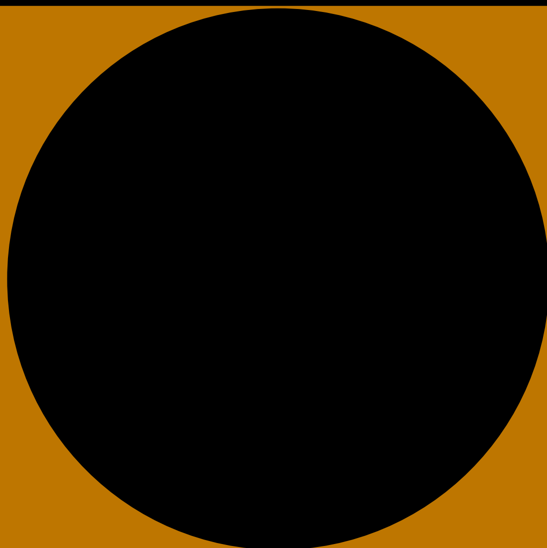
Community-led networks and civil society organisations across the region underscored the lack of funds as a major barrier to their efforts in relation to both advocacy and service delivery.[38,39,40] Consequently, access to harm reduction services remains low. The Global Drug Policy Index 2021 reported average harm reduction coverage to be 37% in Kenya, 16% in Mozambique, 27% in South Africa and 4% in Uganda.[41] Yet, drug use is projected to increase by 40% by 2030 in Africa, and East and Southern Africa has become a drug transit hub and destination market.[42,43] This trend calls for an urgent increase in harm reduction coverage, yet punitive drug law enforcement remains the predominant approach to drug control in the region. The biggest funding boost for harm reduction in Eastern and Southern Africa would be for governments to stop funding punitive approaches to drugs and invest in harm reduction.

“The biggest funding boost for harm reduction in Eastern and Southern Africa would be for governments to stop funding punitive approaches to drugs and invest in harm reduction.”

1 UNAIDS, (2023), *UNAIDS regional fact sheet: Eastern and southern Africa*, UNAIDS, Geneva. Available from https://thepath.unaids.org/wp-content/themes/unaids2023/assets/files/regional_fs_eastern_southern_africa.pdf
2 Ibid.
3 Global Commission on Drug Policy, (2012), *The war on drugs and HIV/AIDS: How the criminalization of drug use fuels the global pandemic*, GCDP, Geneva. Available from http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf
4 Ibid.
5 The Lancet HIV, (May 2019), 'Editorial: The war on drugs is incompatible with the fight against HIV', *The Lancet HIV*, vol. 6, no. 5, e269. Available from www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30112-2/fulltext
6 Republic of Botswana, (2023), *Botswana HIV prevention road map 2023-2025,* Republic of Botswana Government, Gaborone. Available from https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/botswana_hiv_prevention_road_map_nov_2023.pdf
7 Republic of Namibia Ministry of Health and Social Services, Directorate of Special Programmes, (2023), *National Strategic Framework for HIV and AIDS Response in Namibia 2023/24 to 2027/28*, Republic of Namibia Government, Windhoek. Available from https://hivpreventioncoalition.unaids.org/en/resources/national-strategic-framework-hiv-and-aids-response-namibia-2023-24-2027-2028
8 Mutombene, J., (2024), 'Global State of Harm Reduction 2024 survey response, Mozambique'.
9 Frontline AIDS, (2023), *Zimbabwe: HIV prevention & Accountability: A community perspective 2023*, Brighton, UK. Available from https://frontlineaids.org/wp-content/uploads/2023/11/Zimbabwe-Shadow-Report_DIGITALMASTER-.pdf
10 Leafwell, (2024), 'Is marijuana legal in Mauritius?' online article, accessed 20 July 2024, Miami. Available from https://leafwell.com/blog/is-marijuana-legal-in-mauritius
11 Dagga Diaries, (2024), 'Cannabis in Mauritius: Is cannabis legal in Mauritius?' online article, accessed 20 July 2024. Available from www.daggadiaries.com/countries/cannabis-in-mauritius
12 Trevedy, C., (2024), 'Global State of Harm Reduction 2024 survey response, Mauritius'.
13 Benimana, E., (2024), 'Global State of Harm Reduction 2024 survey response, Rwanda'.
14 Muhirwa, S., (2024), 'Global State of Harm Reduction 2024 survey response, Rwanda'.
15 Scheibe, A. J., (2024), 'Global State of Harm Reduction 2024 survey response, South Africa'.
16 MacDonnell, J., (2024), 'Global State of Harm Reduction 2024 survey response South Africa'.
17 United Nations Office on Drugs and Crime, (15 November 2022), 'UNODC and Central Drug Authority organize a Collaborative meeting to discuss an integrated approach for the implementation of harm reduction and Opioid Substitution Therapy in South Africa' online article, accessed 20 June 2024, UNODC, Vienna. Available from www.unodc.org/southernafrica/en/aml/harm_reduction.html
18 Networking HIV and AIDS Community of Southern Africa, (6 September 2023), 'NACOSA Advocates for People-Centred Drug Policy', online article, accessed 20 July 2024, NACOSA, Cape Town. Available from www.nacosa.org.za/2023/09/06/nacosa-advocates-for-people-centred-drug-policy/
19 Africa Press (4 February 2023), 'Drug abusers to be treated as criminals, not victims – Muguti', online article, accessed 20 July 2024, Zimbabwe. Available from www.africa-press.net/zimbabwe/all-news/drug-abusers-to-be-treated-as-criminals-not-victims-muguti
20 Chronicle (17 June 2024), 'Foreign national nabbed with one sachet of cocaine', online article, accessed 20 July 2024, Bulawayo. Available from www.chronicle.co.zw/foreign-national-nabbed-with-one-sachet-of-cocaine/
21 Mainline et al., (December 2022), *Zimbabwe situational analysis of drug use in five provinces to inform HIV and TB programming for people who use drugs*, Mainline, Amsterdam. Available from https://mainline.nl/wp-content/uploads/2023/11/Final_research_report_situational_assessment_Zimbabwe.pdf
22 Zimbabwe Independent, (4 February 2023), 'Govt declares war on drug abusers' online article, accessed 20 July 2024, Harare. Available from www.newsday.co.zw/theindependent/local-news/article/200006999/govt-declares-war-on-drug-abusers
23 Uganda Police Force, (9 May 2023), 'Police to continue tackling narcotics related offences in the National Drug Policy and Authority Act, (NDA) 1993' online article, accessed August 2024, UPF, Kampala. Available from www.upf.go.ug/police-to-continue-tackling-narcotics-related-offences-in-the-national-drug-policy-and-authority-act-nda-1993/
24 Mmegi Online, (25 November 2022), 'The Presidential Commission of Inquiry into the Review of the Constitution has recommended that the death penalty should be imposed on drug lords and drug traffickers' online article accessed 20 July 2024, Gaborone. Available at www.mmegi.bw/news/death-penalty-for-drug-lords/news
25 The Defi Plus, (5 August 2023), 'Mauritius and Seychelles the world's largest heroin users' online article, accessed 20 July 2024. Port-Louis.
26 Institute for Security Studies, (2022), 'Africa is losing the battle against extreme poverty' web page, accessed 20 July 2024, ISS, Pretoria. Available from https://issafrica.org/iss-today/africa-is-losing-the-battle-against-extreme-poverty
27 Robert Carr Fund, (2024), 'Eastern and Southern Africa' web page, accessed 20 July 2024, RCF, Amsterdam. Available from https://robertcarrfund.org/networks/regions/eastern-and-southern-africa
28 UNAIDS, (27 January 2023), 'Press statement: United Nations Under-Secretary-General calls on leaders to address the debt crisis that is crushing developing countries' media release, accessed 20 July 2024, UNAIDS, Geneva. Available from www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2023/january/20230127_debt-crisis
29 Global HIV Prevention Coalition, (7 May 2024), 'Low-income countries such as Madagascar lack funds to fight Aids' online article, accessed 20 July 2024, UNAIDS, Geneva. Available from https://hivpreventioncoalition.unaids.org/en/news/low-income-countries-such-madagascar-lack-funds-fight-aids
30 UNAIDS, (2023), 'Country factsheets: South Sudan 2023' web page, accessed 26 August 2024, UNAIDS, Geneva. Available from www.unaids.org/en/regionscountries/countries/southsudan
31 SANPUD and Harm Reduction International, (2024), *Harm reduction information note – South Africa*, HRI, London. Available from https://hri.global/wp-content/uploads/2024/07/SA-info-note-2507-1.pdf
32 Wamala, T., (2024), 'Global State of Harm Reduction 2024 survey response, Uganda'.
33 Uganda Harm Reduction Network and Harm Reduction International, (2021), *Rapid assessment of harm reduction funding and investment in Uganda*, UHRN, Kampala. Available from https://ugandaharmreduction.org/wp-content/uploads/2021/05/Rapid-Assessment-of-Harm-Reduction-Funding-in-Uganda-1.pdf
34 Harm Reduction International, (2022) *Harm reduction financing landscape analysis in Kenya*, HRI, London. Available from https://hri.global/wp-content/uploads/2023/04/KENYA-DESIGN_FINAL.pdf
35 PEPFAR, (18 July 2022), *Country Operational Plan 2022 Kenya: Strategic Direction Summary*, PEPFAR, Washington, DC. Available from www.state.gov/wp-content/uploads/2022/09/Kenya-COP22-SDS-.pdf
36 Republic of Mauritius, Ministry of Health and Wellness, (2023), *Republic of Mauritius National HIV Action Plan 2023 – 2027*, Republic of Mauritius, Port-Louis. Available from https://health.govmu.org/health/wp-content/uploads/2023/10/NAP-Final-2023-2027.pdf
37 The Global Fund to Fight AIDS, Tuberculosis and Malaria, 'The data explorer – Mauritius' web page, accessed 7 August 2024, the Global Fund, Geneva. Available from https://data.theglobalfund.org/location/MUS/overview
38 Mwakasungula, U., (2024), 'Global State of Harm Reduction 2024 survey response, Malawi'.
39 Dheka, C., (2024), 'Global State of Harm Reduction 2024 survey response, Zimbabwe'.
40 SANPUD and Harm Reduction International, (2024), *Harm reduction information note – South Africa*, HRI, London. Available from https://hri.global/wp-content/uploads/2024/07/SA-info-note-2507-1.pdf
41 The Global Drug Policy Index, (2021), *The Global Drug Policy Index 2021*. Available from https://globaldrugpolicyindex.net/wp-content/themes/gdpi/uploads/GDPI%202021%20Report%20EN.pdf
42 African Union, (6 November 2023), 'AU high level session on addressing substance use and related mental health disorders among youth, women and children' media statement, accessed 7 August 2024, AU, Addis Ababa. Available from https://au.int/en/newsevents/20231106/au-high-level-session-addressing-substance-use-and-related-mental-health
43 Eastern and Southern African Commission on Drugs, (2021), *Illicit Drug Markets of Eastern and Southern Africa. An overview of production, supply and use,* the Global Initiative Against Transnational Organized Crime, Geneva. Available from https://globalinitiative.net/wp-content/uploads/2024/02/Jason-Eligh-Illicit-drug-markets-of-Eastern-and-Southern-Africa-GI-TOC-April-2021.pdf

REGIONAL OVERVIEW: EURASIA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHOR OF EURASIA REGIONAL OVERVIEW: **Maria Plotko**

Maria Plotko is the Senior Programme Officer at the Eurasian Harm Reduction Association. Maria leads grants management, research and human rights related activities. Her work focuses on women who use drugs, quality of harm reduction services, community-led monitoring and human rights.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EURASIA

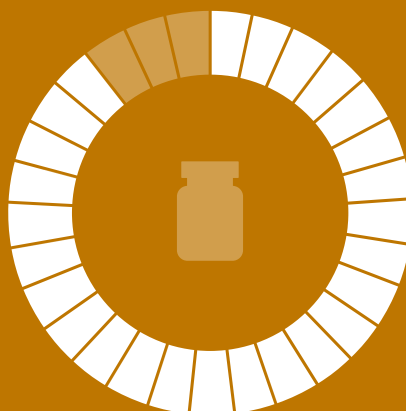
Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Albania	8,700	0.1	56	18	✓ 2	✓ M B	✕	✕	✕
Armenia	14,000	2.6	49.2	nd[f]	✓ 12	✓ M	✕	✕	✕
Azerbaijan	60,300	6.1	59.3	7.9	✓ 17	✓ M	✕	✕	✕
Belarus	80,000	22.7	59	9.6	✓ 34	✓ M B	✕	✕	✕
Bosnia and Herzegovina	12,500	1.1	30.8	2.5	✕	✓ M	✕	✕	✕
Bulgaria	10,000	12.8	78.3	5.9	✓ 2	✓ M MO	✕	✕	✓
Croatia	6,344	0.3	30.7	3.1	✓ 8[g]	✓ M B MO	✕	✕	✕
Czechia	44,900	0.1	37.7	0	✓ 111	✓ M B	✕	✕	✓
Estonia	8,600	54	73	5	✓ 35	✓ M B	✕	✕	✓
Georgia	49,700	0.9	32.1	2.5	✓ 14	✓ M B	✓	✕	✕
Hungary	6,500	0	35.9	1	✓ 31	✓ M B	✕	✕	✕
Kazakhstan	79,900	7.6	58.6	8.3	✓ 125	✓ M	✕	✕	✕
Kosovo	4,600	0	23.8	5	✓	✓ M B	✕	✕	✕
Kyrgyzstan	17,379	16.5	64.5	11.3	✓ 14	✓ M B	✓	✕	✕
Latvia	7,715	26	51.3	0.4	✓ 20	✓ M	✕	✕	✕
Lithuania	8,868	4.7	85.9	4.9	✓ 11	✓ M B	✕	✕	✕
Moldova	27,500	11.4	42.7	5.4	✓ 28	✓ M B	✕	✕	✓
Montenegro	2,300	0.5	62.8	1.4	✓ 2	✓ M B	✕	✕	✕
North Macedonia	6,500	0	65.4	5.6	✓ 16	✓ M B	✕	✕	✕
Poland	14,664	14-21	57.9	2.9	✓ 7	✓ M B	✕	✕	✕
Romania	10,000	19.4	72.7	3.2	✓ 2	✓ M B	✕	✕	✕
Russia	1,881,000	49.8	72.5	nd	✓	✕	✕	✕	✕
Serbia	20,500	1.5	61.4	10.5	✓ 1	✓ M B	✕	✕	✕
Slovakia	8,818	0.1	32.5	6.3	✓ 19	✓ M B	✕	✕	✓
Slovenia	4,900	0	25	4.2	✓ 12	✓ M B	✓	✕	✓
Tajikistan	18,200	8.9	61.3	2	✓ 48	✓ M	✓	✕	✕
Turkmenistan	nd	nd	nd	nd	✕	✕	✕	✕	✕
Ukraine	350,000	20.9	67	46.7	✓ 2,380	✓ M B	✕	✕	✕
Uzbekistan	54,500	2.9	20.9	5.1	✓ 230	✕	✕	✕	✕

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data.
g 8 NSP are fixed and 129 outreach

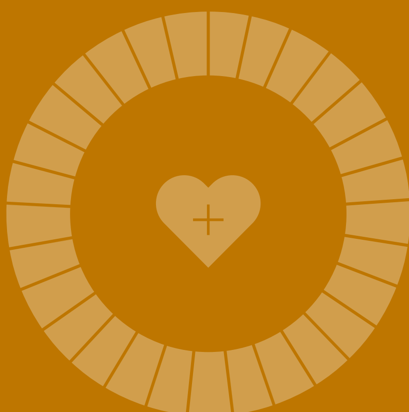
AVAILABILITY OF HARM REDUCTION SERVICES

NSP, OAT, DCRs AND SAFER SMOKING KITS

27 countries (93%) in Eurasia provide **needle and syringe programmes** (no change from 2022)



26 countries (90%) in Eurasia provide **opioid agonist therapy** (no change from 2022)



No country in Eurasia provides **drug consumptions rooms** (no change from 2022)

6 countries (21%) in Eurasia provides **safer smoking kits** (+1 from 2022, Bulgaria)

KEY ISSUE

CRACKDOWN ON CIVIL SOCIETY

Global donors funded harm reduction in Eastern Europe and Central Asia (Eurasia) as an effective tool for HIV prevention and helped to begin and scale-up many needle and syringe programmes (NSP) and opioid agonist therapy (OAT). Harm reduction through an HIV lens was and still is politically safer in the region, while drug policy reform and harm reduction are perceived as foreign ideas contradictory to 'traditional' values.

Laws and policies criminalising sex work, the possession and use of drugs, HIV transmission and same-sex relationships in the region significantly obstruct access to healthcare.

With most harm reduction programmes still reliant on international funding, the growing number of foreign agent and anti-LGBTQI+ laws poses a significant threat to the continuation of HIV-related services and support for key population groups.[a,1]

Representatives from Georgia, Russia, Kazakhstan and Tajikistan who responded to the *Global State of Harm Reduction* survey[2] stated that civil society organisations in their countries are under threat for delivering or being involved in harm reduction services and advocacy. Representatives from Russia and Tajikistan reported decreases in the number of NSPs.

Russia was the first country in the region to introduce specific laws targeting civil society organisations that do not support government policy and/or are supported by international funding. At the heart of this issue are four main laws: the law on foreign agents, the law on undesirable organisations, and the so-called drug and LGBTQI+ propaganda laws. The vaguely worded Foreign Agent Law,[3] adopted in 2012, has been used as a tool to stigmatise, discredit and silence NGOs critical of authorities, and it has forced international donors to gradually withdraw their support. Over 320 NGOs in Russia have been labelled as foreign agents since the law was enacted.[4] In 2016, the Andrey Rylkov Foundation (ARF), an organisation that provides harm reduction services and is actively engaged in drug policy reform, became the first public health organisation to be listed as a foreign agent. Steep fines for not complying with the new regulations and additional reporting requirements, especially for smaller organisations, make it difficult to secure funding and operate which forces organisations to shut down. In 2018, ARF was fined USD 12,000, which it was able to pay through crowdfunding.[5] In June 2024, the European Court of Human Rights issued a judgment[6] (*Case of Andrey Rylkov Foundation and Others v. Russia*) highlighting the ongoing misuse of repressive laws in Russia aimed at stifling dissent and suppressing civic freedom.

Russia's draconian drug propaganda law[7] criminalises not only advocacy for harm reduction and drug policy reform, but even pictures of controlled substances and any kind of discussion

a 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.

that is not in line with prohibitionist values.[8,9] It also describes 'propaganda' relating to drug use for medical purposes, which is generally understood as a ban on advocating for OAT.

Such crackdowns on civil society instil fear and self-censorship. Russia's repression of NGOs serves as a blueprint for neighbouring countries, where similar laws are either in place or under consideration. These countries include Azerbaijan, Kazakhstan, Belarus, Kyrgyzstan, Tajikistan, Uzbekistan, Hungary and Georgia. Hungary enacted similarly repressive legislation when it passed the Russian-like Sovereignty Protection Act in 2023.[10,11] In March 2024, the UN Special Rapporteur on the situation of human rights defenders criticised the dissolution of 700 NGOs in Tajikistan. In the same year, laws similar to the Russian Foreign Agent law were adopted in Kyrgyzstan and Georgia.[12] Serbia[13] and Bosnia and Herzegovina[14] also attempted to pass similar laws but were unsuccessful. Civil society is fighting against these crackdowns where possible. In Kazakhstan, for example, civil society is campaigning to save OAT and stop an anti-LGBTQI+ law from being adopted. The law on foreign representatives adopted in April 2024[15,16] in Kyrgyzstan grants the authorities extensive oversight over NGOs engaging in what is broadly termed political activities and receiving foreign funding. Failure to register as a foreign representative could result in an NGO's operations being suspended for up to six months without a court order, and possibly forced liquidation. Soros Foundation Kyrgyzstan, which among other activities had been providing legal support for key populations, has already closed down. Harm reduction NGOs have ceased their advocacy activities and smaller community organisations have announced their plans to shut down pre-emptively. In Georgia, the law on transparency of foreign influence,[17,18,19] branded by civil society as the 'Russian law', was adopted in May 2024 despite the president vetoing it. It declares civil society and media organisations which receive more than 20% of their funding from foreign sources as 'organisations acting in the interest of a foreign power'. Such organisations are now required to register as such and are subject to increased reporting requirements, inspections and administrative liability, including the equivalent of up to more than EUR 9,000 in fines for violations. In recent months, the government has launched a smear campaign against many NGOs and media organisations, accusing them of acting on behalf of foreign governments and undermining the Georgian state. The bylaws are still underway, and it is not clear how the law will be applied, but civil society already feels the threat if they are involved in harm reduction services and advocacy.[20] Those who register as foreign representatives could end up having to self-censor and stop advocacy work. At the same time, the Georgian parliament has advanced the set of bills that include bans on promoting same-sex relationships and gender reassignment surgeries.[21]

Foreign agents laws pose serious threats to organisations engaged in advocacy, community development, the documentation of human rights violations, and harm reduction.

This undermines the achievements of the globally agreed goal to end AIDS as a public health threat by 2030, making it challenging to support community-led responses and significantly reduce stigma and discrimination against key populations.[22] International bodies and officials have condemned recent developments in Kyrgyzstan and Georgia.[23,24,25,26,27,28] Urgent international attention and support are essential to safeguard harm reduction, community-led HIV responses and human rights in the region.

“Russia’s repression of NGOs serves as a blueprint for neighbouring countries, where similar laws are either in place or under consideration. These countries include Azerbaijan, Kazakhstan, Belarus, Kyrgyzstan, Tajikistan, Uzbekistan, Hungary and Georgia.”

KEY ISSUE

CHALLENGES ADVANCING DRUG CHECKING SERVICES

The implementation of drug checking services in Eurasia, despite operating in a legally grey area, represents a critical step forward. Nine out of 28 countries have introduced the service to some extent, mostly through the support of international donors or donations, except for Czechia and Slovenia where the service is funded by the state. Ukraine is unique, as drug checking is supported through the national grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. A pilot project in Croatia to distribute reagent test kits through a drop-in centre in Rijeka is awaiting approval from the Ministry of Health.

According to the current legislation in all Eurasia countries, staff in drug checking services are not allowed to come into contact with substances and perform tests themselves due to the laws criminalising possession of controlled substances, which makes possessing the sample or giving the sample back to the user illegal. To mitigate this issue, organisations distribute colorimetric reagent test kits to clients so they can perform the tests themselves. Reagents are chemicals that turn different colours in the presence of certain drugs. They are useful for learning more about the general content of the substance in hand and identifying 'red flags' (i.e. unexpected substances). Reagent test kits are only able to detect the presence of a drug, not the quantity or purity. All drug checking is community-led, and programme staff provide counselling, basic harm reduction supplies and educational materials.[29]

In Slovenia, drug checking is part of the National Early Warning System on Psychoactive Substances coordinated by the National Institute of Public Health. The DrogArt[30] drug checking service collects substances through several harm reduction sites, packs them in specially labelled envelopes and sends them to the National Laboratory for Health, Environment and Food for analysis. Results are provided in four to seven days. Colorimetric reagent tests are also available at harm reduction stands in nightlife settings.

In Hungary, Estonia, Czechia,[31] Lithuania, Slovakia, Georgia, Ukraine and Poland, NGOs distribute reagent test kits, mostly in nightlife settings and during music festivals. After a consultation, the clients perform the tests themselves and are invited to come back to discuss the results. The Ukrainian Drugstore project, in addition to distributing test kits during parties,[32] provides drug checking and online counselling services via its website and app Free2Ask.[33]

The Polish Social Drug Policy Initiative[34] has been working at events in clubs and at music festivals since 2015 where it provides harm reduction services, including reagent test kits, psychological counselling and educational information. The Polish PRO Test, run by the organisation Chemical Safety, operates as a social business.[35] Its website offers colorimetric tests for purchase and educational materials, and in cooperation with local NGOs it provides harm reduction information and publishes alerts for dangerous substances.

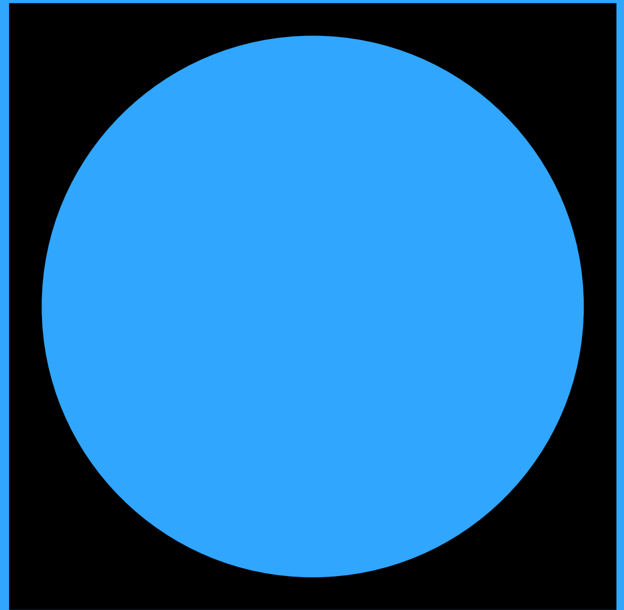
Czechia, Georgia and Lithuania also have walk-in drug checking facilities. In Czechia, test kits can be accessed in NSP sites. In Georgia, the NGO Mandala,[36] and in Lithuania the NGO Young Wave,[37] mainly work with young people who use drugs. Both organisations have offices in the respective capitals where people can come to collect test kits.

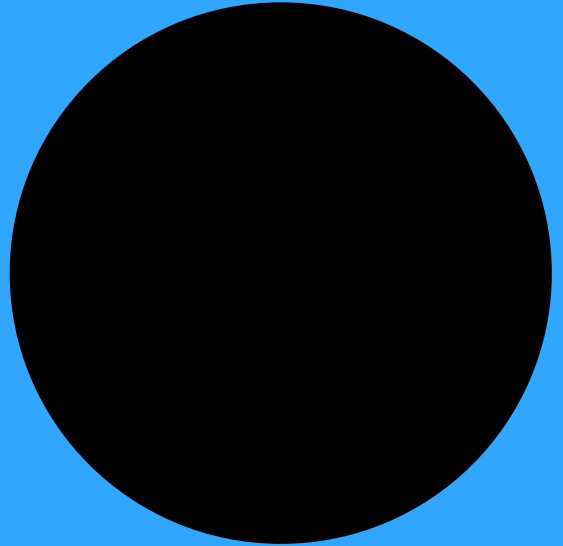
Since drug checking is not supported by the state in most countries, organisations struggle to provide uninterrupted services. The lack of resources also prevents these services from expanding. Georgia, Czechia, Ukraine and Croatia report[38] that only a very limited number of people who need them have access to drug checking services. In 2023, to expand drug checking in the country, the Addiction Research Centre Alternative Georgia started providing drug checking kits through syringe vending machines in Tbilisi.[39] The primary goal of the vending machines is to access hard-to-reach groups of people who use drugs and to cover underserved geographical areas. Vending machines were installed near pharmacies and served both the general population and people who inject drugs. Harm reduction services distribute plastic cards to people who use drugs, who can use them to access a hidden menu on the machine, allowing them to obtain an HIV prevention kit.[40]

Colorimetric tests are a very basic tool that can serve as a gateway for implementing comprehensive drug checking services. Introducing this service without waiting for legal changes once again highlights community efforts to meet the needs of people who use drugs, address the overdose crisis and provide essential harm reduction tools despite restrictive operating environments. Continued support and expansion of these services is crucial for supporting the health and wellbeing of people who use drugs and addressing the evolving challenges of drug use, particularly in relation to the spread of new psychoactive substances in the region.

1 Lay, K., (7 August 2024), 'Russian influence in Eastern Europe is aggravating HIV epidemic, say experts' [online article, accessed August 2024], The Guardian, London. Available from www.theguardian.com/global-development/article/2024/aug/07/russian-influence-in-eastern-europe-is-aggravating-hiv-epidemic-aids.
2 Lahov, A., (2024), 'Global State of Harm Reduction 2024 survey response, Russia'; Ibragimova, O., (2024), 'Global State of Harm Reduction 2024 survey response, Kazakhstan'; Azizmamadov, M., (2024), 'Global State of Harm Reduction 2024 survey response, Tajikistan'; Gogia, M., (2024), 'Global State of Harm Reduction 2024 survey response, Georgia'.
3 Amnesty International, (18 November 2016), 'Russia: New repressive legislation against "undesirable" organizations' [online article, accessed August 2024], AI, London. Available from www.amnesty.org/en/documents/eur46/5147/2016/en/.
4 Amnesty International, (2023), *Punished for dissent: Russia's restriction on NGOs, media, and civil society*, AI, London.
5 Andrey Rylkov Foundation, (21 April 2020), 'Russian NGO accused of 'narco-propaganda' over COVID-19 advocacy for people who use drugs' [online article, accessed August 2024], Talking Drugs, London. Available from www.talkingdrugs.org/russian-ngo-accused-of-narco-propaganda-over-covid-19-advocacy-for-people-who-use-drugs/.
6 European Court of Human Rights, 'Case of Andrey Rylkov Foundation and others v. Russia' [web page, accessed August 2024], ECHR, Strasbourg. Available from https://hudoc.echr.coe.int/eng?i=001-234260.
7 Eurasian Harm Reduction Association, (2020), *Drug Propaganda Submission to Special Rapporteurs: Russia*, EHRA, Vilnius.
8 Meduza, (20 June 2018),'Russian court fines news website 800,000 rubles for 'drug propaganda' because of an interview with a libertarian' [online article, accessed August 2024], Meduza Project SIA, Riga, Latvia. Available from https://meduza.io/en/news/2018/06/20/russian-court-fines-news-website-800-000-rubles-for-drug-propaganda-because-of-an-interview-with-a-libertarian.
9 Meduza, (11 June 2021), 'Russian YouTuber Yury Dud facing misdemeanor charge in 'drug propaganda' case' [online article, accessed August 2024], Meduza Project SIA, Riga, Latvia. Available from https://meduza.io/en/news/2021/06/11/russian-youtuber-yury-dud-facing-misdemeanor-charge-in-drug-propaganda-case.
10 AFP, (13 December 2023), 'Hungary passes controversial law protecting national sovereignty' [online article, accessed August 2024], Euronews, Lyon, France. Available from www.euronews.com/2023/12/13/hungary-passes-controversial-law-protecting-national-sovereignty.
11 ARTICLE 19, (2024), *Hungary: Act on the Defence of National Sovereignty: Legal Analysis,* ARTICLE 19, London.
12 United Nations Human Rights Office of the High Commissioner, (8 March 2024), 'Tajikistan: UN expert criticises dissolution of 700 NGOs' [online article, accessed August 2024], OHCHR, Geneva. Available from www.ohchr.org/en/press-releases/2024/03/tajikistan-un-expert-criticises-dissolution-700-ngos.
13 Euronews, (21 May 2024), 'Serbian parliamentary minnow pushes for Russian law equivalent' [online article, accessed August 2024], Euronews, Lyon, France. Available from www.euronews.com/my-europe/2024/05/21/serbian-parliamentary-minnow-pushes-for-russian-law-equivalent.
14 Radio Free Europe/Radio Liberty, (28 May 2024), 'Republika Srpska withdraws foreign agents draft law' [online article, accessed August 2024], RFERL, Prague. Available from www.rferl.org/a/republika-srpska-foreign-agents-draft-law-withdraw/32967576.html.
15 Kirova, I., (4 April 2024), 'Foreign agent laws spread as EU dithers on support for civil society' [online article, accessed August 2024], Human Rights Watch, New York. Available from www.hrw.org/news/2024/04/04/foreign-agent-laws-spread-eu-dithers-support-civil-society.
16 OSCE Office for Democratic Institutions and Human Rights, (2022), *Urgent Interim Opinion on the Draft Law "On Non-Profit non-Governmental Organizations" and Draft Amendments on "Foreign Representatives": Kyrgyz Region,* ODIHR, Warsaw.
17 Forestier-Walker, R., (4 May 2024), '"No to the Russian law": Georgia protesters demand a European pat', [online article, accessed August 2024], Al Jazeera, Doha. Available from www.aljazeera.com/features/2024/5/4/no-to-the-russian-law-georgia-protesters-demand-a-european.
18 Amnesty International, (16 April 2024), 'Georgia: Stop the bill on transparency of foreign influence that threatens civil society' [online article, accessed August 2024], AI, London. Available from www.amnesty.org/en/latest/news/2024/04/georgia-stop-the-bill-on-transparency-of-foreign-influence-that-threatens-civil-society/.
19 Human Rights Watch, (9 May 2024), 'Georgia: Foreign influence bill threatens rights' [online article, accessed August 2024], HRW, New York. Available from www.hrw.org/news/2024/05/09/georgia-foreign-influence-bill-threatens-rights.
20 Gogia, M. (2024), 'Global State of Harm Reduction 2024 survey response, Georgia'.
21 Amnesty International, (26 March 2024), 'Georgia: Halt legislative assault on LGBTI rights' [online article, accessed August 2024], HRW, New York. Available from www.amnesty.org/en/latest/news/2024/03/georgia-halt-legislative-assault-on-lgbti-rights/.
22 UNAIDS, '2025 AIDS targets' [web page, accessed August 2024], UNAIDS, Geneva. Available from https://aidstargets2025.unaids.org/.
23 United Nations Human Rights Office of the High Commissioner, (15 May 2024), 'Georgia: UN experts condemn adoption of law on transparency of foreign influence' [online article, accessed August 2024], OHCHR, Geneva. Available from www.ohchr.org/en/press-releases/2024/05/georgia-un-experts-condemn-adoption-law-transparency-foreign-influence.
24 United Nations Kyrgyzstan, (6 October 2023), 'Speech: UN Special Rapporteurs have urged the Government of Kyrgyz Republic to reconsider and withdraw draft law on NGOs', [web page, accessed August 2024], UN Kyrgyzstan, Bishkek. Available from https://kyrgyzstan.un.org/en/248422-un-special-rapporteurs-have-urged-government-kyrgyz-republic-reconsider-and-withdraw-draft.
25 United Nations Kyrgyzstan, (8 April 2024), 'Press release: Spokesperson for the UN High Commissioner for Human Rights: "Kyrgyzstan's new 'foreign representatives' law deeply concerning" [online media release, accessed August 2024], UN Kyrgyzstan, Bishkek. Available from https://kyrgyzstan.un.org/en.
26 United Nations Human Rights Office of the High Commissioner, (18 June 2024), 'We must urgently find our way back to peace, says High Commissioner' [online article, accessed August 2024], OHCHR, Geneva. Available from www.ohchr.org/en/statements-and-speeches/2024/06/we-must-urgently-find-our-way-back-peace-says-high-commissioner.
27 United Nations Human Rights Office of the High Commissioner, (15 May 2024), 'Türk deeply regrets adoption of foreign influence law in Georgia' [online article, accessed August 2024], OHCHR, Geneva. Available from www.ohchr.org/en/press-releases/2024/05/turk-deeply-regrets-adoption-foreign-influence-law-georgia.
28 Organization for Security and Co-operation in Europe, (7 February 2024), 'Human rights situation in Georgia: ODIHR's report on the foreign influence law' [online article, accessed August 2024], OSCE, Warsaw and Vienna. Available from www.osce.org/odihr/562449.
29 Stöver, H., (2022), *Regional analysis of the provision of drug checking services in the Central and Eastern Europe and Central Asia region,* Eurasian Harm Reduction Association, Vilnius.
30 DrogArt, 'Promoting safer drug use and harm reduction in Slovenia' [web page, accessed August 2024], DrogArt, Ljubljana, Solvenia. Available from www.drogart.org/.
31 Czech Drug Users' Union, 'Harm reduction and drug policy advocacy in the Czech Republic' [web page, accessed August 2024], CDUU, Prague. Available from https://czsub.cz/.
32 Kushakov, I. et al., 'The first study of psychoactive substance use and drug checking', [AIDS 2022 poster presentation], International AIDS Society, Geneva.
33 Drugstore Project, 'Consultations' [web page, accessed August 2024], APH, Kyiv. Available from https://drugstore.org.ua/en/consultants.
34 Społeczna Inicjatywa Narkopolityki, 'Jesteśmy SIN' [web page, accessed August 2024], SIN, Warsaw. Available from https://sin.org.pl/.
35 PRO-Test, 'Drug test kits – Drug purity testing kits' [web page, accessed August 2024], Chemical Safety, Warsaw. Available from https://protestkit.eu/.
36 Mandala, 'Nothing about us without us', [web page, accessed August 2024], Mandala, Tbilisi. Available from www.mndl.ge/.
37 Young Wave, 'What's wrong with you? Harm reduction of psychoactive substances', [web page, accessed August 2024], YW, Vilnius, Available from: https://youngwave.lt/.
38 Gogia, M., (2024), 'Global State of Harm Reduction 2024 survey response, Georgia'; Pešek, D., (2024), 'Global State of Harm Reduction 2024 survey response, Czechia'; Vlasenko, L. (2024), 'Global State of Harm Reduction 2024 survey response, Ukraine'; Jovovic, I., (2024), 'Global State of Harm Reduction 2024 survey response, Croatia'.
39 Eurasian Harm Reduction Association, 'Drug checking through vending machines? Mission (im)possible' [web page, accessed August 2024], EHRA, Vilnius. Available from https://harmreductioneurasia.org/advocacy/in-action/drug-checking-through-vending-machines-mission-im-possible.
40 Sherozia, M. and S. Shamanadze, (2023), *Strengthening and advocacy of drug-checking service in Georgia*, Addiction Research Center Alternative Georgia, Tbilisi.

REGIONAL OVERVIEW: LATIN AMERICA AND THE CARIBBEAN





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

AUTHORS OF LATIN AMERICA AND THE CARIBBEAN REGIONAL OVERVIEW: **Carolina Ahumada and Jorgelina Di Iorio**

Carolina Ahumada is a sociologist from the University of Buenos Aires. She is the Advocacy and Intervention Assistant at Intercambios civil association (Argentina) and Youth Engagement Programme Lead at the international youth-led organisation, Youth RISE.

Jorgelina Di Iorio is a PhD researcher at CONICET. She is the Coordinator of the Intervention Area at Intercambios civil association. Jorjelina is also a lecturer at the University of Buenos Aires and the National University of Lanus.

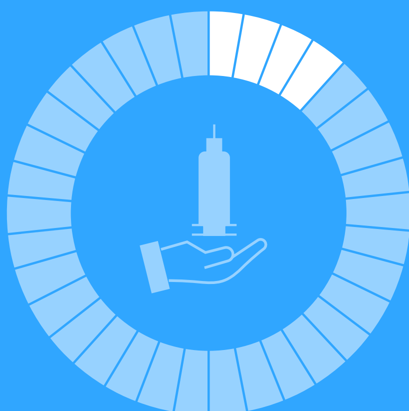
TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN LATIN AMERICA AND THE CARIBBEAN

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Antigua and Barbuda	nd[f]	nd	nd	nd	nd	nd	nd	✗	nd
Argentina	nd	nd	nd	nd	✗	✓ M	✗	✗	✗
Bahamas	nd	nd	nd	nd	nd	nd	nd	✗	nd
Barbados	nd	nd	nd	nd	nd	nd	nd	✗	nd
Belize	nd	nd	nd	nd	nd	nd	nd	✗	nd
Bolivia	nd	nd	nd	nd	nd	nd	nd	✗	nd
Brazil	nd	nd	48.6	nd	✓	✗	✗	✗	✓
Chile	nd	nd	nd	nd	✗	✗	✗	✗	✗
Colombia	6,601	5.7	30.5	nd	✓ 7	✓ M	✓	✓ 1	✗
Costa Rica	nd	nd	nd	nd	✗	✗	✗	✗	✗
Cuba	nd	nd	nd	nd	nd	nd	nd	✗	nd
Dominica	nd	nd	nd	nd	nd	nd	nd	✗	nd
Domincan Republic	nd	nd	nd	nd	nd	nd	nd	✗	nd
Ecuador	nd	nd	nd	nd	✗	✗	✗	✗	✗
El Salvador	nd	nd	nd	nd	nd	nd	nd	✗	nd
Grenada	nd	nd	nd	nd	nd	nd	nd	✗	nd
Guatemala	nd	No	No	No	✗	✗	✗	✗	✗
Guyana	nd	nd	nd	nd	nd	nd	nd	✗	nd
Haiti	nd	nd	nd	nd	nd	nd	nd	✗	nd
Honduras	nd	nd	nd	nd	nd	nd	nd	✗	nd
Jamaica	nd	nd	nd	nd	nd	nd	nd	✗	nd
Mexico	150,000	15.8	nd	nd	✓ 3	✓ M B N	✓	✓ 2	✓
Nicaragua	nd	nd	nd	nd	nd	nd	nd	✗	nd
Panama	nd	nd	nd	nd	nd	nd	nd	✗	nd
Paraguay	nd	nd	nd	nd	nd	nd	nd	✗	nd
Peru	nd	nd	nd	nd	✗	✓ M B	✗	✗	✗
Puerto Rico	nd	6	78.4	nd	✓ 9	✓ M B N	✓	✗	✓
Saint Kitts and Nevis	nd	nd	nd	nd	nd	nd	nd	✗	nd
Saint Lucia	nd	nd	nd	nd	nd	nd	nd	✗	nd
Saint Vincent and the Grenadines	nd	nd	nd	nd	nd	nd	nd	✗	nd
Suriname	nd	nd	nd	nd	nd	nd	nd	✗	nd
Trinidad and Tobago	nd	nd	nd	nd	nd	nd	nd	✗	nd
Uruguay	nd	nd	nd	nd	✗	nd	✗	✗	✗
Venezuela	nd	nd	nd	nd	nd	nd	nd	✗	nd

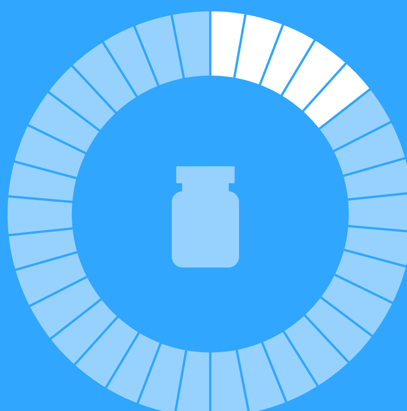
a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd= no data.

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

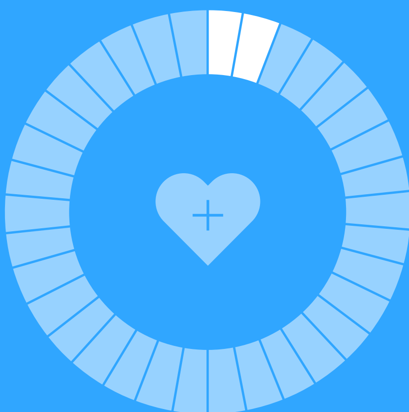
NSP, OAT, DCRs AND SAFER SMOKING KITS



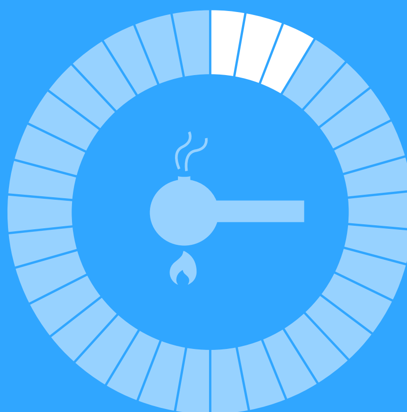
4 countries (12%) in Latin America and the Caribbean provide **needle and syringe programmes** (no change from 2022)



5 countries (15%) in Latin America and the Caribbean provide **opioid agonist therapy** (+1 from 2022, Perú)



2 countries (6%) in Latin America and the Caribbean provide **drug consumptions rooms** (+1 from 2022, Colombia)



3 countries (9%) in Latin America and the Caribbean provide **safer smoking kits** (+2 from 2022, Mexico and Puerto Rico)

KEY ISSUE

UNEVEN PROGRESS AND SETBACKS

The policy landscape in Latin America and the Caribbean is characterised by a mix of progress and setbacks. There are more progressive administrations in countries such as Colombia, Brazil, Mexico and Chile, and conservative-leaning administrations in Argentina, Ecuador, Peru, Guatemala, Costa Rica, Paraguay and the Caribbean countries. This mixed trend is even evident within single countries, where harm reduction strategies and punitive approaches to drug use exist simultaneously.

Uruguay makes explicit reference to harm reduction in its national drug policy strategies.[1,2] Colombia,[3] Mexico[4] and Brazil[5] are currently reviewing their national drug policies and incorporating new perspectives, including those from civil society organisations. Although Brazil's *National Policy on Alcohol and Other Drugs* (law 11.343/2006)[6] was implemented in 2006, some changes were made during the Bolsonaro administration towards a more punitive approach.[7]

In most countries in the region, national harm reduction policies are often lacking, yet guidelines exist for responses to drugs that emphasise harm reduction despite punitive drug laws. Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico, Puerto Rico and Uruguay explicitly mention harm reduction in HIV, mental health or drug policy regulations.[8]

Harm reduction programmes run by civil society have grown throughout the region in the last two years, although they are not funded by national governments, and international funding has continued to decrease since 2022.

In most of the region's countries, with the exception of Colombia,[9] Uruguay[10] and Costa Rica, personal use and possession of drugs is still a crime.[11] In Costa Rica, despite the fact that personal use and possession of all drugs is decriminalised, people who use drugs continue to be stigmatised and criminalised.[12]

Adult use of cannabis is only legal in Uruguay.[13] Colombia[14] and Mexico[15] attempted to legalise the adult use of cannabis, but neither bill progressed through the full legislative process.[16] Chile[17] and Brazil[18] have ended prison sentences for personal use of cannabis, but punishment for certain circumstances has shifted to fines or compulsory rehabilitation. Even though these reforms mark progress, the use and possession of cannabis is still not effectively or fully decriminalised in either country.[19]

Medical use of cannabis is decriminalised in Antigua and Barbuda, Argentina, Barbados, Brazil, Chile, Costa Rica, Colombia, Dominican Republic, Ecuador, Guyana, Jamaica, Mexico, Paraguay, Panama, Peru, Puerto Rico, St Kitts and Nevis, St Vincent and the Grenadines and Uruguay,[20] although access varies widely. In Bolivia, Cuba and Venezuela, such as in most Central American countries, there are no legal differences between medical and non-medical use.[21]

Civil society organisations are particularly concerned about the criminalisation and stigmatisation of people who use drugs and the increase of violence associated with organised crime and drug trafficking, especially in Central America,[22] Mexico[23] and Ecuador.[24] The impact of the cocaine trade in the current prohibitionist context is visible in different parts of the region, such as Ecuador, where, in recent years, drug trafficking has resulted in a wave of lethal violence linked to local and transnational crime groups.[25] In the Caribbean, in countries such as Jamaica, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, the Bahamas and Haiti, violence has increased due to competition between criminal groups for drug markets.[26] El Salvador, however, is experiencing a gradual replacement of gang violence with state violence.[27] El Salvador's maximum-security jail is part of a controversial national security policy that has been accused of perpetrating human rights abuses, including detentions without proper legal procedures like arrest warrants in place.[28,29]

The region's intricate and shifting drug policies highlight a pivotal moment where the call for comprehensive reform – anchored in harm reduction and human rights – is more critical than ever to tackle the intertwined challenges of violence, criminalisation and public health.

KEY ISSUE

STIMULANT HARM REDUCTION

Latin America and the Caribbean are characterised by a complex matrix of social inequality. Factors such as socioeconomic status, gender, age, ethnicity and race, territory, migration status and disability contribute to multiple layers of exclusion and discrimination. The COVID-19 pandemic, socio-political crises and the regression of socio-economic policies have greatly exacerbated social gaps.[30,31] According to the majority of the responses to the *Global State of Harm Reduction* survey from Latin American and Caribbean respondents, harm reduction is primarily being provided against a backdrop of increased unemployment, housing crises and migration.[32]

Unlike in other regions, injecting drug use is not prevalent in Latin America and the Caribbean.[33] However, it is more common along Mexico's northern border with the USA, Puerto Rico and some Colombian cities, and harm reduction organisations operate needle and syringe programmes in these locations.[34] Drug consumption rooms can be found in Tijuana and Mexicali in Mexico and Bogotá in Colombia. They are run by civil society organisations and take a strong peer-led approach.[a, 35]

Stimulant drug use is common in Latin America and the Caribbean.[36] Smoking substances like cannabis and cocaine is the most common type of drug use in the region. But the harm reduction interventions needed for this, such as safer smoking kits, are not widely available. The drug consumption room in Tijuana, Mexico offers a space for women who smoke drugs.[37] The recreational use of other stimulants, like MDMA, methamphetamines[38] and tusi,[39] are increasing.[40] As a response, peer-led colorimetric drug checking managed by civil society organisations is being implemented in Argentina, Brazil, Chile, Uruguay, Peru, Colombia and Mexico.[41] The majority of these interventions operate without government regulation or support.

Although opioid use is not prevalent in the region,[42] and fentanyl is not recorded as a substance used, except in isolated cases along the northern US-Mexico border, the issue is framed as an important problem in public discourse in Latin America. Harm reduction organisations in Mexico, Colombia, Peru, Costa Rica and Argentina agree that increased fentanyl use, such as has occurred in the USA and Canada, is not as likely in the region because the illicit use of fentanyl and other opioids is different.[43] In particular, they refer to the low use of heroin and other opiates, and the existence of national regulations on the legal use of fentanyl. Despite this, the 'fentanyl ghost' haunts the narrative. The media's handling of fentanyl use in Latin America lacks an evidence-base, and it has created an alarming public narrative which is empowering local governments to strengthen punitive drug policies.[44]

a The civil society organisations are Prevencasa in Tijuana, Verter in Mexicali and Acción Técnica Social in Bogotá.

“Stimulant drug use is common in Latin America and the Caribbean. Smoking substances like cannabis and cocaine is the most common type of drug use in the region. But the harm reduction interventions needed for this, such as safer smoking kits, are not widely available.”

1 Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London.
2 Junta Nacional de Drogas, (2021), *2021-2025 National Drug Strategy*, Uruguay Presidencia, Montevideo.
3 Ministerio de Interior y Justicia Colombia, (2023), *Sembrando Vida Desterramos el Narcotráfico: Política Nacional de Drogas 2023-2033*, MIJ, Bogotá.
4 Comisión Nacional contra las Adicciones Mexico, (2020), *Guía breve para la implementación del enfoque de reducción de riesgos y daños con usuarios de drogas, Comisión Nacional contra las Adicciones*, CONADIC, Mexico City; Snapp, Z. et al., (2024), *Guía Técnica y Caja de Herramientas de trabajo de campo para el abordaje de consumos de metanfetamina y fentanilo en México*, Instituto RIA AC, Mexico.
5 Ministério da Justiça e Segurança Pública Brazil, 'Guia metodológico: Plano Nacional de Políticas sobre Drogas 2021-2025 diagnóstico, elaboração, monitoramento e avaliação' [web page accessed September 2024], MoJ, Brasília. Available from www.gov.br/mj/pt-br/assuntos/sua-protecao/politicas-sobre-drogas/consulta-publica-do-planad; da Silva Petuco, D.R., (2024), Global State of Harm Reduction 2024 survey response, EPSJV/Fiocruz, Brazil, 2024; Comis, A., Global State of Harm Reduction 2024 survey response, E de Lei, Brazil, 2024.
6 Presidência da República Secretaria-Geral, Subchefia para Assuntos Jurídicos, Brazil, 'LEI Nº 11.343, 2006' [web page, accessed September 2024], President of the Federative Republic of Brazil, Brasília. Available from www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11343.htm.
7 Ministério da Justiça e Segurança Pública Brazil, 'Plano Nacional de Políticas sobre Drogas 2022-2027' [web page, accessed September 2024], MoJ, Brasília. Available from www.gov.br/mj/pt-br/assuntos/sua-protecao/politicas-sobre-drogas/consulta-publica-do-planad; interview with Comis, A., E de Lei Brazil, 2024.
8 Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London.
9 Interview with Ospina, P.A., Elementa DDHH, Colombia, 2024; Pereira Arana, I., (16 May 2024), 'Avances y paradojas: 30 años de la despenalización del uso y porte personal de drogas' [online article, accessed, September 2024], Dejustica, Bogotá. Available from www.dejusticia.org/despenalizacion-de-drogas.
10 Transnational Institute, (30 July 2015),'Reforma de la ley de drogas en el Uruguay: guía básica' [web article, accessed, September 2024], TNI, Amsterdam. Available from www.tni.org/es/publicaci%C3%B3n/reforma-de-la-ley-de-drogas-en-el-uruguay-guia-basica.
11 Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London.
12 Sandí, R., (13 October 2023), 'Imprudente mensaje del ministro de Seguridad, Mario Zamora, causó dolor y culpa' [online article, accessed, September 2024], La Teja, Costa Rica. Available from www.lateja.cr/nacional/imprudente-mensaje-del-ministro-de-seguridad-mario/LDZKMZDX4BCVLBELSROXXJJFTA/story/; Bolaños, Y.A., (9 October 2023), 'Consumidores de droga 'son cómplices' de los homicidios, dice Mario Zamora' [online article, accessed September 2024], La Nación, Costa Rica. Available from www.nacion.com/sucesos/seguridad/consumidores-de-droga-son-complices-de-los/KIVZ6BWG6BDW5DVEMW2DEIYUCM/story/.
13 Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London.
14 Rodríguez, S. R., (12 December 2023), 'Plenaria del Senado hundió regulación de uso adulto del cannabis en Colombia' [online article, accessed September 2024], Infobae, Buenos Aires, 2023. Available from www.infobae.com/colombia/2023/12/12/plenaria-del-senado-hundio-regulacion-de-uso-adulto-del-cannabis-en-colombia/.
15 Mercado, P. C. and J.R. Vadillo, (2024), *La política de la reforma de la regulación del cannabis en méxico*, Universidad Nacional Autónoma de México, Instituto de Investigaciones Jurídicas, Mexico City.
16 De Vicente, J.E., (2024), Global State of Harm Reduction 2024 survey response, México Unido Contra la Delincuencia, AC, Mexico.
17 SENDA, Ministerio del Interior y Seguridad Pública, 'Ley 20.000: Sanciona el tráfico ilícito de estupefacientes y sustancias sicotrópicas' [web page, accessed September 2024], SENDA, Santiago. Available from www.senda.gob.cl/informacion-sobre-drogas/leyes/ley-20-000-sanciona-el-trafico-ilicito-de-estupefacientes-y-sustancias-sicotropicas.
18 Richter, A., (26 June 2024), 'La Corte Suprema de Brasil despenaliza consumo personal de marihuana' [online article, accessed September 2024], Agência Brasil, Brasília. Available from https://agenciabrasil.ebc.com.br/es/justica/noticia/2024-06/la-corte-suprema-de-brasil-despenaliza-consumo-personal-de-marihuana.
19 Interview with Alejandro, C., Intercambios Asociación Civil, Argentina, July 2024.
20 Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London; Transnational Institute, (31 October 2022), 'Corporate capture of the Latin American medical cannabis market, 2022' [online article, accessed, September 2024], TNI, Amsterdam. Available from www.tni.org/en/publication/corporate-capture-of-the-latin-american-medical-cannabis-market.
21 Fausto, F., (2022), 'Despenalización del uso personal de cannabis en América Latina: un aporte para su medición y análisis', *Revista electrónica de estudios latinoamericanos*, vol. 20, no. 79.
22 Morales, J., (2024), Global State of Harm Reduction 2024 survey response, LANPUD/ INPUD, Guatemala; Cortés, E., (2024), Global State of Harm Reduction 2024 survey response, ACEID, Costa Rica.
23 Polo, A.M., (2024), Global State of Harm Reduction 2024 survey response, Elementa DDHH, México; Pasaran, S.S., (2024), Global State of Harm Reduction 2024 survey response, Integración Social Verter AC, Mexico; Ramos Rodríguez, M.E., (2024), Global State of Harm Reduction 2024 survey response, Programa Compañeros, A.C. y Red Mexicana de Reducción de Daños, Mexico.
24 Paz, E., (2024), Global State of Harm Reduction 2024 survey response, LANPUD, Ecuador.
25 United Nations Office on Drugs and Crime, (2023), *World Drug Report 2023*, UNODC, Vienna.
26 United Nations Office on Drugs and Crime, (2023), *UNODC Global Study on Homicide 2023: Homicide and organized crime in Latin America and the Caribbean*, UNODC, Vienna.
27 Méndez Dardón, A.M., (3 August 2023), 'Mass Trials in El Salvador Reflect Unsustainability of the State of Emergency' [online article, accessed September 2024], Washington Office on Latin America, Washington DC. Available from www.wola.org/analysis/mass-trials-el-salvador-reflect-unsustainability-state-of-emergency/.
28 Cristosal, 'La excepción se volvió la norma. Una mirada a las reformas penales y su impacto en las garantías ciudadanas' [web page, accessed September 2024], Cristosal, Burlington, VT. and San Salvador. Available from https://cristosal.org/ES/la-excepcion-se-volvio-la-norma-una-mirada-a-las-reformas-penales-y-su-impacto-en-las-garantias-ciudadanas/.
29 Amnesty International, (2 June 2022), 'El Salvador: President Bukele engulfs the country in a human rights crisis after three years in government' [online article, accessed September 2024], AI, London. Available from www.amnesty.org/en/latest/news/2022/06/el-salvador-president-bukele-human-rights-crisis/.
30 Halpern, B., et al., (2022), 'Lessons From the COVID-19 Pandemic in Latin America: Vulnerability Leading to More Vulnerability', *American Journal of Public Health*.
31 Economic Commission for Latin America and the Caribbean, (2022), *The sociodemographic impacts of the COVID-19 pandemic in Latin America and the Caribbean*, ECLAC, Santiago, 2022.
32 Pedroso, J., C. Araujo and C. Corradi-Webster, (2024), 'The joy and pain of being a harm reduction worker: a qualitative study of the meanings about harm reduction in Brazil', *Harm Reduction Journal,* vol. 21, no. 56.
33 United Nations Office on Drugs and Crime, (2023), *World Drug Report 2023*, UNODC, Vienna; Harm Reduction International, (2022), *Global State of Harm Reduction 2022 Regional Overview: Latin America and the Caribbean,* HRI, London; Shirley-Beavan, S. et al. and LANPUD, (2021), *Inclusion and participation of people who use drugs in Global Fund processes: Report of findings from a Global Fund Community, Rights and Gender short- term technical assistance project,* HRI, London.
34 Pasaran, S.S., (2024), Global State of Harm Reduction 2024 survey response, Integración Social Verter AC, Mexico; Castro, H., (2024), Global State of Harm Reduction 2024 survey response, Temeride, Colombia; Rojas Estupiñan, D., (2024), Global State of Harm Reduction 2024 survey response, Proyecto Cambie, Corporación Acción Técnica Social – ATS, Colombia; Flores, A., (2024), Global State of Harm Reduction 2024 survey response, Intercambios Puerto Rico; Albizu, C., (2024), Global State of Harm Reduction 2024 survey response, UPR School of Public Health Puerto Rico.
35 Pasaran, S.S., (2024), Global State of Harm Reduction 2024 survey response, Integración Social Verter AC, Mexico; Castro, H., (2024), Global State of Harm Reduction 2024 survey response, Temeride, Colombia; Rojas. D., Estupiñan, (2024), Global State of Harm Reduction 2024 survey response, Proyecto Cambie, Corporación Acción Técnica Social – ATS, Colombia; Flores, A., (2024), Global State of Harm Reduction 2024 survey response, Intercambios Puerto Rico.
36 da Silva Petuco, D.R., (2024), Global State of Harm Reduction 2024 survey response, EPSJV/Fiocruz, Brazil; Morales, J., (2024), Global State of Harm Reduction 2024 survey response, LANPUD/ INPUD, Guatemala; del Pilar Deheza, R., (2024), Global State of Harm Reduction 2024 survey response, Imaginario 9, Uruguay; Touzé, G., (2024), Global State of Harm Reduction 2024 survey response, Intercambios AC, Argentina.
37 Segovia Acosta, L.A., (2024), Global State of Harm Reduction 2024 survey response, Prevencasa AC, Mexico; Ramos Rodríguez, M.E., (2024), Global State of Harm Reduction 2024 survey response, Programa Compañeros, A.C. and Red Mexicana de Reducción de Daños, REDUMEX, Mexico; Chavez, A., (2024), Global State of Harm Reduction 2024 survey response, Prevencasa AC, Mexico, July 2024.
38 De Vicente Encarnación, J., (2024), Global State of Harm Reduction 2024 survey response, México Unido Contra la Delincuencia, A.C, Mexico.
39 Echele Cabeza, 'What is Tusi?, Cuando Se De En La Cabeza' [web page, accessed September 2024], Acción Técnica Social, Bogotá. Available from www.echelecabeza.com/tusi-tusibi/.
40 United Nations Office on Drugs and Crime, (2023), *World Drug Report 2023*, UNODC, Vienna.
41 Andres Quintero López, J., (2024), Global State of Harm Reduction 2024 survey response, Corporacion Acción Técnica Social, Colombia; Pasaran, S.S., (2024), Global State of Harm Reduction 2024 survey response, Integración Social Verter AC, Mexico; del Pilar Deheza, R., (2024), Global State of Harm Reduction 2024 survey response, Imaginario 9, Uruguay; da Silva Petuco, D.R., EPSJV/Fiocruz, Brazil; Ahumada, C., (2024), Global State of Harm Reduction 2024 survey

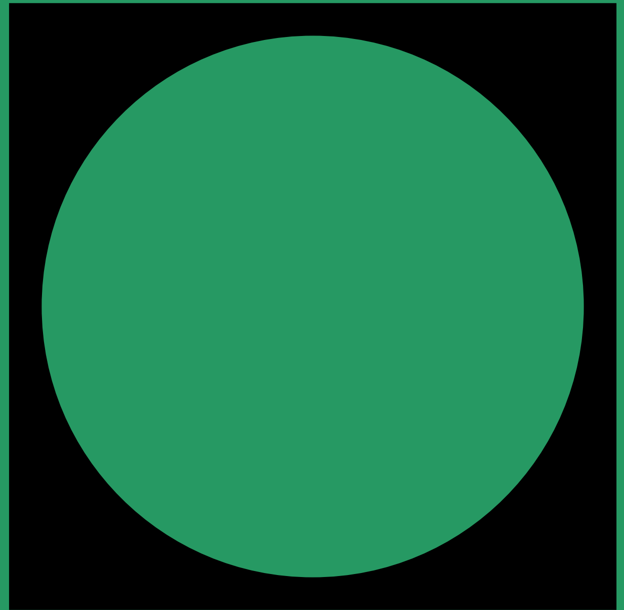
response, Intercambios Asociación Civil, Argentina; Rotondo, H., (2024), Global State of Harm Reduction 2024 survey response, Proyecto Soma, Perú; Obregón Fernández, C., (2024), Global State of Harm Reduction 2024 survey response, Reduciendo Daño, Chile; Snapp, Z., (2024), Global State of Harm Reduction 2024 survey response, Instituto RIA, Mexico.

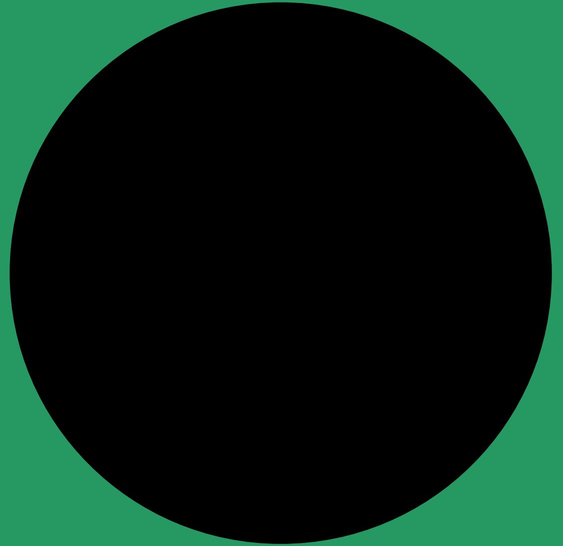
42 United Nations Office on Drugs and Crime, (2023), *World Drug Report 2023*, UNODC, Vienna.

43 Andres Quintero López, J., (2024), Global State of Harm Reduction 2024 survey response, Corporacion Acción Técnica Social, Colombia; Pasaran, S.S., (2024), Global State of Harm Reduction 2024 survey response, Integración Social Verter AC, Mexico; Ahumada, C., (2024), Global State of Harm Reduction 2024 survey response, Intercambios AC, Argentina; Rotondo, H., (2024), Global State of Harm Reduction 2024 survey response, Proyecto Soma, Perú.

44 Martínez, S., (27 November 2023), '¿Está Latinoamérica en riesgo de enfrentar su propia crisis de fentanilo?' [online article, accessed September 2024], Ciencia y Salud, Voice of America, Washington DC. Available from www.vozdeamerica.com/a/podria-latinoamerica-enfrentar-una-crisis-de-fentanilo-similar-a-la-de-eeuu/7372504.html; Méndez, R.L., (12 September 2023), '¿Debe alarmarse América Latina por el fentanilo?' [online article, accessed September 2024], Soma and Talking Drugs, London. Available from https://proyectosoma.com/2023/09/12/debe-alarmarse-america-latina-por-el-fentanilo-latinoamerica/;
La Opinión, (21 November 2023), 'Con ayuda de la DEA, desmantelan Costa Rica red de tráfico de fentanilo; mezclaban droga con paracetamol', [online article, accessed September 2024], La Opinión, Costa Rica. Available from https://laopinion.com/2023/11/21/con-ayuda-de-la-dea-desmantelan-costa-rica-red-de-trafico-de-fentanilo-mezclaban-droga-con-paracetamol/.

REGIONAL OVERVIEW: MIDDLE EAST AND NORTH AFRICA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

AUTHORS OF MIDDLE EAST AND NORTH AFRICA REGIONAL OVERVIEW: **Isabelle Salameh and Elie Aaraj**

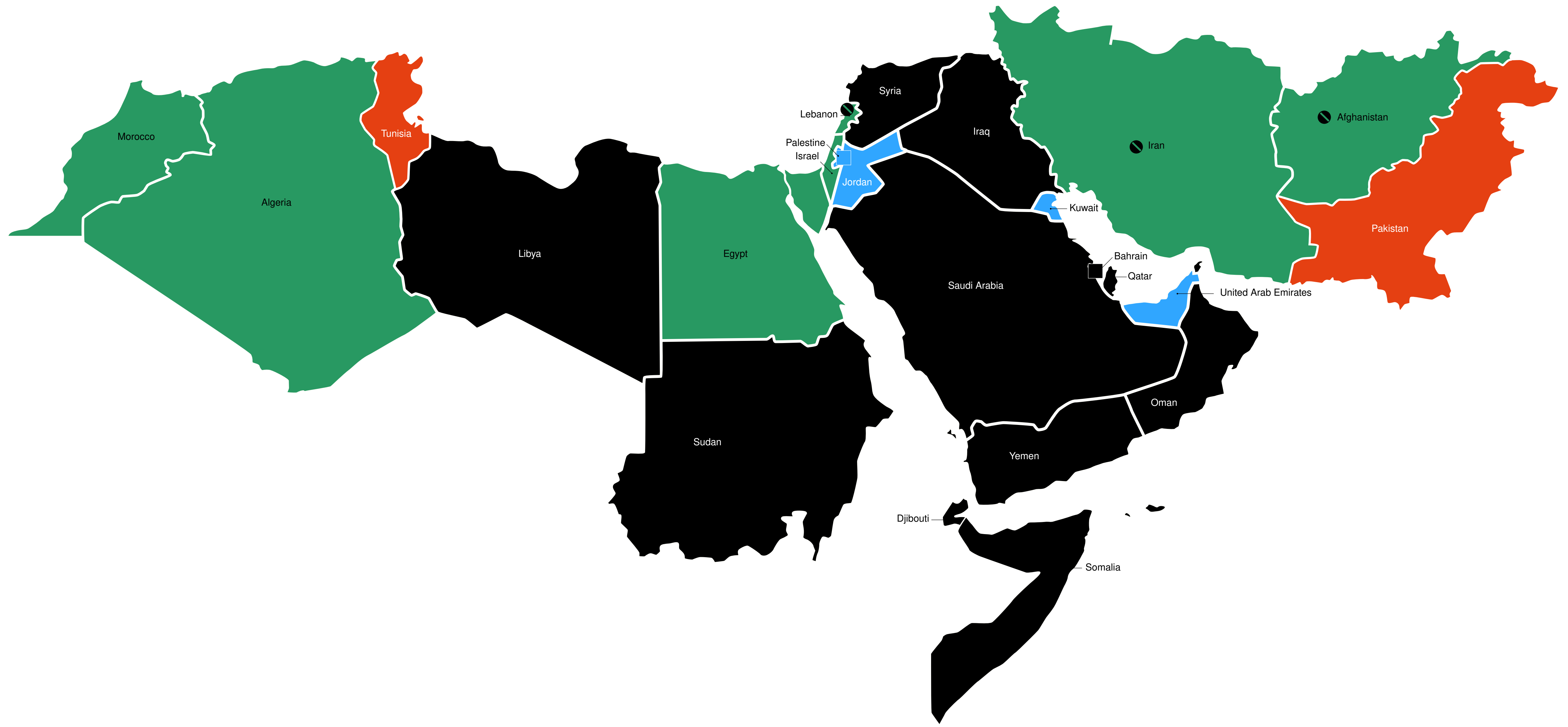
Isabelle Salameh is the Programme Coordinator at the Middle East and North Africa Harm Reduction Association (MENAHRA) in Beirut, Lebanon.

Elie Aaraj is the Executive Director at the Middle East and North Africa Harm Reduction Association (MENAHRA) in Beirut, Lebanon.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN ASIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Afghanistan	57,207	1.41	23.08	2.77	✓ 8	✓ M	✓	×	×
Algeria	17,000	nd[f]	nd	nd	✓ 3	✓ M	nd	nd	×
Bahrain	5,100	3.89	3.89	nd	×	nd	×	×	×
Djibouti	nd	nd	nd	nd	×	nd	×	×	×
Egypt	96,230	3.73	nd	nd	✓	✓ M	×	×	×
Iraq	39,277	nd	nd	nd	×	×	×	×	×
Iran	138,250	8.3	36.8	3.04	✓	✓ M B	✓	×	×
Israel	nd	nd	nd	nd	✓	✓ M B	×	×	×
Jordan	10,488	0	nd	nd	×	✓	×	×	×
Kuwait	12,000	0.1	30.87	1.52	×	✓	×	×	×
Lebanon	9,000	0.05	23.59	1.07	✓ 1	✓ B	✓	×	×
Libya	6,677	87.1	94.2	4.5	×	×	×	×	×
Morocco	17,750	5.05	63.13	nd	✓ 3	✓ M	×	×	×
Oman	2,922	0.53	36.56	6.29	×	×	×	×	×
Pakistan	430,000	33.2	51.32	2.66	✓[g]	×	×	×	×
Palestine	5,000	0	41.48	6.15	×	✓ M B	×	×	×
Qatar	1,827	nd	nd	nd	×	×	×	×	×
Saudi Arabia	3,400	2.46	62.61	7.7	×	×	×	×	×
Somalia	392	nd	nd	nd	×	×	×	×	×
Sudan	986	nd	nd	nd	×	×	×	×	×
Syria	10,000	0	3.3	0.5	×	×	×	×	×
Tunisia	11,000	3.54	28.32	4.3	✓	×	×	×	×
United Arab Emirates	6,247	nd	nd	nd	×	✓	×	×	×
Yemen	844	nd	nd	nd	×	×	×	×	×

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training and facilitates secondary distribution of naloxone between peers.
d At least on drug consumption room (also known as safe consumption sites among other names) operational in the country or territory.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g NSP in 45 district-level Continuum of Prevention and Care (CoPC+) sites and covers 62 districts through outreach.



- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone

NSP, OAT, DCRs AND SAFER SMOKING KITS

9 countries (38%) in the Middle East and North Africa provide **needle and syringe programmes** (no change from 2022)

11 countries (45%) in the Middle East and North Africa provide **opioid agonist therapy** (+4 from 2022, Egypt, Jordan, Kuwait, United Arab Emirates)

No country in the Middle East and North Africa provide **drug consumptions rooms** (no change from 2022)

No country in the Middle East and North Africa provide **safer smoking kits** (no change from 2022)

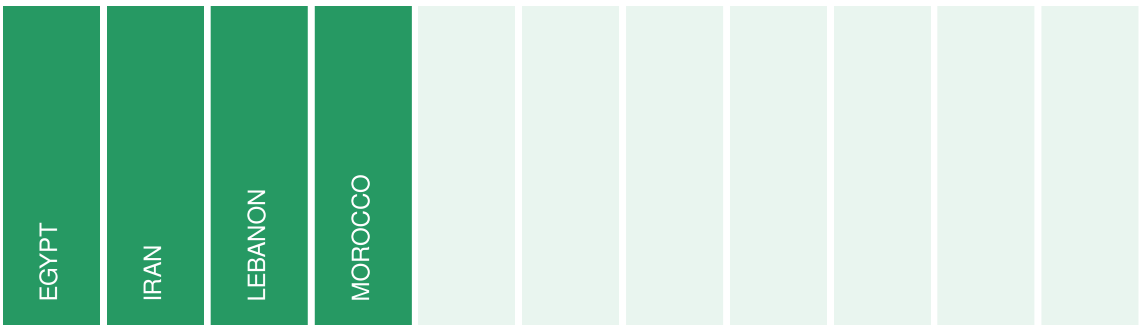
KEY ISSUE

BARRIERS TO HARM REDUCTION SERVICES

Socio-cultural barriers, such as stigma, discrimination, lack of public understanding, community resistance and religious factors, hinder the availability and accessibility of health services for people who use drugs.[1] These barriers are present not only in society but also within healthcare settings, affecting services related to needle and syringe programmes (NSP), opioid agonist therapy (OAT) and HIV.[2] In Egypt, a 2023 study found that healthcare staff in hospitals regularly stigmatise and discriminate against people who use drugs, which directly impacts access to services.[3]

Religiously-framed narratives in predominantly Islamic countries further restrict access to harm reduction services.[4,5] A systematic narrative review of studies on the experiences of people who use drugs in Muslim communities in Iran, Afghanistan, Egypt, Lebanon and the United Arab Emirates highlights the scarcity of research and data on drug use and harm reduction, stigma, and the psychosocial and organisational barriers that make it challenging for people who use drugs to access services.[6,7] In Algeria, religious barriers prevent people from seeking NSP services because using drugs is considered a major sin.[8] In Iran, unrealistic expectations from family and society, as well as stigma and the intertwining of treatment with ethical and religious principles, are identified as the most significant socio-cultural barriers to harm reduction and HIV treatment.[9] In Egypt, despite the significant scale-up of harm reduction services, some healthcare providers still perceive these services as culturally and religiously unacceptable.[10]

Although 11 countries mention harm reduction and people who use drugs in national policy documents, only 4 have adopted supportive policies in their National HIV Strategic Plans



- countries that mention harm reduction in national policy documents
- countries that have adopted harm reduction in their National HIV Strategic Plans

Policymakers' unwillingness to prioritise and implement harm reduction measures, combined with centralised political power and 'top-down' health systems, significantly undermines harm reduction efforts. This results in poor implementation and sustainability, even when harm reduction is mentioned in national strategies.[11]

Although 11 countries mention harm reduction and people who use drugs in national policy documents, only 4 (Egypt, Iran, Lebanon and Morocco) have adopted supportive policies in their National HIV Strategic Plan.[12] As a result, the coverage of harm reduction services remains inadequate in the region.[13]

Punitive laws which criminalise the use of drugs further hinder the implementation of harm reduction services,[14] discourage people who use drugs from seeking services and increase levels of stigma and discrimination.[15] Strict punitive laws that criminalise the possession or use of drugs were documented in 14 countries in the region, while data from other countries is lacking.[16] In Iran, in 2023, the government executed 459 people for drug-related offences, a 79% increase from 2022 and the highest number in the country since 2015.[17,18,19] In Lebanon, around 3,000 people are arrested each year on charges related to substance use, depriving basic rights, such as treatment, support, education and employment, for those who are sentenced.[20]

These interlinked factors affect the resources allocated for harm reduction services, increase the stigmatisation and marginalisation of people who use drugs and discourage people who use drugs from seeking services.[21,22] Availability, accessibility and quality of harm reduction services, not only within communities but within prisons and other closed settings, are also impacted.[23,24] In Morocco, for instance, although OAT is available in prisons and other closed settings, it is reported to be largely inaccessible, and NSP and condoms are entirely unavailable as prison authorities believe these measures would incentivise drug use and sexual activity.[25] In Egypt, women who use drugs report being denied harm reduction services and rehabilitation treatment and also report humiliating experiences while in prison.[26]

As documented by the United Nations Development Programme (UNDP), key informants from Punjab in Pakistan reported that none of the province's 43 prisons, including 5 women's prisons, provide HIV services.[27] However, Nai Zindagi, a non-governmental organisation (NGO) in Pakistan, offers harm reduction services in 24 prisons (23 in Sindh and 1 in Khyber Pakhtunkhwa). Three of these are female prisons, and three are juvenile prisons. Harm reduction services provided are HIV testing, counselling on safer sex, linkages to antiretroviral treatment (ART) for HIV, adherence support, baseline investigation to initiate ART and linkages to hepatitis C treatment.

Due to budget cuts, UNAIDS was forced to close its Middle East and North Africa regional office. This has led to concerns about the continuity and sustainability of leadership and advocacy for HIV and the harm reduction response in the region.[28]

It has also made it challenging for community organisations that work on HIV, given that 70% of HIV infections in the region are among key populations,[a] and community-led NGOs provide the main frontline support for them.

a 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.

> “Punitive laws which criminalise the use of drugs further hinder the implementation of harm reduction strategies, discourage people who use drugs from seeking services and increase levels of stigma and discrimination. Strict punitive laws that criminalise the possession or use of drugs were documented in 14 countries in the region, while data from other countries is lacking.”

KEY ISSUE

BARRIERS TO MEANINGFUL ENGAGEMENT OF KEY POPULATIONS

Representation and inclusion of affected communities are crucial for ensuring effective and equitable health responses. This is especially true in the Middle East and North Africa, where marginalised communities most affected by HIV are often excluded from decision-making processes.[29] People who use drugs face significant barriers to participating in the decision-making processes that affect them, leading to gaps in harm reduction services and policies that fail to appropriately address their needs. The barriers that prevent people who use drugs from participating in decision-making and programming relate to social and cultural factors, a lack of political will and commitment, stigma, discrimination and repressive and punitive legal frameworks.[30]

Despite this challenging backdrop, over the past two years, representation and engagement of key populations in the region has increased.[31] For instance, MENAROSA, a regional network established in 2010 for women living with HIV, and MENANPUD (the Middle East and North African Network for People who Use Drugs), an NGO established in 2007 to advocate for the rights of people who use drugs in the region, have participated and engaged in advocacy, campaigns, planning, research, mapping and programme implementation for people who use drugs. For the first time, in 2024, an important collaboration between the two organisations took place, with representatives developing a joint advocacy plan.[32,33] In mid-2024, they also began coordinating the MENA Learning Hub to focus on community engagement and learning in relation to the Global Fund's procedures and processes in the region.[34] The hub's first project will be to assess the learning needs of certain marginalised communities. This will focus on people living with HIV, women living with HIV, people who use drugs and people living with tuberculosis (TB) in all Global Fund eligible countries (Algeria, Djibouti, Egypt, Jordan, Morocco, Iraq, Lebanon, Libya, Palestine, the Syrian Arab Republic, Tunisia and Yemen).[35,36]

Despite the efforts of the last two years, it is still a significant challenge to include and represent people who use drugs in scaling up harm reduction services in the region.

The *Global State of Harm Reduction 2024* survey responses revealed varied involvement of people who use drugs in planning and implementation across different countries in the region for services related to NSP and OAT. In Egypt and Tunisia, NGOs reported no meaningful involvement of people who use drugs.[37,38] In Algeria and Afghanistan, responses were mixed, with some respondents unsure about the level of involvement and others affirming meaningful participation.[39,40,41.] In Lebanon, the responses were inconsistent, with some stating involvement in planning only, implementation only, both, or none at all.[42] This highlights the lack of clarity regarding the engagement of people who use drugs in these programmes.

Civil society organisations have conducted various situation assessments and consultations on harm reduction in the region over the past few years. These assessments and engagements underscored the urgent need to involve and engage people who use drugs in the planning, implementation, monitoring and evaluation of advocacy initiatives, service delivery and policymaking. This involvement is essential to ensure effective, person-centred efforts and accountable decision making.

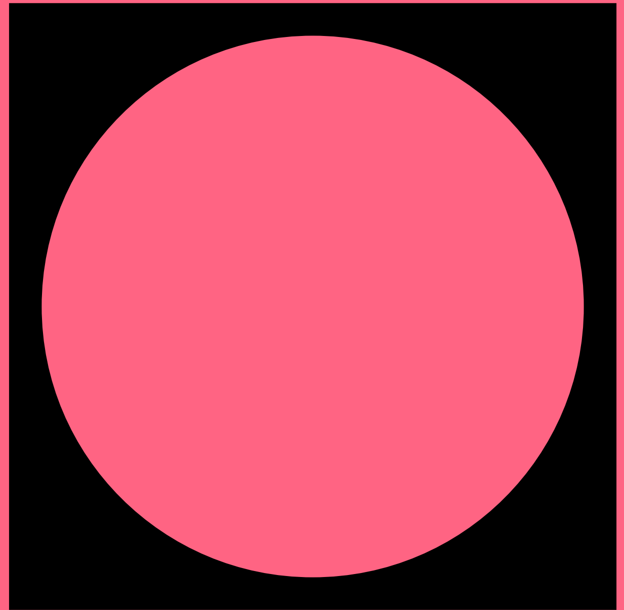
There have been several capacity building initiatives for key populations and organisations working in the harm reduction field, ensuring that all stakeholders have the essential skills and resources to meaningfully contribute to harm reduction efforts. For instance, in 2023, during a regional consultation, representatives from Libya and Yemen emphasised the need for meaningful engagement of people who use drugs in the creation of HIV National Strategic Plans and responses founded on human rights and gender equality. Representatives from Libya and Pakistan also advocated for a National Multi-Stakeholder Accountability Framework for people who use drugs to address the availability and accessibility of harm reduction services.[43] The need for community engagement in emergency situations was also highlighted in COVID-19 Emergency Preparedness Plans for Egypt, Jordan, Lebanon, Morocco, Tunisia and Yemen in order to ensure effective and timely crisis responses.[44]

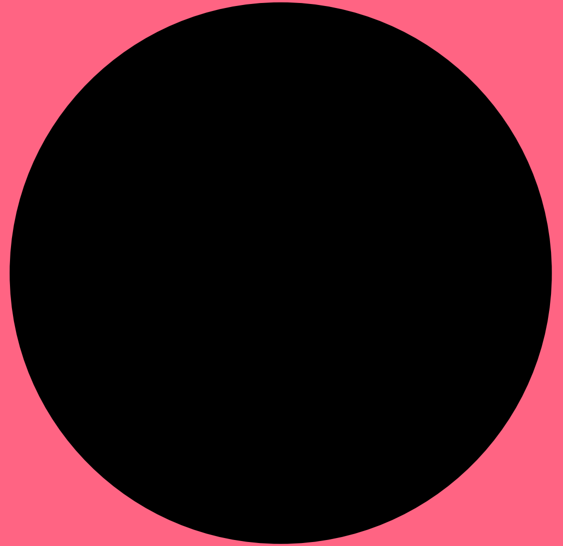
The Global Fund Community, Rights and Gender (CRG) assessment on TB in Lebanon emphasised the importance of patient-centred care, community inclusion and patient rights. However, the *Lebanon National Strategic Plan to End Tuberculosis (2023-2030)* did not integrate community participation, revealing a gap in policy implementation.[45] The CRG assessment recommended promoting the involvement of people who use drugs and prioritising their unique needs so that key populations can be more effectively linked to essential TB services and support networks.

While there have been notable efforts to increase the representation and engagement of key populations, social, cultural and legal barriers continue to hinder meaningful participation, leading to gaps in harm reduction services and policymaking. Continued advocacy and targeted efforts are essential to ensure these communities are not only included in but are central to the development and execution of initiatives that directly affect their lives.

1 Various respondents, (2024), 'Global State of Harm Reduction survey responses 2024, Middle East and North Africa'.
2 Karbasi, A., et al., (2023), 'An Evolving HIV Epidemic in the Middle East and North Africa (MENA) Region: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 3844.
3 Ibid.
4 Ibid.
5 Al-Ghafri, Q., P. Radcliffe and G. Gilchrist, (2023), 'Barriers and facilitators to accessing inpatient and community substance use treatment and harm reduction services for people who use drugs in the Muslim communities: A systematic narrative review of studies on the experiences of people who receive services and service providers', *Drug and Alcohol Dependence*, vol. 244, e109790.
6 Karbasi, A., et al., (2023), 'An Evolving HIV Epidemic in the Middle East and North Africa (MENA) Region: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 3844.
7 Al-Ghafri, Q., P. Radcliffe and G. Gilchrist, (2023), 'Barriers and facilitators to accessing inpatient and community substance use treatment and harm reduction services for people who use drugs in the Muslim communities: A systematic narrative review of studies on the experiences of people who receive services and service providers', *Drug and Alcohol Dependence*, vol. 244, e109790.
8 Alihalassa, S., (2024), 'Global State of Harm Reduction survey response 2024, Algeria'.
9 Mallik, S., et al., (2021), "An undercover problem in the Muslim community": A qualitative study of imams' perspectives on substance use', *Journal of Substance Abuse Treatment,* vol. 123, e108224.
10 Van Hout, M., et al., (2023), "Secrecy, Trust, Safety": a Multi-stakeholder Situation Assessment of Gendered and Contextual Vulnerabilities and Service Level Responsiveness to the Needs of Women Who Use Drugs in Egypt', I*nternational Journal of Mental Health and Addiction.*
11 Van Hout, M. and E. Aaraj, (25 May 2020), 'Pandemic Stresses the Human Rights Imperatives of Tackling HIV and Hepatitis in Middle East and North African Prisons' [online blog, accessed September 2024] Health and Human Rights Journal, Boston. Available from www.hhrjournal.org/2020/05/pandemic-stresses-the-human-rights-imperatives-of-tackling-hiv-and-hepatitis-in-middle-east-and-north-african-prisons.
12 Karbasi, A., et al., (2023), 'An Evolving HIV Epidemic in the Middle East and North Africa (MENA) Region: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 3844.
13 Ibid.
14 Various respondents, (2024), 'Global State of Harm Reduction survey responses 2024, Middle East and North Africa'.
15 Van Hout, M., P. Haddad and E. Aaraj, (2021), 'The Impact of COVID-19 on Drug Use and Harm Reduction Programming in the Middle East and North Africa (MENA) Region: a Regional Consultation of Stakeholders and People Who Use Drugs', *International Journal of Mental Health and Addiction*, vol. 20, no.4, p.2072–2085.
16 Karbasi, A., et al., (2023), 'An Evolving HIV Epidemic in the Middle East and North Africa (MENA) Region: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 3844.
17 Amnesty International, (2 June 2023), 'Iran: Prisons turned into killing fields as drug-related executions almost triple this year' [online article, accessed September 2024] Amnesty International, London. Available from www.amnesty.org/en/latest/news/2023/06/iran-prisons-turned-into-killing-fields-as-drug-related-executions-almost-triple-this-year.
18 Harm Reduction International, (2024), *The Death Penalty for Drug Offences: Global Overview 2023*, HRI, London.
19 ECPM, (March 2024), 'Death penalty in Iran: An appalling number of executions in 2023' online media release, accessed September 2024, ECPM, Paris. Available from http://www.ecpm.org/en/death-penalty-iran-2023.
20 International Drug Policy Consortium, (1 July 2022), 'Drug law reform should be among the priorities of the Lebanese parliament' [online article, accessed September 2024] IDPC, London. Available from idpc.net/news/2022/07/drug-law-reform-should-be-among-the-priorities-of-the-lebanese-parliament.
21 Karbasi, A., et al., (2023), 'An Evolving HIV Epidemic in the Middle East and North Africa (MENA) Region: A Scoping Review', *International Journal of Environmental Research and Public Health*, vol. 20, no. 3844.
22 Van Hout, M., P. Haddad and E. Aaraj, (2021), 'The Impact of COVID-19 on Drug Use and Harm Reduction Programming in the Middle East and North Africa (MENA) Region: a Regional Consultation of Stakeholders and People Who Use Drugs', *International Journal of Mental Health and Addiction*, vol. 20, no.4, p.2072–2085.
23 Various respondents, (2024), 'Global State of Harm Reduction survey responses 2024, Middle East and North Africa'.
24 Van Hout, M. and E. Aaraj, (25 May 2020), 'Pandemic Stresses the Human Rights Imperatives of Tackling HIV and Hepatitis in Middle East and North African Prisons' [online blog, accessed September 2024] Health and Human Rights Journal, Boston. Available from www.hhrjournal.org/2020/05/pandemic-stresses-the-human-rights-imperatives-of-tackling-hiv-and-hepatitis-in-middle-east-and-north-african-prisons/.
25 Data from the Love Alliance database for Morocco, for access see Aidsfonds, (4 March 2024), 'Love Alliance: A Database on Key Drug Policy & Harm Reduction Indicators' online article, accessed September 2024, Aidsfonds, Amsterdam.
26 Van Hout, M., et al., (2023), "Secrecy, Trust, Safety": a Multi-stakeholder Situation Assessment of Gendered and Contextual Vulnerabilities and Service Level Responsiveness to the Needs of Women Who Use Drugs in Egypt', *International Journal of Mental Health and Addiction.*
27 United Nations Development Programme, (2024), C*ommunity Voices: An HIV Gender Assessment in Pakistan,* UNDP, New York.
28 Burki, T., (2023), 'UNAIDS departure leaves vacuum in leadership in MENA', *The Lancet HIV*, vol. 10, no. 10, e637.
29 Personal communication with Elie Aaraj, MENAHRA Executive Director, 2024.
30 Ibid.
31 Personal communication with programmes coordinator at MENAHRA, 2024.
32 Personal communication with MENANPUD, 2024.
33 Personal communication with MENAROSA, 2024.
34 See Global Fund to Fight AIDS, Tuberculosis and Malaria, (22 January 2024), *Community Engagement Strategic Initiative: Regional Learning Hubs*, Global Fund, Geneva.
35 Personal communication with MENANPUD, 2024.
36 Personal communication with MENAROSA, 2024.
37 Tariq, M., (2024), 'Global State of Harm Reduction survey response 2024'.
38 Association Tunisienne de information et orientation sur le sida et la toxicomanie, (2024), 'Global State of Harm Reduction survey response 2024'.
39 Association AIDS Algerie, (2024), 'Global State of Harm Reduction survey response 2024'.
40 Alihalassa, S., (2024), 'Global State of Harm Reduction survey response 2024, Algeria'.
41 Organisation for Harm Reduction in Afghanistan, (2024), 'Global State of Harm Reduction survey response 2024'.
42 Various respondents, (2024), 'Global State of Harm Reduction survey responses 2024, Middle East and North Africa'.
43 Middle East Harm Reduction Association, (2023), *Regional Consultation Meeting on TB*, MENAHRA, Beirut.
44 Middle East Harm Reduction Association, (2023), *Emergency Preparedness Plans for HIV and Harm Reduction Service Providers*, MENAHRA, Beirut.
45 Middle East Harm Reduction Association, (2024), *Lebanon Tuberculosis Community Rights and Gender (CRG) Assessment Report*, MENAHRA, Beirut.

REGIONAL OVERVIEW: NORTH AMERICA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

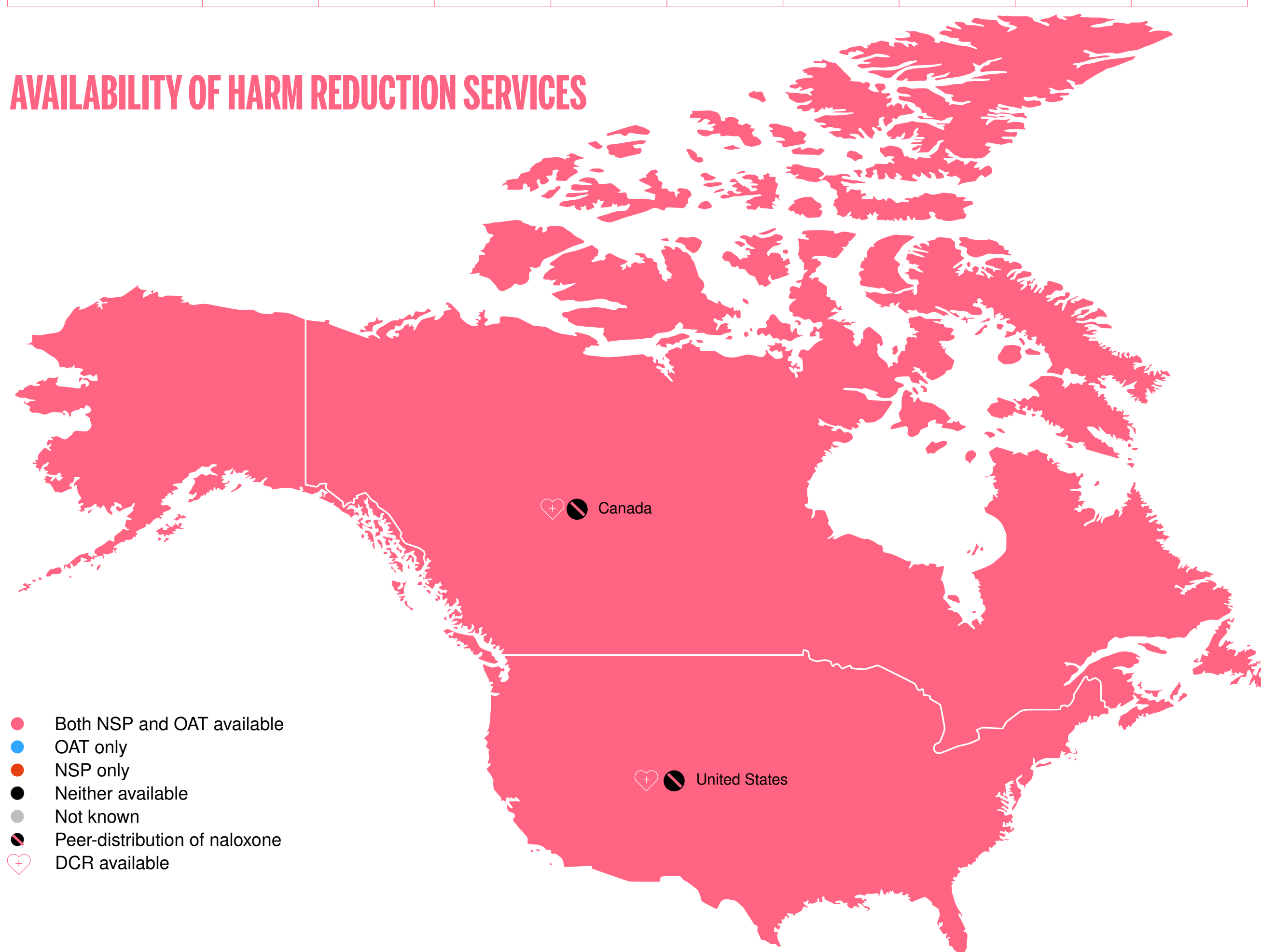
AUTHOR OF NORTH AMERICA REGIONAL OVERVIEW: **Thomas Kerr**

Dr. Thomas Kerr, PhD, is Head of the Division of Social Medicine in the Department of Medicine at the University of British Columbia. He is also the Director of Research at the British Columbia Centre on Substance Use. Dr. Kerr has extensive research experience characterising high-risk substance use, as well as the impact of related health interventions and policy.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN NORTH AMERICA

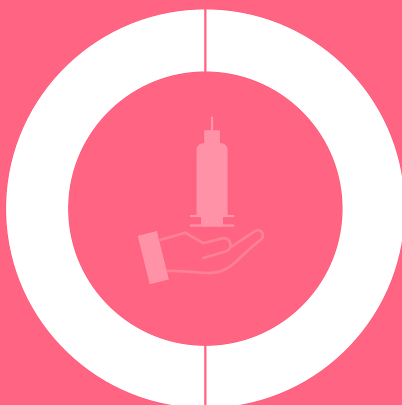
Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Canada	174,500	10.3	64.2	nd[f]	✓	✓ M B	✓	✓ 41[g]	✓
United States of America	3,695,400	5.9	53.5	4.8	✓	✓ M B	✓	✓ 2	✓

AVAILABILITY OF HARM REDUCTION SERVICES

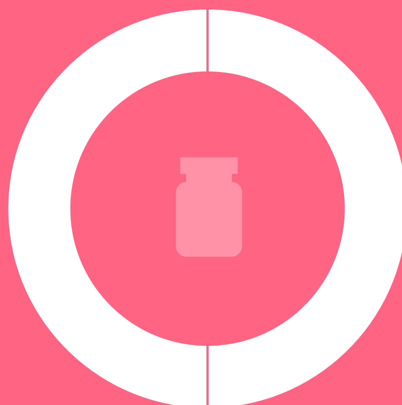


a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (DCR) (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
g This includes one prison DCR in Drumheller, Alberta.
f nd = no data.
g This includes three DCRs in prisons.

NSP, OAT, DCRs AND SAFER SMOKING KITS

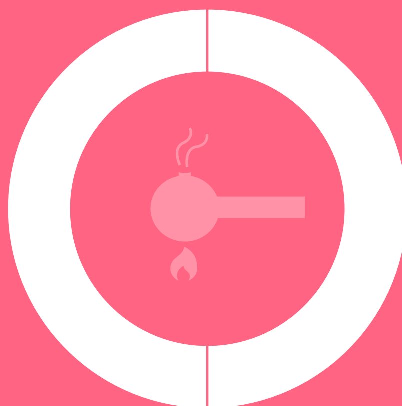


2 countries (100%) in North America provide **needle and syringe programmes** (no change from 2022)



2 countries (100%) in North America provide **opioid agonist therapy** (no change from 2022)

2 countries in North America provide **drug consumption rooms** (no change from 2022)



2 countries in North America provide **safer smoking kits** (no change from 2022)

TABLE STATE-BY-STATE ACCESS TO HARM REDUCTION IN THE UNITED STATES

State	Needle and syringe programmes	Is possession of syringes criminalised by drug paraphernalia laws?	Licensed opioid treatment programmes	Licensed drug consumption rooms
Alabama	1	Yes	Yes	No
Alaska	4	No	Yes	No
Arizona	15	Yes	Yes	No
Arkansas	2	Yes	Yes	No
California	58	No	Yes	No
Colorado	13	Yes, but NSP clients exempt	Yes	No
Connecticut	9	No	Yes	No
Delaware	1	Yes, but NSP clients exempt	Yes	No
Florida	6	Yes, but NSP clients exempt	Yes	No
Georgia	6	Yes	Yes	No
Hawaii	1	Yes, but NSP clients exempt	Yes	No
Idaho	5	Yes	Yes	No
Illinois	14	Yes, but NSP clients exempt	Yes	No
Indiana	12	Yes	Yes	No
Iowa	1	Yes	Yes	No
Kansas	0	Yes	Yes	No
Kentucky	35	Yes, but NSP clients exempt	Yes	No
Louisiana	6	Yes	Yes	No
Maine	8	Yes, but NSP clients exempt	Yes	No
Maryland	8	Yes, but NSP clients exempt	Yes	No
Massachusetts	15	No	Yes	No
Michigan	23	No	Yes	No
Minnesota	13	No	Yes	No
Mississippi	0	Yes	Yes	No
Missouri	4	Yes	Yes	No
Montana	4	Yes	Yes	No
Nebraska	0	Yes	Yes	No
Nevada	2	No	Yes	No
New Hampshire	9	No	Yes	No
New Jersey	3	Yes, but NSP clients exempt	Yes	No
New Mexico	5	Yes, but NSP clients exempt	Yes	No
New York	25	Yes, but NSP clients exempt	Yes	Yes 2
North Carolina	32	Yes, but NSP clients exempt	Yes	No
North Dakota	5	Yes, but NSP clients exempt	Yes	No
Ohio	20	Yes, but NSP clients exempt	Yes	No
Oklahoma	4	Yes	Yes	No
Oregon	13	No	Yes	No

State	Needle and syringe programmes	Is possession of syringes criminalised by drug paraphernalia laws?	Licensed opioid treatment programmes	Licensed drug consumption rooms
Pennsylvania	7	Yes	Yes	No
Rhode Island	2	No	Yes	No
South Carolina	4	No	Yes	No
South Dakota	0	Yes	Yes	No
Tennessee	9	Yes, but NSP clients exempt	Yes	No
Texas	8	Yes	Yes	No
Utah	6	Yes, but NSP clients exempt	Yes	No
Vermont	4	Yes, but NSP clients exempt	Yes	No
Virginia	3	Yes, but NSP clients exempt	Yes	No
Washington	29	Yes, but NSP clients exempt	Yes	No
West Virginia	8	Yes, but NSP clients exempt	Yes	No
Wisconsin	16	No	Yes	No
Wyoming	0	Yes	No	No
Washington DC	4	Yes, but NSP clients exempt	Yes	No

KEY ISSUE

DRUG CONSUMPTION ROOMS

Drug consumption rooms (DCRs), also known as overdose prevention centres, supervised injection sites or safe injection facilities, are spaces where individuals can consume pre-obtained drugs under the supervision of healthcare providers or other trained staff.[1] DCRs typically provide emergency overdose response, primary medical care and referrals to internal and external services, including treatment for substance dependence and housing.[2] DCR objectives are to reduce infectious disease transmission, reduce deaths and ill-health associated with overdose, connect people who use drugs to the services they need and reduce risks associated with the consumption of drugs in public spaces.[3,4]

Insite, the first DCR in North America, opened in 2003 in Vancouver, Canada.[4] This DCR was subjected to rigorous evaluation; over 40 peer-reviewed studies indicated that

Insite was successful in meeting its objectives and was associated with declines in overdose deaths, infectious disease transmissions and risks associated with the consumption of drugs in public, and increased uptake of substance use treatment.[5,6]

The success of Insite prompted the establishment of DCRs throughout Canada. Now, 39 federally sanctioned DCRs operate in five provinces.[7] DCRs operate as stand-alone facilities, integrated within other facilities, or as mobile sites such as vans.[8]

In response to the worsening overdose crisis in Canada, around 50 'urgent public health needs sites' or overdose prevention centres have been opened.[9,10] These are often temporary facilities, which makes numbers difficult to track. They also tend to be simpler in operation and design than conventional DCRs and have a primary focus on overdose prevention and response.[5] The expansion of DCRs in Canada has generated some backlash. The province of Ontario recently announced a ban on DCRs within 200 feet of schools and childcare centres, which may result in the closure of 10 DCRs by 31 March 2025.[11]

The USA has been slow to adopt DCRs despite over a decade of advocacy efforts focused on their establishment, as well as the operation of unsanctioned DCRs in some places.[12] Two locally sanctioned DCRs currently operate in New York City, and another two are scheduled to open in Rhode Island and Vermont as both states have enacted authorising legislation and allocated state funding to support their operations.[13,14] Minnesota has also enacted legislation allocating funding for establishing and operating DCRs.[15] A DCR also operated in San Francisco in 2022 with city approval, which reversed 333 overdoses during its existence. However, it was closed after one year for vague political reasons.[16]

The DCRs in New York were opened by OnPoint NYC in November 2021.[17] Both DCRs operate within a Harm Reduction Wellness Hub which provides a range of wrap-around services under a single roof.[18] In addition to the DCR, services at the hub include syringe services, drug checking, clinical care, mental health services, case management, food and nutrition and peer support.[19]

The OnPoint DCRs include booths and tables for injecting (eight spaces per site), as well as enclosed, communal, ventilated rooms for inhaling/smoking.[20] As of July 2024, 5,330 people have used the DCRs, engaging in around 149,700 drug consumption episodes, and OnPoint staff successfully intervened in 1,570 overdoses.[21] One in five people who have used an OnPoint DCR were referred to housing, detox, treatment, primary care or an employment opportunity.[22] Initial evidence from the evaluation of the New York City sites indicates that establishing the DCRs did not result in increased disorder or crime.[23]

Plans to establish DCRs in other US cities have not been realised, typically as a result of political or legal barriers.[24,25] The federal Anti-Drug Abuse Act prohibits operating spaces 'for the purpose of…using a controlled substance'[26,27] and was recently used by the Department of Justice to prevent the opening of a DCR in Philadelphia.[28] Efforts to open other DCRs have also been met with considerable political opposition in some regions, while jurisdictions like Rhode Island, Vermont and Minnesota continue to move forward.[29,30]

The evidence concerning the effectiveness of DCRs has grown substantially in recent years. There are now three peer-reviewed systematic reviews of the evidence specific to DCRs.[31,32,33] These reviews all reach the conclusion that DCRs are effective in meeting their objectives, and do not produce feared consequences, such as enabling further drug use, undermining treatment efforts or exacerbating crime.[34,35,36] Importantly, no one has ever died of an overdose in a DCR anywhere, and peer-reviewed research indicates that the establishment of DCRs is associated with declines in overdose deaths within neighbourhoods,[37,38] and all-cause deaths.[39] Available evidence also indicates that, if people can access a DCR they are more likely to enter into detoxification and drug dependency treatment programmes[40,41] and cease injecting drug use.[42] Given that consuming drugs in DCRs is clearly safer than consuming drugs in other spaces, it has been deemed unethical for studies to randomize individuals to DCR access or no DCR access.[43,44] This has resulted in never-ending questions regarding the research specific to DCRs,[45] despite an accumulation of high quality and consistent observational evidence, including data derived from longitudinal cohort studies and studies relying on administrative data (e.g., treatment admissions, police-collected crime statistics).[46,47,48]

The evidence concerning the effectiveness of DCRs continues to grow.[1] Although several studies indicate that these services do not exacerbate crime or drug dependency,[49,50,51] they continue to be politicised and misrepresented by a range of stakeholders.[52] This has constrained their implementation in some settings.[53,54] But the way forward is clear: DCRs meet their objectives without causing negative consequences, and they have high potential to contribute to preventing people from overdosing across the world. And as the following section shows, widespread DCRs are urgently needed across the region to help prevent increasing overdose deaths.

“In many settings, crime, people experiencing homelessness and a lack of affordable housing is being attributed to the existence of harm reduction programmes, despite a lack of evidence to demonstrate such relationships.”

KEY ISSUE

DRUG OVERDOSES

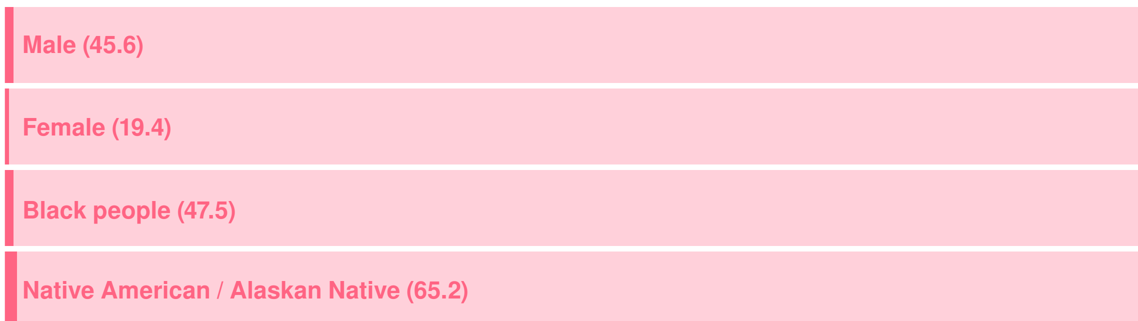
North America is contending with a public health crisis driven by accidental drug-related overdose deaths which has only worsened in recent years. A range of interventions and policies designed to prevent overdose deaths have been implemented, but they remain limited in terms of scale and coverage. At the same time, punitive approaches to drug use have continued to dominate in many settings. The epidemiology of overdose in North America is highly gendered and is having a disproportionate impact among certain racial and ethnic minority groups, as well as people of Indigenous, Native and Indian ancestry.

In the USA, according to the US Centers for Disease Control, an estimated 107,941 people died from a drug overdose in 2022 (32.6 per 100,000 people).[55] This represents a greater than 600% increase from 2000, when 16,849 people died from overdose (6.1 per 100,000).[56] Similar dynamics are evident in Canada, where 11,528 deaths occurred in 2023 (34.8 per 100,000 people).[57] This represents a greater than 500% increase since 2018, when 2,297 deaths occurred (7.8 per 100,000).[58]

Males in North America continue to die of overdose at higher rates than females. In the USA, the rate of overdose death in 2022 was 45.6 per 100,000 for males and 19.4 per 100,000 for females.[59] In Canada, males accounted for 72% of those who died of an overdose in 2023.[60] In the USA, Black and Indigenous people have experienced the highest rates of death due to overdose of any racial or ethnic group (47.5 deaths per 100,000 among Black people, and 65.2 deaths per 100,000 among Native American/Alaskan Native people),[61] while people of Indigenous ancestry in Canada are also disproportionally affected.[62]

The factors driving the current overdose crisis are similar in the USA and Canada. Both countries have witnessed a large and growing increase in the presence of illegally manufactured synthetic drugs, as well as the rising co-use of stimulants and opioids.[63,64,65] For example, while synthetic opioids such as fentanyl were involved in only 9% of overdose deaths in 2014 in the USA, this increased to 68% in 2022. Likewise, in Canada in 2023, 82% of all overdose deaths involved fentanyl or related

Overdose death rate per 100,000 people (USA)



analogues, while only 44% did in 2016.[66,67] More recently, other synthetics, including xylazine and synthetic benzodiazepines, have entered the drug supply and complicated overdose risk and response and the delivery of harm reduction services.[68,69,70] Aside from the growing contamination and toxicity of the drug supply, other factors continue to drive overdose deaths, including various social and economic conditions such as poverty and economic disadvantage, structural racism, pain, drug market policing, unstable housing and people experiencing homelessness.[71,72,73,74,75,76]

In the USA, the Department of Health and Human Services' *Overdose Prevention Strategy* seeks to address four core areas: prevention, evidence-based treatment, harm reduction and recovery.[77] Spanning the areas of treatment and harm reduction, medications for opioid agonist therapy (OAT), such as methadone and buprenorphine, remain primary approaches. While in some settings OAT is more widely available,[78] access is more restricted in other areas.[79] Barriers to OAT persist, with factors such as distance, stigma, insurance and restrictive programme delivery practices constraining access and retention.[80] Naloxone distribution appears to have increased in the USA, although coverage is generally regarded as inadequate.[81,82] However, stigma and financial constraints still act as barriers to access in some settings.[83] Recently, as discussed above, two DCRs opened in the USA and two more are set to open, but this form of intervention remains controversial, and attempts to open such services in some states have been denied.[84,85,86,87] There have also been significant increases in the availability of drug checking services in the USA, although their impact remains unclear.[88]

Canada's national Drugs and Substances Strategy seeks to balance prevention and education, evidence, substance use services and supports and substance controls (i.e., drug laws, enforcement). Substance use services span harm reduction, recovery and treatment programmes.[89] A variety of harm reduction programmes exist in Canada, including needle and syringe programmes, naloxone provision, drug checking, DCRs and safer supply.[90,91,92]

Safer supply involves providing prescribed medications to people who are at high risk of overdose as a safer alternative to the toxic illegal drug supply [93]

including by providing medications such as hydromorphone, fentanyl powder and patches, dexedrin and clonazepam. Safer supply programmes have been the subject of much controversy, including concerns about diversion.[a,94] However, a growing body of evidence indicates that safer supply programmes reduce overdose risk and healthcare costs, and help people reduce their reliance on an unregulated and contaminated drug supply.[95,96,97]

Throughout North America, there are growing concerns regarding the politicisation of the overdose crisis and backlash against harm reduction policies and interventions in particular.[98,99,100] The government of Ontario's decision to close several DCRs is a prime example of this.[101] In the USA, another example can be seen in the rolling back of Oregon's drug decriminalisation laws.[102,103] In many settings, crime, people experiencing homelessness and a lack of affordable housing is being attributed to the existence of harm reduction programmes, despite a lack of evidence to demonstrate such relationships.[104]

There are also growing concerns about inaction by governments and a lack of funding needed to address the current crisis.[105] Given the ever-worsening epidemic of overdose death in North America, greater investment and action is needed to ensure access to evidence-based harm reduction programmes reach the people most at risk of overdosing. This should include novel interventions that address the rapidly evolving toxic drug supply and approaches designed to address the intersections of overdose with gender, race and Indigenous ancestry.

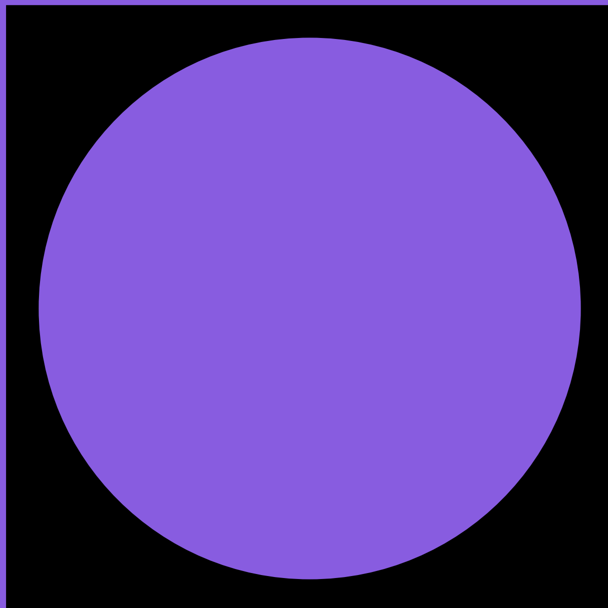
a Diversion is the non-intended or non-medical use of a prescribed medication, or its use by any individual other than the person for whom it was prescribed.

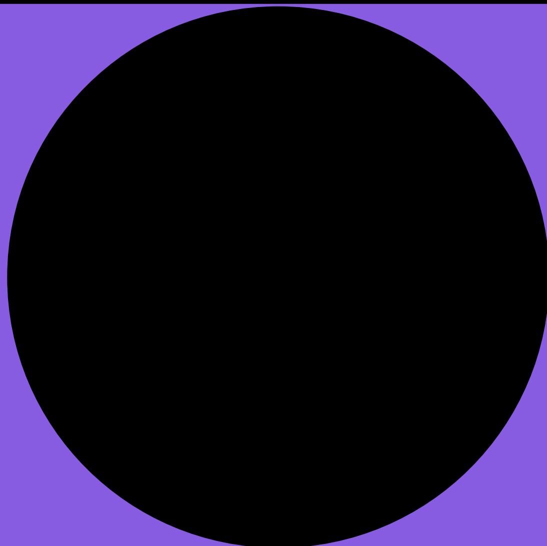
“Aside from the growing contamination and toxicity of the drug supply, other factors continue to drive overdose deaths, including various social and economic conditions such as poverty and economic disadvantage, structural racism, pain, drug market policing, unstable housing and people experiencing homelessness.”

1 Kerr. T., (2017), 'Supervised injection facilities in Canada: past, present, and future', *Harm Reduction Journal*, vol. 14, no. 1. p.28.
2 Broadhead, R.S., et al., (2020), 'Safer injection facilities in North America: Their place in public policy and health initiatives', *Journal of Drug Issues*, vol. 32, vol. 1, p.329-355.
3 Ibid.
4 Kennedy, M.C., M. Karamouzian and T. Kerr, (2017), 'Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review', *Current HIV/AIDS Reports*, vol. 14, no. 5, p.161-183.
5 Ibid.
6 Wood, E., et al., (2006), 'Summary of findings from the evaluation of a pilot medically supervised safer injecting facility', *Canadian Medical Association Journal*, vol. 175, no. 11, p.1399-404.
7 Health Canada, 'Interactive map: Canada's response to the opioid overdose crisis', [web page, accessed August 2024], Government of Canada, Ontario. Available from https://health.canada.ca/en/health-canada/services/drugs-medication/opioids/responding-canada-opioid-crisis/map.html.
8 Hedrich, D., T. Kerr and F. Dubois-Arber, (2003), 'Drug consumption facilities in Europe and beyond', in *Harm reduction: Evidence, impacts and challenges* edited by T. Rhodes, European Monitoring Centre for Drugs and Drug Addiction, Scientific Monograph Series No 10, Office for Official Publications of the European Communities, Luxembourg.
9 Health Canada, 'Supervised consumption explained: types of sites and services' [web page, accessed August 2024], Government of Canada, Ontario. Available from www.canada.ca/en/health-canada/services/substance-use/supervised-consumption-sites/explained.html#a4.
10 PIVOT, 'Canada's supervised consumption and overdose prevention sites' [web page, accessed August 2024], PIVOT, Vancouver. Available from www.pivotlegal.org/scs_ops_map.
11 Jabakhanji, S., (20 August 2024), 'Province to close 5 Toronto supervised drug consumption sites' [online article, accessed September 2024], CBC News, Toronto. Available from www.cbc.ca/news/canada/toronto/toronto-supervised-injection-sites-ontario-restrictions-1.7299398.
12 Kral, A.H., et al., (2020), 'Evaluation of an unsanctioned safe consumption site in the United States', *New England Journal of Medicine*, vol. 383, no. 6, p.589-590.
13 Vakharia, S., (2024) 'Global State of Harm Reduction 2024 survey response'.
14 Rosen, J.G., et al., (2024),"Make yourself un-NIMBY-able": stakeholder perspectives on strategies to mobilize public and political support for overdose prevention centers in the United States of America', *Harm Reduction Journal*, vol. 21, no. 1, p.40.
15 Du, S., (3 April 2024), 'Drug use resource hub opens in north Minneapolis after state legalizes safe injection sites' [online article, accessed August 2024], The Minnesota Star Tribune, Minnesota. Available from www.startribune.com/minnesota-overdose-awareness-opens-drug-use-resource-hub-safe-recovery-site-in-north-minneapolis/600356054.
16 Rosen, J.G., et al., (2024),"Make yourself un-NIMBY-able": stakeholder perspectives on strategies to mobilize public and political support for overdose prevention centers in the United States of America', *Harm Reduction Journal*, vol. 21, no. 1, p.40.
17 Eisen, V., (6 June 2023), 'Here's the truth about what happened inside S.F.'s controversial Tenderloin Centre', [online article, accessed September 2024], San Francisco Chronicle, San Francisco. Available from www.sfchronicle.com/opinion/openforum/article/tenderloin-center-drugs-sf-18136496.php.
18 Ibid.
19 Drug Policy Alliance, (17 June 2024), 'Vermont legislature enacts lifesaving overdose prevention center legislation, overriding Governor Scott's veto' [online statement, accessed August 2024], DPA, Oakland, California. Available from https://drugpolicy.org/news/vermont-legislature-enacts-lifesaving-overdose-prevention-center-legislation-embracing-evidence-and-overriding-scotts-veto.
20 Ibid.
21 Gibson, B., et al., (2023), *ONPOINT NYC: Making history. Saving lives*, OnPoint NYC, New York.
22 Drug Policy Alliance, (17 June 2024), 'Vermont legislature enacts lifesaving overdose prevention center legislation, overriding Governor Scott's veto' [online statement, accessed August 2024], DPA, Oakland, California. Available from https://drugpolicy.org/news/vermont-legislature-enacts-lifesaving-overdose-prevention-center-legislation-embracing-evidence-and-overriding-scotts-veto.
23 Personal communication with Russoniello, K., September 2024.
24 Du, S., (3 April 2024), 'Drug use resource hub opens in north Minneapolis after state legalizes safe injection sites' [online article, accessed August 2024], The Minnesota Star Tribune, Minnesota. Available from www.startribune.com/minnesota-overdose-awareness-opens-drug-use-resource-hub-safe-recovery-site-in-north-minneapolis/600356054.
25 Chalfin, A., B. Del Pozo and D. Mitre-Becerril, (2023), 'Overdose prevention centers, crime, and disorder in New York City', *JAMA Network Open,* vol. 6, no. 11:e2342228.
26 Gibson, B., et al., (2023), *ONPOINT NYC: Making history. Saving lives*, OnPoint NYC, New York.
27 King, C., (2024), 'Global state of harm reduction 2024 survey response'.
28 Rosen, J.G., et al., (2024),"Make yourself un-NIMBY-able": stakeholder perspectives on strategies to mobilize public and political support for overdose prevention centers in the United States of America', *Harm Reduction Journal*, vol. 21, no. 1, p.40.
29 Eisen, V., (6 June 2023), 'Here's the truth about what happened inside S.F.'s controversial Tenderloin Centre', [online article, accessed September 2024], San Francisco Chronicle, San Francisco. Available from https://www.sfchronicle.com/opinion/openforum/article/tenderloin-center-drugs-sf-18136496.php.
30 Beletsky, L., et al., (2008), 'The law (and politics) of safe injection facilities in the United States', *American Journal of Public Health*, vol. 98, no. 2, p.231-7.
31 Kennedy, M.C., M. Karamouzian and T. Kerr, (2017), 'Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review', *Current HIV/AIDS Reports*, vol. 14, no. 5, p.161-183.
32 Shukait, A., (2024), 'Global State of Harm Reduction 2024 survey response.'
33 Potier, C., et al., (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', *Drug & Alcohol Dependence*, vol. 145, p.48-68.
34 Kennedy, M.C., M. Karamouzian and T. Kerr, (2017), 'Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review', *Current HIV/AIDS Reports*, vol. 14, no. 5, p.161-183.
35 Shukait, A., (2024), 'Global State of Harm Reduction 2024 survey response.'
36 Potier, C., et al., (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', *Drug & Alcohol Dependence*, vol. 145, p.48-68.
37 Levengood, T.W., et al., (2021), 'Supervised injection facilities as harm reduction: A systematic review', *American Journal of Preventative Medicine*, vol. 61, no. 5, p.738-749.
38 Rammohan, I., (2024), 'Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis', *Lancet Public Health*, vol. 9, no. 2, e79-e87.
39 Marshall, B.D., et al., (2011), 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', *The Lancet*, vol. 377, no. 9775, p.1429-37.
40 Kennedy, M.C., et al., (2019), 'Supervised injection facility use and all-cause mortality among people who inject drugs in Vancouver, Canada: A cohort study', *PLoS Medicine*, vol. 16, no. 11, p.1-20.
41 Wood, E., et al., (2007), 'Rate of detoxification service use and its impact among a cohort of supervised injecting facility users', *Addiction*, vol. 102, no. 6, p.916-9.
42 Wood, E., et al., (2006), 'Attendance at supervised injecting facilities and use of detoxification services', *New England Journal of Medicine*, vol. 354, no. 23, p.2512-4.
43 Debeck, K., et al., (2011), 'Injection drug use cessation and use of North America's first medically supervised safer injecting facility', *Drug and Alcohol Dependence*, vol. 113, no. 2-3, p.172-6.
44 Wood, E., et al., (2004), 'Methodology for evaluating Insite: Canada's first medically supervised safer injection facility for injection drug users', *Harm Reduction Journal*, vol. 1, no. 9.
45 Christie, T., et al. (2004), 'A comparison of the new Federal Guidelines regulating supervised injection site research in Canada and the Tri-Council Policy Statement on Ethical Conduct for Research Involving Human Subjects', *International Journal of Drug Policy*, vol. 15, no, 1, p.66-73.
46 Kennedy, M.C., M. Karamouzian and T. Kerr, (2017), 'Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review', *Current HIV/AIDS Reports*, vol. 14, no. 5, p.161-183.
47 Shukait, A., (2024), 'Global State of Harm Reduction 2024 survey response'.
48 Potier, C., et al., (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', *Drug & Alcohol Dependence*, vol. 145, p.48-68.
49 Kennedy, M.C., M. Karamouzian and T. Kerr, (2017), 'Public health and public order outcomes associated with supervised drug consumption facilities: a systematic review', *Current HIV/AIDS Reports*, vol. 14, no. 5, p.161-183.3
50 Shukait, A., (2024), 'Global State of Harm Reduction 2024 survey response'.
51 Potier, C., et al., (2014), 'Supervised injection services: what has been demonstrated? A systematic literature review', *Drug & Alcohol Dependence*, vol. 145, p.48-68.
52 Kerr. T., (2017), 'Supervised injection facilities in Canada: past, present, and future', *Harm Reduction Journal*, vol. 14, no. 1. p.28.
53 Rosen, J.G., et al., (2024),"Make yourself un-NIMBY-able": stakeholder perspectives on strategies to mobilize public and political support for overdose prevention centers in the United States of America', *Harm Reduction Journal*, vol. 21, no. 1, p.40.
54 Caulkins, J.P., B. Pardo and B. Kilmer, (2019), 'Supervised consumption sites: a nuanced assessment of the causal evidence', *Addiction*, vol.

114, no. 12, p.2109-2115.
55 Spencer, M.R., M.F. Garnett and A.M. Miniño, (2024), *Drug Overdose Deaths in the United States, 2002–2022, NCHS Data Brief, no 491*, CDC, National Center for Health Statistics, Hyattsville, Maryland.
56 Ibid.
57 Public Health Agency of Canada, 'Federal, Provincial, and Territorial Special Advisory Committee on the Epidemic of Opioid Overdoses Opioid- and Stimulant-related Harms in Canada' [web page, accessed August 2024], Public Health Agency of Canada, Ontario.
58 Ibid.
59 Spencer, M.R., M.F. Garnett and A.M. Miniño, (2024), *Drug Overdose Deaths in the United States, 2002–2022, NCHS Data Brief, no 491*, CDC, National Center for Health Statistics, Hyattsville, Maryland.
60 Public Health Agency of Canada, 'Federal, Provincial, and Territorial Special Advisory Committee on the Epidemic of Opioid Overdoses Opioid- and Stimulant-related Harms in Canada' [web page, accessed August 2024], Public Health Agency of Canada, Ontario.
61 Spencer, M.R., M.F. Garnett and A.M. Miniño, (2024), *Drug Overdose Deaths in the United States, 2002–2022, NCHS Data Brief, no 491*, CDC, National Center for Health Statistics, Hyattsville, Maryland. Ibid.
62 Public Health Agency of Canada, 'Federal, Provincial, and Territorial Special Advisory Committee on the Epidemic of Opioid Overdoses Opioid- and Stimulant-related Harms in Canada' [web page, accessed August 2024], Public Health Agency of Canada, Ontario.
63 Jain, L., et al., (2024), 'Fentanyl and xylazine crisis: Crafting coherent strategies for opioid overdose prevention', *World Journal of Psychiatry*, vol. 14, no. 6, p.760-766.
64 Bowles, J.M., et al., (2021) 'Xylazine detected in unregulated opioids and drug administration equipment in Toronto, Canada: clinical and social implications', *Harm Reduction Journal*, vol. 18, no. 1, p.104.
65 Mars, S., et al., (2024), 'The influence of transformations in supply on methamphetamine initiation among people injecting opioids in the United States,' *Harm Reduction Journal*, vol. 21, no. 1, p.57.
66 Public Health Agency of Canada, 'Federal, Provincial, and Territorial Special Advisory Committee on the Epidemic of Opioid Overdoses Opioid- and Stimulant-related Harms in Canada' [web page, accessed August 2024], Public Health Agency of Canada, Ontario.
67 Public Health Agency of Canada, (2022), *Substance-related acute toxicity deaths in Canada from 2016 to 2017: A review of coroner and medical examiner files,* Public Health Agency of Canada, Ontario.
68 Bowles, J.M., et al., (2021) 'Xylazine detected in unregulated opioids and drug administration equipment in Toronto, Canada: clinical and social implications', *Harm Reduction Journal*, vol. 18, no. 1, p.104.
69 Public Health Agency of Canada, (2022), *Substance-related acute toxicity deaths in Canada from 2016 to 2017: A review of coroner and medical examiner files,* Public Health Agency of Canada, Ontario.
70 Lo Faro, A.F., et al., (2023), 'New Psychoactive Substances Intoxications and Fatalities during the COVID-19 Epidemic', *Biology*, vol. 12, no. 2.
71 Fink, D.S, et al., (2024), 'Social and economic determinants of drug overdose deaths: a systematic review of spatial relationships', *Social Psychiatry Psychiatric Epidemiology*, vol. 59, no. 7, p.1087-1112.
72 Srinivasan, S., et al., (2024), 'Risk factors for persistent fatal opioid-involved overdose clusters in Massachusetts 2011-2021: a spatial statistical analysis with socio-economic, accessibility, and prescription factors', *BMC Public Health*, vol. 24, no.1, p.1893.
73 Lindenfeld, Z., et al., (2024), 'Examining the relationship between social determinants of health, measures of structural racism and county-level overdose deaths from 2017-2020', *PLoS One*, vol. 19, no. 5, e0304256.
74 van Steelandt, A., et al., (2024), 'Housing status and accidental substance-related acute toxicity deaths in Canada, 2016-2017', *Health Promotion Chronic Disease Prevention Canada*, vol. 44, no.7-8, p.319-330.
75 Venugopal J., et al., (2024), 'Chronic pain and accidental acute toxicity deaths in Canada, 2016-2017', *Health Promotion and Chronic Disease Prevention Canada*, vol. 44, no. 7-8, p.306-318.
76 Ray, B., et al., (2023), 'Spatiotemporal analysis exploring the effect of law enforcement drug market disruptions on overdose, Indianapolis, Indiana, 2020-2021', *American Journal of Public Health*, vol. 113, no. 7, p.750-758.
77 U.S. Department of Health and Human Services, *Overdose prevention strategy*, DHHS, Washington DC.
78 Brokos, Z., (2024), 'Global State of Harm Reduction 2024 survey response'.
79 Pounder, M., (2024), 'Global State of Harm Reduction 2024 survey response'.
80 Krawczyk, N., et al., (2023), 'Recent modifications to the US methadone treatment system are a Band-Aid-not a solution-to the nation's broken opioid use disorder treatment system', *Health Affairs Scholar*, vol. 1, no. 1.
81 Bohler, R.M., et al., 'The policy landscape for naloxone distribution in four states highly impacted by fatal opioid overdoses', *Drug & Alcohol Dependence Reports*, vol. 6.
82 Irvine, M.A., et al., (2022), 'Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study', *The Lancet Public Health*, vol. 7, no.3, e210-e218.
83 Stringfellow, L.N., (2024), 'Global State of Harm Reduction 2024 survey response'; Cooper, R.L., (2024), 'Global State of Harm Reduction 2024 survey response'.
84 Chalfin, A., B. Del Pozo and D. Mitre-Becerril, (2023), 'Overdose Prevention Centers, Crime, and Disorder in New York City', *JAMA Network Open*, vol. 6, no. 11, e2342228.
85 Rosen, J.G., (2024), '"Make yourself un-NIMBY-able": stakeholder perspectives on strategies to mobilize public and political support for overdose prevention centers in the United States of America', *Harm Reduction Journal*, vol. 21, no. 1, p.40.
86 Drug Policy Alliance, (17 June 2024), 'Vermont legislature enacts lifesaving overdose prevention center legislation, overriding Governor Scott's veto' [online statement, accessed August 2024], DPA, Oakland, California. Available from https://drugpolicy.org/news/vermont-legislature-enacts-lifesaving-overdose-prevention-center-legislation-embracing-evidence-and-overriding-scotts-veto.
87 Du, S., (3 April 2024), 'Drug use resource hub opens in north Minneapolis after state legalizes safe injection sites' [online article, accessed August 2024], The Minnesota Star Tribune, Minnesota. Available from www.startribune.com/minnesota-overdose-awareness-opens-drug-use-resource-hub-safe-recovery-site-in-north-minneapolis/600356054.
88 Wagner, K.D., et al., (2023), 'Prevalence of fentanyl in methamphetamine and cocaine samples collected by community-based drug checking services', *Drug and Alcohol Dependency,* vol. 252, e110985.
89 Government of Canada, 'Canadian Drugs and Substances Strategy: Overview' [web page, accessed August], Government of Canada, Ontario. Available from www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy.html.
90 Kerr, T., (2019), 'Public health responses to the opioid crisis in North America', *Journal of Epidemiology and Community Health*, vol. 73, no. 5, p.377-378.
91 Slaunwhite, A., , et al., (2024), 'Effect of Risk Mitigation Guidance opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study', *British Medical Journal*, vol. 384, e076336.
92 Klaire, S. et al., (2022), 'A low-barrier, flexible safe supply program to prevent deaths from overdose', *Canadian Medical Association Journal*, vol. 194, no. 19, e674-676.
93 Health Canada, 'Safer supply' [web page, accessed August 2024], Government of Canada, Ontario. Available from www.canada.ca/en/health-canada/services/opioids/responding-canada-opioid-crisis/safer-supply.html.
94 Michaud, L. et al., (2024), 'Mapping a moral panic: News media narratives and medical expertise in public debates on safer supply, diversion, and youth drug use in Canada', *International Journal of Drug Policy*, vol. 127, e104423.
95 Slaunwhite, A., et al., (2024), 'Effect of Risk Mitigation Guidance opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study', *British Medical Journal*, vol. 384, e076336.
96 Gomes, T., et al., (2022), 'Clinical outcomes and health care costs among people entering a safer opioid supply program in Ontario', *Canadian Medial Association Journal*, vol. 194, no. 36. e1233-1242.
97 Ivsins, A., et al., (2022), 'Overdose Prevention and Housing: a Qualitative Study Examining Drug Use, Overdose Risk, and Access to Safer Supply in Permanent Supportive Housing in Vancouver, Canada', *Journal of Urban Health*, vol. 99, no, p.855-864.
98 Michaud, L., et al., (2024), 'Mapping a moral panic: News media narratives and medical expertise in public debates on safer supply, diversion, and youth drug use in Canada', *International Journal of Drug Policy*, vol. 127, e104423.
99 Kerr, T., et al., (2017), 'Supervised injection facilities in Canada: past, present, and future', *Harm Reduction Journal*, vol. 14, no. 1, p.28.
100 Dass, A., (2024), 'Global State of Harm Reduction 2024 survey response'.
101 Larbentz, M., (23 August 2024), 'Closing supervised consumption sites in Ontario is a fatal mistake' [online article, accessed August 2024], The Globe and Mail, Toronto. Available from www.theglobeandmail.com/opinion/article-closing-supervised-consumption-sites-in-ontario-is-a-fatal-mistake.
102 Fanmin, Z., et al., (12 March 2024), 'Oregon's drug decriminalization law rolled back as homelessness, overdoses on the rise' [online article, accessed August 2024], ABC News, New York. Available from https://abcnews.go.com/US/oregons-drug-decriminalization-law-rolled-back-homeless-overdoses/story?id=107841625.
103 Vakharia, S., (2024), 'Global State of Harm Reduction 2024 survey response'.
104 Larbentz, M., (23 August 2024), 'Closing supervised consumption sites in Ontario is a fatal mistake' [online article, accessed August 2024], The Globe and Mail, Toronto. Available from www.theglobeandmail.com/opinion/article-closing-supervised-consumption-sites-in-ontario-is-a-fatal-mistake.
105 Morris, T., (2024), 'Global State of Harm Reduction 2024 survey response'; Ka Hon Chu, S., (2024), 'Global State of Harm Reduction 2024 survey response'.

REGIONAL OVERVIEW: OCEANIA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

AUTHOR OF OCEANIA REGIONAL OVERVIEW: **John Gobeil**

John Gobeil is the CEO of the Australian Injecting and Illicit Drug Users League (AVIL), the national peak organisation focused on advancing the health and human rights of people with living or lived experience of drug use. They have worked in several frontline and leadership roles for renowned community-led organisations through the years, as well as many local drop-in centres, successfully improving programming and service delivery for the community, building organisational capacity and increasing sustainability. John draws from personal lived and living experience of discrimination, marginalisation and stigma as a neurodivergent LGBTQI+, people who use drugs peer and CALD (culturally and linguistically diverse person) migrant.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN OCEANIA

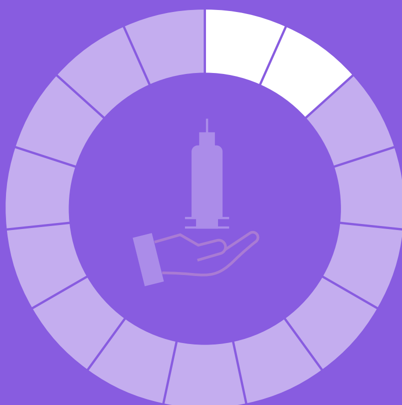
Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Aotearoa New Zealand	nd[f]	0.1	53	2.8	✓ 227	✓ M B N	✓	✕	✕
Australia	98,500[g]	2.1	32	2.2	✓ 4442	✓ M B N	✓	✓ 2	✕
Federated States of Micronesia	nd	nd	nd	nd	nd	nd	nd	nd	nd
Fiji	nd	nd	nd	nd	nd	nd	nd	nd	nd
Kiribati	nd	nd	nd	nd	nd	nd	nd	nd	nd
Marshall Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd
Nauru	nd	nd	nd	nd	nd	nd	nd	nd	nd
Palau	nd	nd	nd	nd	nd	nd	nd	nd	nd
Papua New Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd
Samoa	nd	nd	nd	nd	nd	nd	nd	nd	nd
Solomon Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd
Timor Leste	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tonga	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tuvalu	nd	nd	nd	nd	nd	nd	nd	nd	nd
Vanuatu	nd	nd	nd	nd	nd	nd	nd	nd	nd

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (DCR) (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g Civil society actors believe this to be an underestimate.

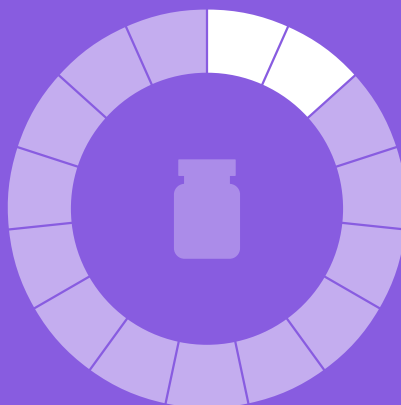
AVAILABILITY OF HARM REDUCTION SERVICES

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone
- DCR available

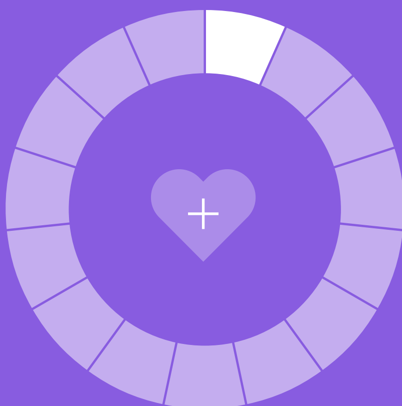
NSP, OAT, DCRs AND SAFER SMOKING KITS



2 countries (13.33%) in Oceania provide **needle and syringe programmes** (no change from 2022)



2 countries (13.33%) in Oceania provide **opioid agonist therapy** (no change from 2022)



1 country in Oceania provides **drug consumptions rooms** (no change from 2022)

There is no country in Oceania that provides **safer smoking kits**

KEY ISSUE

DIVERSE LANDSCAPE, CONSISTENT CRIMINALISATION

The Oceania region comprises a combination of high-and low-income countries such as Australia, Aotearoa New Zealand, Fiji, Papua New Guinea and Tonga.

Although many countries in the region are small, each country has unique cultural, linguistic, political and social landscapes, alongside differing histories, locations and economic development,[1,2] which impact the availability and use of drugs in each context. However, all countries in Oceania criminalise and stigmatise people who use drugs.

Countries in the region show variable commitments to harm reduction. Australia and Aotearoa New Zealand are recognised for pioneering the implementation of harm reduction and HIV prevention services for people who use drugs. There is a relatively good understanding of the ways drugs are used in both countries, and national needle and syringe programmes (NSP) have been implemented in Australia and Aotearoa New Zealand since 1986 and 1988, respectively.[3,4]

Far less is known about drug use in many other Oceania countries. In the last decade, the increase in drug trafficking routes between Asia and the Americas to Australia and Aotearoa New Zealand has resulted in an increase in drug seizures, including cocaine, ketamine and methamphetamine, and the availability and use of these drugs in countries such as Papua New Guinea and Fiji.[5,6] However, information and data relating to patterns of drug use and the availability of harm reduction in these countries is limited, and there is little demonstrated commitment to implementing health, human rights and harm reduction policies and services for people who use drugs.[7]

While Australia and Aotearoa New Zealand are recognised as harm reduction leaders, no country in the region has legalised or decriminalised drug use entirely. The only place in Oceania where some decriminalisation has happened is the Australian Capital Territory, which decriminalised small amounts of drugs for personal use in October 2023.[a,8]

Due in part to consistent criminalisation, social and systemic stigma and discrimination against people who use drugs is rampant.[9] People who use drugs continue to be harmed by laws and regulations, and even the agencies that are designed to protect them.[10,11] This inequitable treatment has prevented policymakers and governments across the region from prioritising and developing lifesaving harm reduction interventions, especially those that are peer-led.[12,13]

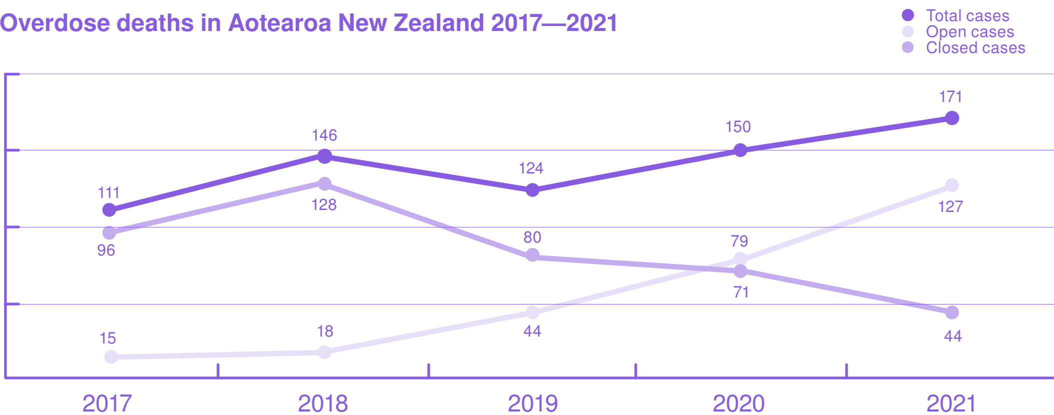
Even in Australia and Aotearoa New Zealand, investment and support for harm reduction is declining.

a Amounts that are decriminalised for use are limited to 1.5g of methamphetamine, 1.5g of MDMA, 1.5g of cocaine, 1g of heroin, 1.5g of psilocybin (dry or wet), 0.001g of LSD, 50g of dried cannabis and 150g of wet cannabis.

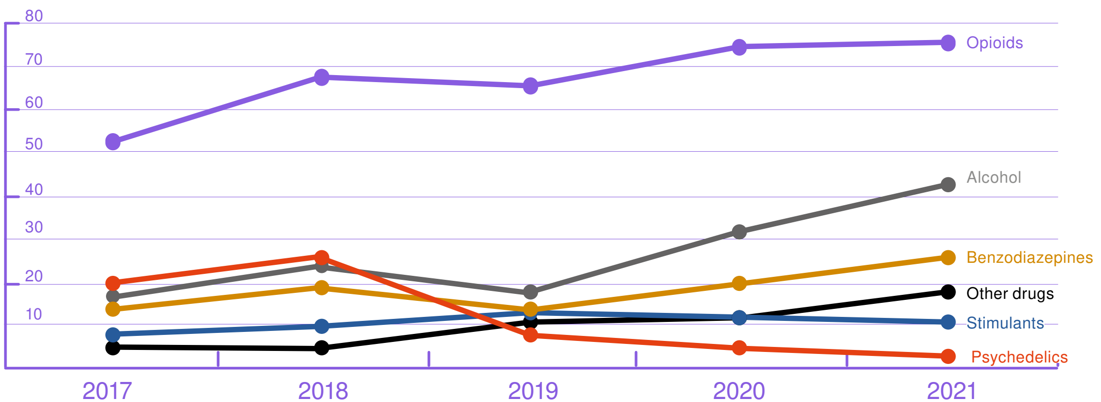
In Australia, funding for harm reduction has decreased over time compared to funding to address drug supply and demand reduction.[14]

In Aotearoa New Zealand, the national NSP, which was set up in 1988, was defunded in 2023.[15] In both countries, drug-related overdoses increase each year, and more people than ever are dying every day from overdoses.[16] In Aotearoa New Zealand, the most recent coronial data identified 702 overdose deaths between 2017 and 2021. Across this five-year period, cases rose by 54%. In comparison, the population of people who use drugs increased by just 6%.[17,18] Recent data from Australia also shows an alarming increase in the number of drug-related deaths, with 2,356 deaths reported in 2022; 79 more than in 2021.[19,20] The impacts of criminalisation, aggressive law enforcement and related stigmatisation prevents people who use drugs from accessing essential services and seeking help, resulting in preventable illnesses and deaths, while drug laws, regulations and the lack of resources hinder the delivery of crucial peer-based harm reduction services and support.[21,22]

Overdose deaths in Aotearoa New Zealand 2017—2021



Overdose deaths in Aotearoa New Zealand by substance 2017—2021



> “Due in part to consistent criminalisation, social and systemic stigma and discrimination against people who use drugs is rampant. People who use drugs continue to be harmed by laws and regulations, and even the agencies that are designed to protect them. This inequitable treatment has prevented policymakers and governments across the region from prioritising and developing lifesaving harm reduction interventions, especially peer-led harm reduction.”

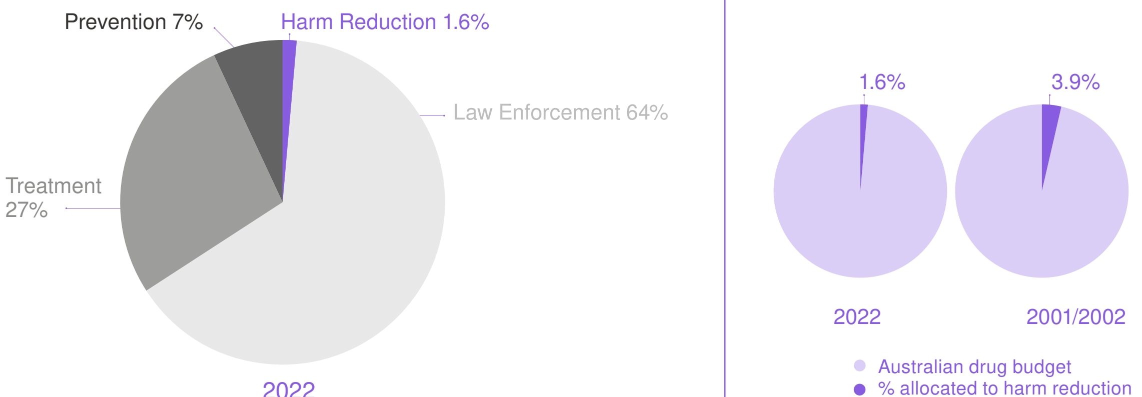
KEY ISSUE

INSUFFICIENT INVESTMENT IN AND SUPPORT FOR HARM REDUCTION

Aotearoa New Zealand and Australia have multiple harm reduction programmes,[23,24,25] including festival-based harm reduction, take-home naloxone and peer distribution, NSPs, OAT, drug checking, medically supervised injecting centres (two in Australia only) and peer-led drug user organisations.[26,27] In Australia, between 2022 and 2024, dispensing fees for opioid agonist therapy (OAT) have finally been funded by the Commonwealth Government to uphold equitable access to OAT and human rights.[28,29] The Queensland government in Australia implemented its first permanent drug checking fixed site and successfully trialled its first multi-day festival drug checking service.[30,31] The New South Wales government implemented its first drug checking service at the Sydney Medically Supervised Injecting Centre.[32] The Victorian government made the Melbourne Medically Supervised Injecting Room permanent,[33] and also announced it would run a drug checking trial with mobile and fixed sites.[34] These changes mean Australia is slowly aligning with Aotearoa New Zealand which legalised drug checking in 2020 and made it permanent under a 2021 law.

But while the governments of Australia and Aotearoa New Zealand fund a range of harm reduction services, including peer-based harm reduction responses, investment remains insufficient. This is despite over 30 years of proven efficacy, impact and cost-effectiveness of these services.[35] A recent report revealed that only 1.6% of the total Australian 'drug budget' for 2021/22 was spent on harm reduction while 64.3% was spent on law enforcement for drug control, 27.4% on treatment and 6.7% on drug use.[36]

Australia's drug budget



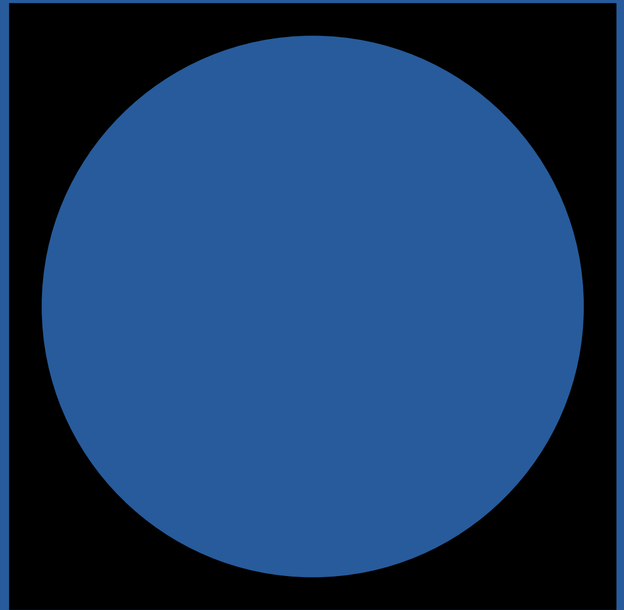
Beyond Australia and Aotearoa New Zealand, other countries in Oceania have either very limited or no harm reduction programmes, and peer-based harm reduction services are unavailable.

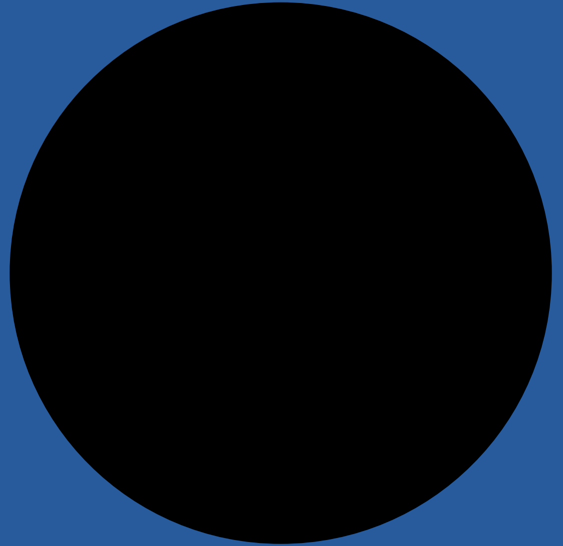
For some low-income countries in the region, expanding drug trafficking routes[37,38] has increased the use of stimulants, including injection use, which has heightened the risk of HIV[39] and hepatitis C[40] infection among people who use drugs. The lack of comprehensive harm reduction programmes means that some countries are vulnerable to HIV and hepatitis C epidemics. Most communities in the region are affected by low resourcing, lack of health infrastructure and limited community experience of blood-borne virus and harm reduction programmes, peer support and education.

There remains a need to develop and expand harm reduction programmes in the region to provide adequate coverage to support the diverse community of people who use drugs and effectively ensure community-led monitoring of services.[41,42,43] There is an urgent need for dedicated funding to ensure that harm reduction programmes are available and accessible in all countries and territories in Oceania.

1 Murray, W., 'Oceania', (2009) in *International Encyclopaedia of Human Geography,* edited by R. Kitchin and N. Thrift, Elsevier, Oxford, p.1–13.
2 Clare, A., 'Pacific Islands – key issues' [web page, accessed September 2024] Parliament of Australia, Canberra. Available from www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/BriefingBook47p/PacificKeyIssues.
3 Holly, C., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
4 George, J., (2024), 'Global State of Harm Reduction 2024 survey response, Aotearoa New Zealand'.
5 Global Initiative Against Transnational Organized Crime, 'Transnational Organized Crime and the Pacific Islands' [web page, accessed September 2024] GI-TOC, Geneva. Available from https://globalinitiative.net/analysis/transnational-organized-crime-and-the-pacific-islands.
6 Sousa-Santos, J., (16 February 2022), 'Drug trafficking in the Pacific Islands: The impact of transnational crime' [online article, accessed September 2024] Lowy Institute, Sydney. Available from www.lowyinstitute.org/publications/drug-trafficking-pacific-islands-impact-transnational-crime.
7 Devaney, M., et al., (2006), 'Illicit drug use and responses in six Pacific Island countries', *Drug and Alcohol Review*, vol. 25, p.387–90.
8 ACT Government, 'Drug law reform: Quantities and types of illicit drugs included in the changes' [web page, accessed September 2024] Government of Australia, Canberra. Available from www.act.gov.au/health/topics/drugs-alcohol-smoking-and-vaping/drug-law-reform.
9 Gough, C., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
10 Ebdon, E., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
11 UN High Commissioner for Human Rights, (no date), *Human Rights Challenges in Addressing and Countering all Aspects of the World Drug Problem*, UNOHCR, Geneva.
12 Barrat, M., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
13 UN High Commissioner for Human Rights, (23 June 2023), 'UN experts call for end to global "war on drugs"' [media release, accessed September 2024, OHCHR], Geneva. Available from www.ohchr.org/en/press-releases/2023/06/un-experts-call-end-global-war-drugs.
14 Davey, G., 'Global State of Harm Reduction 2024 survey response, Australia'.
15 Ritter, A., et al., (2024), 'Monograph No 36: The Australian "drug budget": Government drug policy expenditure 2021/22' [online resource, accessed September 2024] UNSW, Sydney. Available from https://unsworks.unsw.edu.au/entities/publication/a69c1e51-4ac7-4d97-9247-86619b2d4986.
16 Noller, G., (2024), 'Global State of Harm Reduction 2024 survey response, Aotearoa New Zealand'.
17 Crawford, S., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
18 New Zealand Drug Foundation, (5 November 2022), 'Report: Fatal overdoses in Aotearoa 2017-2021' [online article, accessed September 2024] NZDF, Wellington. Available from https://drugfoundation.org.nz/articles/overdose-report-2017-2022.
19 Helms, S., (2024), 'Global State of Harm Reduction 2024 survey response, Aotearoa New Zealand'.
20 Alcohol and Drug Foundation Australia, (8 May 2024), 'Overdoses keep rising; Action urgently needed' [online article, accessed September 2024] AFDF, Melbourne. Available from https://adf.org.au/about/media/08052024-overdose-action-urgently-needed.
21 Hiley, S., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
22 Australia Injecting and Illicit Drug Users League, (2022), *AIVL's Position Statement: The Harms of Criminalising Drugs*, AIVL, Canberra.
23 Harm Reduction International, 'Tracking Funding for Harm Reduction' webpage accessed September 2024, HRI, London. Available from https://hri.global/topics/funding-for-harm-reduction/tracking-funding-for-harm-reduction.
24 Harris, M., (December 2021), 'Creativity, care and "messy" drug use: A collective history of the early days of peer-led needle exchange in Dunedin, New Zealand', *International Journal of Drug Policy,* vol. 98, e103386.
25 Allison, W., (2024), 'Global State of Harm Reduction 2024 survey response, Aotearoa New Zealand'.
26 Murray, J., (2024), 'Global State of Harm Reduction 2024 survey response Australia'.
27 Australia Injecting and Illicit Drug Users League, 'Member organisations' [webpage, accessed September 2024], AIVL, Canberra. Available from https://aivl.org.au/about-aivl/member-organisations/.
28 Ministers Department of Health and Aged Care, (3 July 2023), 'Pharmacies get major financial boost from 1 July' online media release, accessed September 2024, Australian Department of Health and Aged Care, Canberra. Available from www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pharmacies-get-major-financial-boost-from-1-july.
29 Ritter, A., et al., (2024), 'Monograph No 36: The Australian "drug budget": Government drug policy expenditure 2021/22' [online resource, accessed September 2024] UNSW, Sydney. Available from https://unsworks.unsw.edu.au/entities/publication/a69c1e51-4ac7-4d97-9247-86619b2d4986.
30 Queensland Government, (20 April 2024), 'Queensland's first permanent pill testing location opens' [online media statement, accessed September 2024] Queensland Government, Queensland. Available from https://statements.qld.gov.au/statements/100161.
31 Queensland Government, (3 April 2024), 'Pill testing results show service's importance to health and safety' [online media statement, accessed September 2024] Queensland Government, Queensland. Available from https://statements.qld.gov.au/statements/100044.
32 New South Wales Government, (2023), *Pill Testing Trial Bill 2023*, NSW Government, Sydney.
33 Department of Health, Victoria, 'Medically supervised injecting room' [webpage, accessed September 2024] DoH Vic, Melbourne. Available from www.health.vic.gov.au/aod-treatment-services/medically-supervised-injecting-room.
34 Premier of Victoria, (24 June 2024), 'Pill Testing Trial To Keep People Safe – And Save Lives' [online article, accessed September 2024] Government of Victoria, Melbourne. Available from www.premier.vic.gov.au/pill-testing-trial-keep-people-safe-and-save-lives.
35 Harm Reduction International, (2020), *Making the investment case: Cost-effectiveness evidence for harm reduction*, HRI, London. Available from https://hri.global/publications/making-the-investment-case-cost-effectiveness-evidence-for-harm-reduction/
36 Ritter, A., et al., (2024), 'Monograph No 36: The Australian "drug budget": Government drug policy expenditure 2021/22' [online resource, accessed September 2024] UNSW, Sydney. Available from https://unsworks.unsw.edu.au/entities/publication/a69c1e51-4ac7-4d97-9247-86619b2d4986.
37 Power, R., L. Schmich and V. Nosa, (2015), 'A response for substance and harm reduction in Pacific Island countries and territories', *Harm Reduction Journal*, vol. 12, no. 48.
38 Sousa-Santos, J., (16 February 2022), 'Drug trafficking in the Pacific Islands: The impact of transnational crime' [online article, accessed September 2024] Lowy Institute, Sydney. Available from www.lowyinstitute.org/publications/drug-trafficking-pacific-islands-impact-transnational-crime.
39 UNAIDS, (2023), *Asia and the Pacific: Regional factsheet*, UNAIDS, Geneva.
40 World Health Organization, (2024), *Hepatitis C factsheet*, WHO, Geneva.
41 Heard, S., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
42 Dietze, P., (2024), 'Global State of Harm Reduction 2024 survey response, Australia'.
43 Australian Institute of Health and Welfare, (10 July 2024), 'Illicit drug use' [online article, accessed September 2024] AIHW, Canberra. Available from www.aihw.gov.au/reports/illicit-use-of-drugs/illicit-drug-use.

REGIONAL OVERVIEW: WEST AND CENTRAL AFRICA





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHORS OF WEST AND CENTRAL AFRICA REGIONAL OVERVIEW: **Aniedi Akpan** and **Prince Bull Luseni**

Aniedi Akpan is a drug user community advocate with lived experience of drug use. He is the Chairperson of the Drug Harm Reduction Advocacy Network Nigeria (DHRAN), Team Lead of Drug Free and Preventive Healthcare organisation and a member of the Global Fund Communities Delegations representing the Key Populations constituency. He also serves as a member of the National Technical Working Group for Drug Demand Reduction and Harm Reduction at the Federal Ministry of Health where he is an active voice in advocating for harm reduction programmes for people who use drugs.

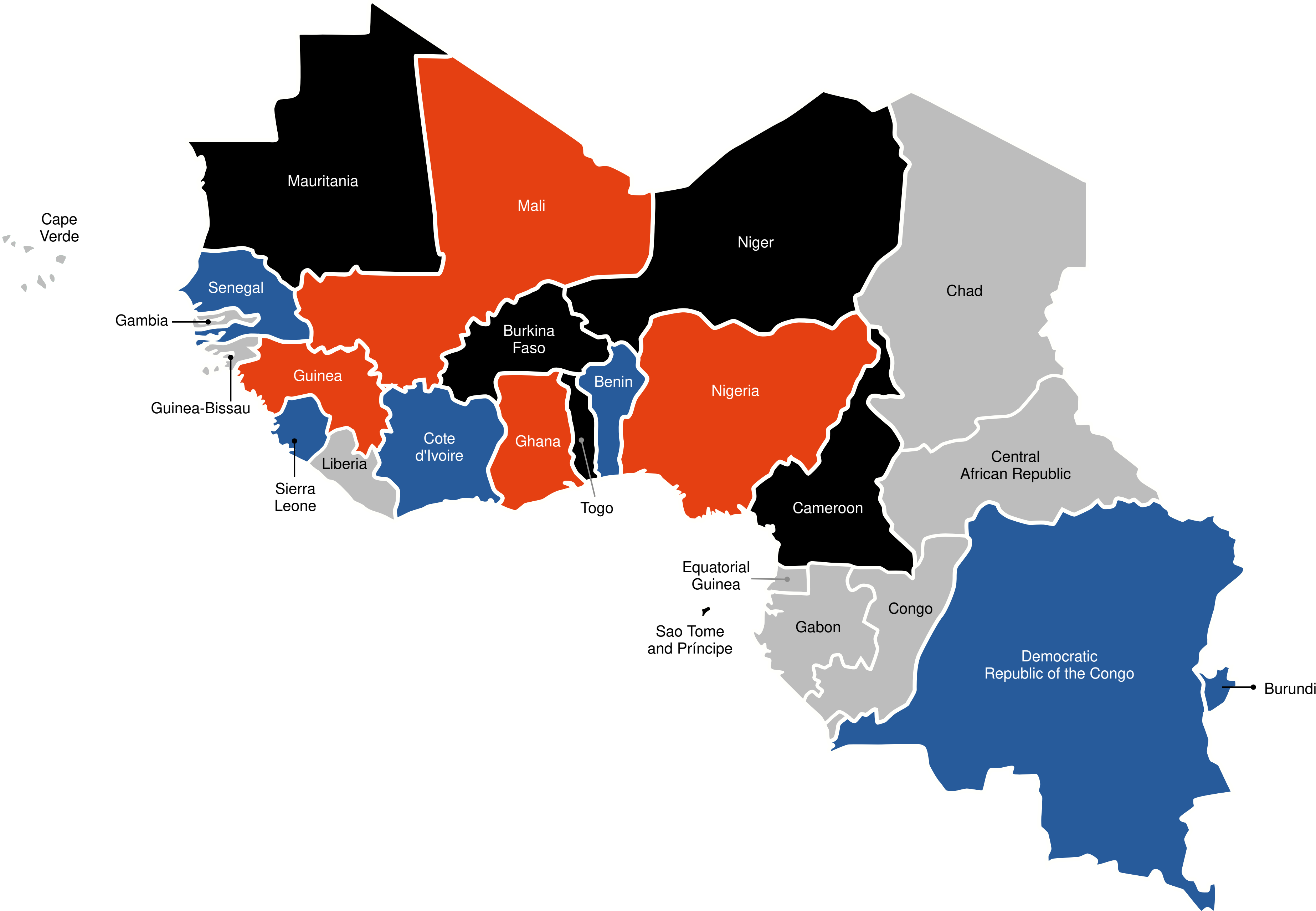
Prince Bull Luseni is the Executive Director of the West Africa Drug Policy Network (WADPN). Prince is also the President and Founder of the Institute for Drug Control and Human Security (IDCHS), a Sierra Leone based not-for-profit civil society organisation which promotes evidence-based advocacy for drug law reform.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN WEST AND CENTRAL AFRICA

Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Benin	800	2.1	nd[f]	nd	✓ 1	✓ M	×	×	×
Burkina Faso	90	nd	nd	nd	×	×	×	×	×
Burundi	nd	10.2	5.5	9.4	✓ 4	✓ M	×	×	×
Cameroon	3,500	nd	nd	nd	×	×	×	×	×
Cape Verde	nd	nd	nd	nd	nd	nd	nd	nd	nd
Central African Republic	nd	nd	nd	nd	nd	nd	nd	nd	nd
Chad	700	nd	nd	nd	nd	nd	nd	nd	nd
Congo	2,500	nd	nd	nd	nd	nd	nd	nd	nd
Côte d'Ivoire	2,600	3.4	1.8	10.5	✓ 3	✓	×	×	×
Democratic Republic of the Congo	168,000	3.9	nd	nd	✓	✓	nd	nd	nd
Equatorial Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gabon	nd	nd	nd	nd	nd	nd	nd	nd	nd
Gambia	nd	nd	nd	nd	nd	nd	nd	nd	nd
Ghana	20,000	2.7	2.3	nd	✓ 1	nd	nd	nd	nd
Guinea	600	nd	nd	nd	✓	nd	nd	nd	nd
Guinea-Bissau	3,500	nd	nd	nd	nd	nd	nd	nd	nd
Liberia	4,100	3.9	nd	nd	nd	nd	nd	nd	nd
Mali	5,600	nd	nd	nd	✓ 6	×	nd	nd	nd
Mauritania	nd	nd	nd	nd	×	nd	nd	nd	nd
Niger	nd	nd	nd	nd	×	nd	nd	nd	nd
Nigeria	177,500	10.9	5.8	6.7	✓ 7	×	nd	nd	nd
Sao Tome and Principe	nd	nd	nd	nd	×	nd	nd	nd	nd
Senegal	1,000	3.7	39.3	nd	✓	✓	nd	nd	nd
Sierra Leone	7,600	4.2	nd	nd	✓ 1	✓ S	nd	✓ 1	nd
Togo	2,700	3.4	nd	nd	×	×	nd	nd	nd

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone, S=Suboxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data

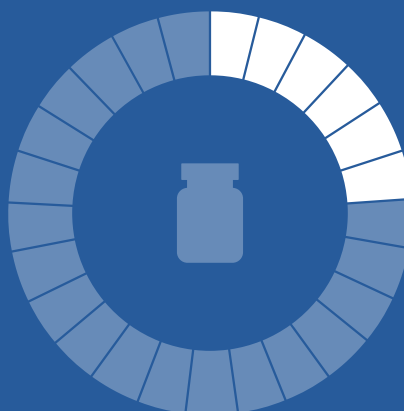
AVAILABILITY OF HARM REDUCTION SERVICES



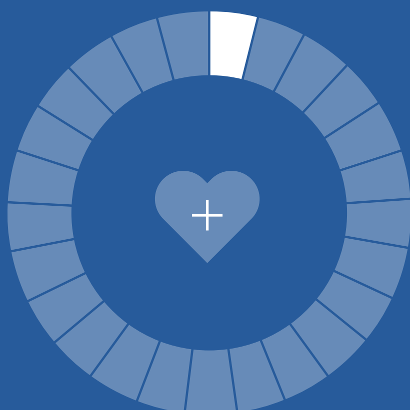
- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone

NSP, OAT, DCRs AND SAFER SMOKING KITS

10 countries (25%) in West and Central Africa provide **needle and syringe programmes** (+1 from 2022, Ghana)



6 countries (20%) in West and Central Africa provide **opioid agonist therapy** (+1 from 2022, Benin)



1 country in West and Central Africa provides **drug consumptions rooms** (+ Sierra Leone from 2022)

There is no country in West and Central Africa that provides **safer smoking kits**

KEY ISSUE

INADEQUATE COVERAGE OF HARM REDUCTION SERVICES

Out of the 25 countries[1] that make up West and Central Africa,[2] 10 offer needle and syringe programmes (NSP): Benin, Burkina Faso, Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Guinea, Mali, Nigeria, Senegal and Sierra Leone. Six countries provide opioid agonist therapy (OAT): Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Senegal, Benin and Sierra Leone. Sierra Leone also offers take-home naloxone, peer distribution of naloxone, and has one drug consumption room (DCR), and Côte d'Ivoire and Sierra Leone both provide safer smoking kits.

Since 2022, some countries in the region have reported an increase in the number of people who inject drugs, including Côte d'Ivoire (82% to 2,100 people),[3] Sierra Leone (74% to 5,600 people)[4] and Nigeria (60% to 268,500 people)[5].

Although Côte d'Ivoire offers two critical harm reduction services – NSP and OAT – a large proportion of people who inject drugs in the country do not have access to these services.[6] Among all the countries that offer NSPs, Nigeria has made great efforts to expand its interventions to other locations.[a][7] However, this implementation has not been without challenges, as is the case for other countries, including Sierra Leone,[8] Côte d'Ivoire and Senegal.[9]

Major and persistent challenges that hinder healthcare for people who use drugs include the criminalisation of people who use drugs and the stigmatisation of drug use, the preference for law enforcement for drug control over harm reduction, the lack of adequate training and support for peer workers, exclusionary attitudes and policies and the failure to ground interventions in the lived experiences of people who use drugs.[10]

Peer-delivered health services play a crucial role in bridging the gap between people and the health system, particularly for those from marginalised and under-represented communities.[11]

Globally, peer-delivered harm reduction services were introduced by some countries as far back as the 1980s in response to the AIDS crisis among people who inject drugs. With the right training, peer workers can engage in diverse harm reduction activities, including outreach, risk-reduction education, policy advocacy and community-based research. There is hardly any data in the region to show that peers have received specialised training and certification to provide such support and assistance.

a NSP has been scaled up from the initial 3 pilot states to 10 (Abia, Akwa Ibom, Cross River, Federal Capital Territory , Gombe, Kano, Lagos, Oyo, Plateau and Rivers). The number of people who inject drugs enrolled has increased from 2,731 to 70,738.

There is a lack of naloxone peer distribution in most countries in West and Central Africa

Peer networks in Sierra Leone and Senegal distributed injecting equipment during the COVID-19 pandemic, enabling vital NSPs to continue.[12] In Burkina Faso, a country without a harm reduction programme, civil society organisations have made significant strides in peer involvement for people who use drugs, primarily through peer-led dissemination of information about risks and law reform and the development of specific services relating to community needs.[13] But there remains a huge gap in engaging people who use drugs as peer workers in the region, particularly when it comes to harm reduction.[14]

Another major challenge is the lack of services that seek to address the specific needs of women who inject drugs,[15] including the provision of sexual and reproductive health services.[16] Women who inject drugs face more serious consequences from co-infection such as HIV, hepatitis C (HCV) and hepatitis B (HBV) and other sexually transmitted infections compared to their male counterparts. Services also do not respond to the intersectionalities that women who use drugs experience.[b 17] Due to the punitive legal framework in the region, women who use drugs are usually separated from their children and tend to avoid healthcare, including giving birth at facilities, to avoid punishment. While services such as psychosocial support and legal assistance may be available to other marginalised women, they rarely target or are adapted to the needs of women who use drugs.[18] Investment in holistic harm reduction programmes with specific gender-sensitive services and interventions to meet the needs of women who use and inject drugs are needed. Such programmes must consider creating safe spaces where women feel secure and respected, free from judgement or discrimination. Involving female peers in the programmes is an effective way to foster trust and encourage participation.

The region's lack of adequate harm reduction interventions poses challenges to the health and wellbeing of people who use drugs. Drug use trends in the region have shifted from domestically sourced cannabis to substances such as cocaine, heroin and methamphetamine,[19] and there is a 1.3% prevalence of pharmaceutical opioid use. Drug mixtures, such as kush, khadafi and monkey tail, are emerging as regional public health threats.[20] In countries like Guinea, Liberia and Sierra Leone,[21] kush is impacting the lives and health of young people.[22]

Due to the lack of adequate life-saving harm reduction interventions to prevent overdose deaths, countries are ill-prepared to tackle any increases in opioid use or a toxic drug supply that may emerge. For instance, while there is no official mortality data in Sierra Leone for overdose deaths relating to kush, one doctor told the BBC that "in recent months" hundreds of young men in the capital, Freetown have died from organ failure caused by kush.[23] In Nigeria, the National Drug Law Enforcement Agency announced in November 2022 that it had uncovered plans for fentanyl to be introduced into the country's illicit drugs market.[24] Given Nigeria's growing population and strained healthcare infrastructure, coupled with the lack of adequate overdose intervention programmes, there are concerns that the country could be particularly vulnerable if fentanyl becomes more common in the market.[25]

Despite the increasing number of people who inject drugs, and the high prevalence rates of HIV, HBV and HBC among this population, harm reduction interventions such as NSP, OAT and take-home naloxone remain inadequate, even in countries where these interventions are provided. This is largely due to punitive drug control laws, limited funding[26] and the false perception among policymakers and the public that harm reduction encourages drug use,[27] for which there is no evidence. More governments in the region must consider adopting legislation that is explicitly supportive of harm reduction and provide the resources to implement a full range of services.

b UNAIDS considers gay men and other men who have sex with men, sex workers, trans and gender diverse 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.

Encouragingly, Ghana and Liberia are already taking this direction. This is in large part due to the West Africa Drug Policy Network (WADPN) and its partners, which spearheaded advocacy efforts in the region for human rights and public health-focused drug policies, leading Ghana[28] and Liberia[29] to enact laws explicitly supporting harm reduction. These laws mandated the establishment of a trust fund, with a specific portion dedicated to the financing of harm reduction programmes.

“Investment in holistic harm reduction programmes with specific gender-sensitive services and interventions to meet the needs of women who use and inject drugs are needed. Such programmes must consider creating safe spaces where women feel secure and respected, free from judgement or discrimination. Involving female peers in the programmes can be an effective way to foster trust and encourage participation.”

KEY ISSUE

LONG-TERM SUSTAINABILITY OF SERVICES

Adequate, long-term funding is critical to the sustainability and scale up of harm reduction programmes in the region. Appropriate levels of funding, based on accurate and up-to-date data on population sizes, results in adequate programming to meet needs and public health goals. Funding for the rapid expansion of HIV prevention, testing and treatment in areas with high HIV prevalence has resulted in strong and steady reductions in HIV infections and AIDS-related deaths. We need to learn from this example and scale up harm reduction services.[30] However, there is a substantial funding gap in the region's HIV response. An additional major concern is the decline in domestic HIV funding, which was 7% lower in 2022 than 2018.[31]

Total HIV resources were 8% lower in 2022 than 2021, and the region's response remains heavily reliant on external donors. This has had a significant impact on harm reduction, as international donors primarily fund these services as part of HIV prevention activities.

The Global Fund to Fight AIDS, Tuberculosis and Malaria,[32,33] United States' Aid (USAID),[34] the Robert Carr Fund,[35] and the United States President's Emergency Plan for AIDS Relief (PEPFAR) are the main international organisations that fund harm reduction programmes in West and Central Africa. However, this funding is falling and is inadequate to meet need. While PEPFAR and USAID increased their contributions to 23% and 85%, respectively, between 2010 and 2020, contributions from other international donors reduced by 79%.[36] The total number of international donors investing in harm reduction remains small, and the total funds invested by international donors is shrinking.[37] Securing domestic funding is a more sustainable approach. Low- and middle-income countries' underinvestment in their HIV responses has contributed significantly to the failure to meet global targets for 2020.[38] This partly explains why the region has not scaled up existing NSPs, and why other lifesaving interventions such as OAT, take-home naloxone and DCRs remain non-existent or inadequate.[39] In addition to the COVID-19 pandemic and the accompanying economic downturn, the lack of government or other domestic resources has caused a difficult funding environment to become even more challenging.[40] Globally, governments spend 750 times more resources to enforce punitive and ineffective drug control laws than they spend on harm reduction programmes.[41]

This funding gap does not only hinder the scaling up of harm reduction programmes, it also restricts advocacy for harm reduction and human rights. It also places a financial burden on people who use drugs and their families, requiring them to pay out-of-pocket for access to harm reduction services.[42] This economic burden varies between countries. For instance, in Ghana, private residential rehabilitation centres charge as much as Ghc 3,000 (USD 200) per month, while a non-residential centre costs an average of Ghc 1,500 (USD 100) per month.

Over-reliance on external funding for public health programmes can result in poor programming. For example, the Federal Ministry of Health in Nigeria procured a large supply of methadone under the Drug Revolving Fund scheme. However, while the Ministry was seeking donor investment to support the implementation of an OAT programme, the treatments expired.[43] In another example, the Economic Community of West African States (ECOWAS) Commission agreed with the Sierra Leone government to establish the first drug treatment, rehabilitation and harm reduction centre in the country. The government designated its only psychiatric teaching hospital, which receives most drug referrals, as the location and renovated it in 2020 with support from Partners in Health and Handicap International so that it would be able to offer these services. However, these services are yet to commence due to ECOWAS funding delays.[44]

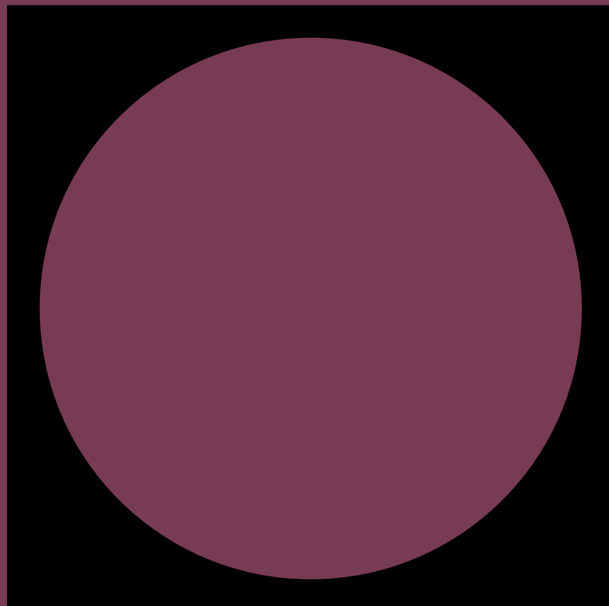
In Senegal, while drug use is still criminalised, the government supports the Centre de Prise en Charge Intégrée des Addictions de Dakar (the Integrated Addictions Management Centre of Dakar), a drop-in clinic that aims to curb the spread of HIV. The fact that the centre does not solely depend on external donors for funding[45] partially explains its sustainability since 2014 and the expansion of its services. The centre has gone from providing methadone as the first harm reduction centre in West and Central Africa to becoming a testing and diagnostic centre for HIV, tuberculosis and hepatitis and also implements condom distribution.[46]

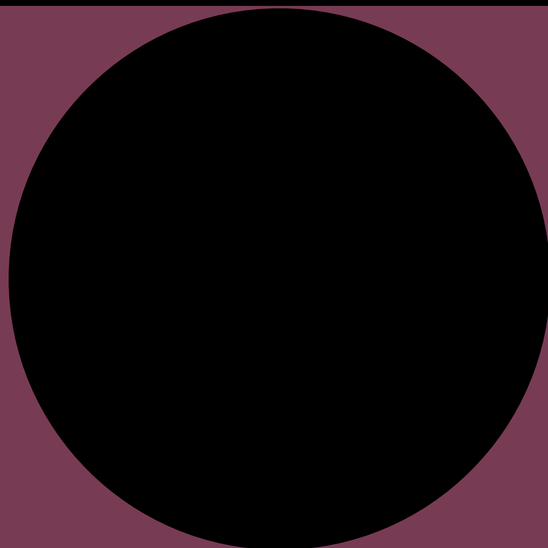
In July 2024, Ghana launched its first harm reduction (drop-in) centre for people who inject drugs and people living with HIV with support from the Global Fund. This is a timely opportunity for the government to invest domestic resources in the programme to ensure its sustainability.

Mobilising both external and in-country resources, as well as increasing national health budgets and prioritising HIV, key population programming and harm reduction services within those budges, will be critical to the sustainability of harm reduction programmes in the region.

1 Harm Reduction International, (2022), *Regional Overview: West and Central Africa: The Global State of Harm Reduction 2022*, HRI, London.
2 Harm Reduction International, (2022), *The Global State of Harm Reduction 2022*, HRI, London.
3 Yomi, T.F., (2024), 'The Global State of Harm Reduction 2024 survey response'.
4 Habib, K.T., (2024) 'The Global State of Harm Reduction 2024 survey response'.
5 Aniedi, A.E., (2024), 'The Global State of Harm Reduction 2024 survey response'.
6 Yomi, T.F., (2024), 'The Global State of Harm Reduction 2024 survey response'.
7 Ediomo-Ubong, N., (2024), *Policy Brief 20: Harm reduction programmes for people who inject drugs in Nigeria: Challenges in implementation and sustainability*, Global Drug Policy Observatory, Swansea.
8 Global Fund to Fight AIDS, Tuberculosis and Malaria, (2020), *SIERRA LEONE Mid-term Assessment Global Fund Breaking Down Barriers Initiative*, Global Fund, Geneva.
9 Global Fund to Fight AIDS, Tuberculosis and Malaria, (2022),*Global Fund - Mid-term Assessment Summary Report Global Fund Breaking Down Barriers Initiative*, Global Fund, Geneva.
10 Marshall, Z., et al., (2015), 'Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives', *Drug and Alcohol Dependence*, vol. 151, 1-14.
11 National Council for Mental Wellbeing, (2024), *Integrating Peer Programs for People Who Use Drugs*, NCMW, Washington DC.
12 Harm Reduction International, (2022), *Regional Overview: West and Central Africa: The Global State of Harm Reduction 2022*, HRI. London.
13 Aidsfonds, (2022), *Policy brief Burkina Faso*, Aidsfonds, Amsterdam.
14 Harm Reduction International, (2023*), The Global State of Harm Reduction (2023) Update to Key Data*, HRI, London.
15 Harm Reduction International, (2022), *Regional Overview: West and Central Africa: The Global State of Harm Reduction 2022*, HRI, London.
16 Ediomo-Ubong, N., (2024), *Policy Brief 20: Harm reduction programmes for people who inject drugs in Nigeria: Challenges in implementation and sustainability*, Global Drug Policy Observatory, Swansea.
17 Harm Reduction International, (2020), *Regional Overview Middle East and North Africa: The Global State of Harm Reduction 2020*, HRI, London.
18 Aidsfonds, (2022), *Policy brief Burkina Faso*, Aidsfonds, Amsterdam.
19 United Nations Office on Drugs and Crime, (26 June 2024), 'UNODC's World Drug Report 2024: Alarming diversification of local drug markets in Africa poses a growing public health crisis' [online media release, accessed September 2024], UNODC, Accra.
20 Ibid.
21 Bull-Luseni, P., (24 August 2023), 'KUSH: A Potential Threat to Sierra Leone's Human Capital Development Effort' [online article, accessed September 2024], WADPN, Ghana. Available from www.wadpn.org/post/kush-a-potential-threat-to-sierra-leone-s-human-capital-development-effort.
22 Cole, M., (15 January 2024), 'Kush: what is this dangerous new west African drug that supposedly contains human bones?' [online article, accessed September 2024], The Conversation, London. Available from https://theconversation.com/kush-what-is-this-dangerous-new-west-african-drug-that-supposedly-contains-human-bones-220608.
23 Umaru, F., (April 2024), 'Sierra Leone declares emergency over drug kush - made from human bones' [online article, accessed September 2024], BBC News, Freetown. Available from www.bbc.co.uk/news/world-africa-68742694.
24 Babafemi, F., (November 2022), 'Some Drugs Cartels Making Efforts to Introduce Fentanyl To Nigeria, Cause Mass Deaths- Anti-Narcotics Agency, NDLEA Warns' [online article, accessed September 2024], Sahara Reporters, New York. Available from https://saharareporters.com/2022/11/08/some-drugs-cartels-making-efforts-introduce-fentanyl-nigeria-cause-mass-deaths-anti-0.
25 Temidayo, A., (9 August 2023), 'Opinion: Bracing for a Fentanyl Crisis in Nigeria' [online article, accessed September 2024], Undark, Boston, MA. Available from https://undark.org/2023/09/08/bracing-for-a-fentanyl-crisis-in-nigeria/.
26 Economic Community of West African States, (2020), *Regional Strategy for HIV, Tuberculosis, Hepatitis B&C and Sexual and Reproductive Health and Rights among Key Populations*, ECOWAS, Lagos.
27 Harm Reduction International, (2022), *The Global State of Harm Reduction 2022*, HRI, London.
28 Maria-Goretti, A., (3 April 2020), 'Parliament of Ghana passes historic new drug law, paving the way for a West African approach' [online article, accessed September 2024], IDPC, London. Available from https://idpc.net/blog/2020/04/parliament-of-ghana-passes-historic-new-drug-law-paving-the-way-for-a-west-african-approach.
29 Front Page Africa, (17 July 2023), 'Liberia: President Weah Signs Controlled Drugs and Substances Bill into Law' [online article, accessed September 2024], Front Page Africa, Monrovia, Liberia. Available from https://frontpageafricaonline.com/news/liberia-president-weah-signs-controlled-drugs-and-substances-bill-into-law/.
30 UNAIDS, (2021), *DATA 2021*, UNAIDS, Geneva.
31 UNAIDS, (2023*), Regional Fact Sheet: West and Central Africa*, UNAIDS, Geneva.
32 The Global Fund Office of the Inspector General, (2019), *Global Fund – Advisory Report: Grant Implementation in Western and Central Africa*, Global Fund, Geneva.
33 AIDSPAN, (2024), *Undue influence, Harm reduction, Supreme Audit Institutions, Elderly living with HIV, Pandemics*, AIDSPAN, Nairobi.
34 UNAIDS, 'West and Central Africa' [web page, accessed September 2024], UNAIDS, Geneva. Available from www.unaids.org/en/keywords/west-and-central-africa.
35 Robert Carr Fund, 'West and Central Africa' [web page, accessed September 2024], RCF, Amsterdam. Available from https://robertcarrfund.org/networks/regions/west-and-central-africa.
36 UNAIDS, (2021), *DATA 2021*, UNAIDS, Geneva.
37 Harm Reduction International, (2024), *Failure to Fund: The Continued Crisis for Harm Reduction Funding,* HRI, London.
38 UNAIDS, (2021), *DATA 2021*, UNAIDS, Geneva.
39 Ediomo-Ubong, N., (2024), *Policy Brief 20: Harm reduction programmes for people who inject drugs in Nigeria: Challenges in implementation and sustainability*, Global Drug Policy Observatory, Swansea.
40 Harm Reduction International, (2024), *Failure to Fund: The Continued Crisis for Harm Reduction Funding,* HRI, London.
41 Harm Reduction International, (2021), *Failure to Fund: The Continuing Crisis for Harm Reduction in Low- and Middle-Income Countries,* HRI, London.
42 Ibid.
43 Lyes, T. et al., (2023), *West Africa organised crime framework deep dive: New approaches to regulating drugs in West Africa: Exploring the impact of Ghana's drug policy reform,* Organised Crime: West African Response to Trafficking, UNDP Sub-Regional Hub for West and Central Africa, Dakar.
44 Ediomo-Ubong, N., (2024), *Policy Brief 20: Harm reduction programmes for people who inject drugs in Nigeria: Challenges in implementation and sustainability,* Global Drug Policy Observatory, Swansea.
45 The State House Senegal, (June 2020), 'President Julius Maada Bio explains why massive investment in mental matters in present-day Sierra Leone' [online news article, accessed September 2024], The State House, Freetown. Available from https://statehouse.gov.sl/president-julius-maada-bio-explains-why-massive-investment-in-mental-health-matters-in-present-day-sierra-leone/.
46 Lyes, T. et al., (2023), *West Africa organised crime framework deep dive: New approaches to regulating drugs in West Africa: Exploring the impact of Ghana's drug policy reform,* Organised Crime: West African Response to Trafficking, UNDP Sub-Regional Hub for West and Central Africa, Dakar.
47 UNAIDS ,(4 May 2023), 'Leave no one behind and that includes people who use drugs' [online news article, accessed September 2024], UNAIDS, Geneva. Available from www.unaids.org/en/resources/presscentre/featurestories/2023/may/20230504_senegal-cepiad.
48 Kumordzi Tetteh, M., (11 July 2024), 'Ghana Gets its First Harm Reduction Centre (Drop-in Centre) for PWUD/PLHIV' [online news article, accessed September 2024], WADPN, Accra. Available from www.wadpn.org/post/ghana-gets-its-first-harm-reduction-centre-drop-in-centre-for-pwud.

REGIONAL OVERVIEW: WESTERN EUROPE





THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION
INTERNATIONAL

AUTHOR OF WESTERN EUROPE REGIONAL OVERVIEW: **Robert Csák**

Robert Csák is a sociologist and researcher. His research has focused on various aspects of harm reduction. He has worked in needle and syringe programmes, community outreach, HIV and HCV testing and counselling for over 10 years. He has worked on the *Global State of Harm Reduction 2020 and 2022* and is the author of the Harm Reduction International report on Low Dead Space Syringes.

TABLE EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN WESTERN EUROPE

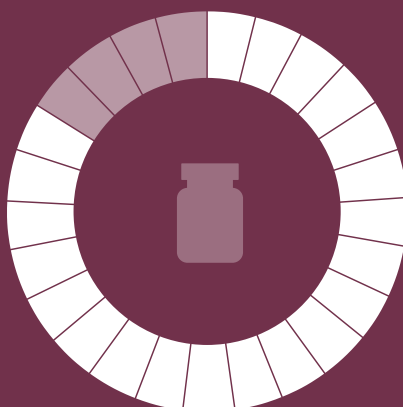
Country/territory	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Andorra	nd[f]	nd	nd	nd	nd	nd	nd	nd	nd
Austria	15,000	12.3	16.7	4.4	✓ 55	✓ B M	✓	✕	✓
Belgium	7,000	4.5	48.8	2	✓ 243	✓ B H M	✕	✓ 2	✓
Cyprus	710	3.5-7.1	42.4	4.7	✓ 33	✓ B M	✕	✕	nd
Denmark	nd	1.3	65.6	1.3	✓ 5	✓ B H M	✕	✓ 5	nd
Finland	25,000	1.2	73.7	nd	✓ 84	✓ B M	✕	✕	nd
France	125,500	6	41.7	0.8	✓ 1,220	✓ B M	✕	✓ 2	✓
Germany	nd	4.1	62.9	0.9	✓ 475	✓ B H M	✓	✓ 25	✓
Greece	3,287	7.3	53.7- 69.6	2.1	✓ 18	✓ B M	✕	✓ 1	✓
Iceland	500	5	10	nd	✓	✓	nd	✓ 1	nd
Ireland	688	8.3	77.2	nd	✓ 140	✓ B M	✓	✕	✓
Italy	105,652	28.3	63.8	nd	✓ 152	✓ B M	✓	✕	✓
Liechtenstein	nd	nd	nd	nd	nd	nd	nd	nd	nd
Luxembourg	822	1.9	71.1	nd	✓ 10	✓ B M	✕	✓ 2	nd
Malta	805	0.2	43.8	0	✓ 10	✓ B M	✕	✕	nd
Monaco	nd	nd	nd	nd	nd	nd	nd	nd	nd
Netherlands	840	2.6	61	0	✓	✓ B H M	✕	✓ 25	✓
Norway	7,878	1.3	38.8	1.5	✓	✓ B H M	✕	✓ 2	nd
Portugal	28,287	13	71.9	5.7	✓ 1997	✓ B M	✓	✓ 3	✓
San Marino	nd	nd	nd	nd	nd	nd	nd	nd	nd
Spain	6,762	32	45.9	5.3	✓ 866	✓ B M	✓	✓ 16	✓
Sweden	nd	5.1	65.2	1.5	✓ 30	✓ B M	✕	✕	nd
Switzerland	42,000	1.4	74.6	nd	✓	✓ B H M	✕	✓ 14	✓
Türkiye	nd	0.8	37.5	3.9	✕	✓ B M	✕	✕	nd
United Kingdom[g]	341,032	1.5	57	5.9	✓	✓ B H M	✓	✕	✓[h]

a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone
c At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
d At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g The United Kingdom population size estimate for people who inject drugs refers to subnational data from England and Scotland only. The data on HIV and viral hepatitis refers to England, Northern Ireland and Wales only.
h Pilot programme

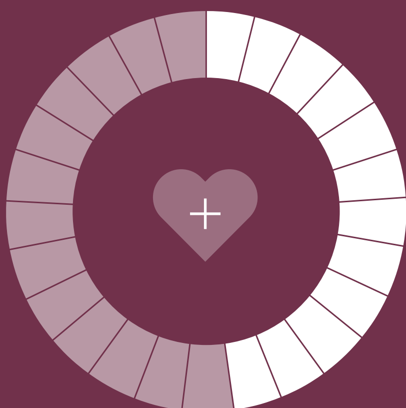
AVAILABILITY OF HARM REDUCTION SERVICES

NSP, OAT, DCRs AND SAFER SMOKING KITS

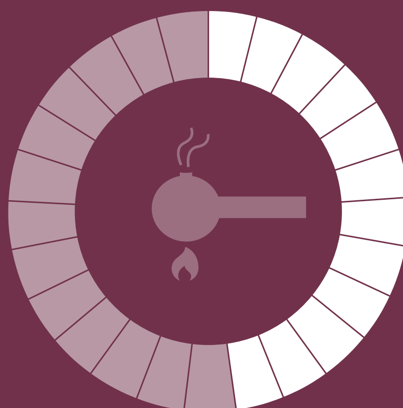
20 countries (80%) in Western Europe provide **needle and syringe programmes** (no change from 2022)



21 countries (84%) in Western Europe provide **opioid agonist therapy** (no change from 2022)



12 countries in Western Europe provide **drug consumptions rooms** (no change from 2022)



12 countries in Western Europe provide **safer smoking kits** (+2 countries from 2022, Greece and Ireland)

KEY ISSUE

SERVICES FOR MARGINALISED GROUPS OF PEOPLE WHO USE DRUGS

Western Europe is one of the regions where core harm reduction services like needle and syringe programmes (NSP) and opioid agonist therapy (OAT) are available in almost every country[1] and harm reduction has been explicitly included in national drug strategies and action plans for years. Western Europe has the most countries of any region in which drug consumption rooms (DCRs) and drug checking services are available. Despite harm reduction being an established public health intervention in the region, marginalised groups such as women, LGBTQI+ people, migrants and people in prison and other closed settings, are underserved and face barriers in accessing harm reduction services.[2,3,4] Marginalised groups of people who use drugs should have access to harm reduction services tailored to their needs to ensure appropriate coverage, not only to achieve public health goals but to realise the right to health and human rights for all.

According to the Correlation-European Harm Reduction Network's recent report, which summarises responses from 35 European cities in 30 countries, harm reduction services are delivered to the greatest extent to people who inject opiates, while the least served population in Europe are young people under the age of 18 who use drugs.[5,6] Despite adolescence being a common time for starting substance use, harm reduction for under 18s, particularly in school settings, is still controversial.[7,8,9,10] Age restrictions prevent adolescents who use drugs from getting vital services. For example, DCR, NSP and drug checking services are for adults-only in many countries as under 18s are not formally permitted to use these services (e.g. in Belgium, Germany, Sweden, Switzerland).[11,12,13,14]

Being at the intersection of different vulnerabilities can make access to services difficult. It can be a precarious situation if you are someone who does not identify as belonging to the groups that are targeted by harm reduction programmes.

For example, people who engage in chemsex can be at the intersection of other marginalised groups and their needs may not be appropriately met either by programmes focusing on gay men and other men who have sex with men or by programmes for people who use drugs – and stigma stops many from engaging with harm reduction services.[15,16] Despite suitable harm reduction services having been developed across the region, people engaging in chemsex are still the second least-served population in Europe.[17,18] The services that are available focus on men, while heterosexual couples in the swingers scene or lesbians and other women who have sex with women are rarely mentioned in the chemsex context. But that does not mean people who use drugs during sex who are outside of the chemsex scene do not need services. O'Yes in Belgium, which offers lesbians and other women who have sex with

women consultations with health professionals to discuss issues related to sexualised drug use, is an example of a service that does cater to underserved populations. But such services are not widespread, and without adequate support these important subpopulations are likely to be missed.[19]

Migrants are also inadequately served by harm reduction services in the region. They face significant barriers to accessing health services; the most prominent relate to their legal status, the discrimination they experience and cultural differences.[20,21,22,23] Migrants who use drugs face many barriers, on top of being stigmatised for using drugs, such as xenophobia and racism. Administrative barriers including language, can hinder access to health and ham reduction services.[24,25,26,27] For example, in Berlin, Russian-speaking migrants, West African migrants and migrants from Maghreb Arab countries are present, all with unique characteristics and needs, speaking different languages.[28] Integrated services involving professionals such as interpreters, multicultural mediators and peer navigators are crucial in this setting.[29,30]

Gaps in the range of available harm reduction services still exist in the region. For example, harm reduction for people who use opioids is the most common type of intervention, but people who use opiates intranasally (through the nose) are greatly underserved and can only receive heroin-assisted treatment in Switzerland.[31,32]

There is a need to bridge these gaps by implementing appropriate services for all, especially in a region where harm reduction is an established intervention supported in national strategies. People who use drugs are a heterogenous group made up of different populations with diverse needs. To ensure appropriate access for everyone, peers from different drug-use groups should be involved in providing support, from designing an intervention to evaluating it, so services and materials are informed by and centred around the specific and diverse needs, circumstances and priorities of all people who use drugs.[33]

"People who use drugs are a heterogenous group made up of different populations with diverse needs. To ensure appropriate access for everyone, peers from different drug-use groups should be involved in providing support, from designing an intervention to evaluating it, so services and materials are informed by and centred around the specific and diverse needs, circumstances and priorities of all people who use drugs."

KEY ISSUE

EXPANSION OF DRUG CHECKING SERVICES

Drug checking services analyse drug samples that people who use drugs submit. These services provide feedback to clients and offer counselling based on the results to help people reduce the risks associated with drugs containing unknown components, unknown quantities of components and unwanted substance interactions.[34] Drug checking services can also be used as a tool to monitor drug markets, and in Western Europe the data they provide is making a substantial contribution to regional knowledge on the substances available and emerging trends.[35,36,37,38] For example, drug checking services were instrumental in detecting synthetic cannabinoid receptor agonists in herbal cannabis in Zurich, Switzerland.[39] Drug checking services are currently available in 13 of 25 countries in the region (Austria, Belgium, France, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Portugal, Spain, Switzerland and the UK).[40,41] In Ireland and Greece, these services are only available at some music festivals.[42,43]

A systematic review of drug checking services since 1990 found that people who used them consistently reported having a greater intention not to use drugs if the result of a drug-checking test was unexpected, questionable or suspicious.[44] Evidence included in the review also demonstrates the capacity of drug checking services to detect new psychoactive substances and drugs of concern that are available on the ground, while providing information on both expected and detected content.[45]

Despite mounting evidence about the benefits of drug checking services, legal barriers – along with a lack of political will to change the policy environment – prevent the implementation or scale up of existing drug checking services in the region.[46]

Other studies also show that drug checking services can influence people's behaviour, and unexpected results can stop people taking the drug being checked, using less and applying harm reduction practices, such as not mixing substances.[47,48] Enacted behaviour over the longer term is less researched.[49] However, a recent study in Portugal followed people who had used a drug checking service at a festival for six months to check their behaviour compared to their intentions after getting unexpected test results.[50] They found that, after six months, 71% of clients reported enacting behaviour that matched the intention they expressed when they got the test result (for example, not taking an ecstasy pill when it did not contain MDMA).[51] Six months after using the drug checking services at the festival, there was an increase in most harm reduction practices among respondents.[52]

Drug checking might be useful outside of nightlife settings too. For example, an organisation in Belgium made drug checking services part of its programme for people engaged in chemsex.[53] Research on heroin and cocaine used in DCRs in Luxembourg compared clients' expectations and

the level of active compound measured, and found that most people had very limited information on the active compound content of the substance they were about to use.[54] In the Netherlands, an intermediate testing project is being piloted until the end of 2024. Here, field workers can test drugs that belong to people who they meet during street outreach, thus providing information on the drugs available in more marginalised communities.[55]

The public health benefits of implementing drug checking services are evident, and may be particularly useful given the emergence of synthetic opioids across the globe, including in Western Europe (for example, nitazenes in the UK, or fentanyl derivatives in Sweden and Austria).[56,57]

Decision makers should be aware that a drug checking service is a simple tool that increases people's safety and helps them to make informed decisions about the drugs they use.[58]

1 European Union Drugs Agency, (2023), 'Infographic. Number of European countries implementing harm reduction interventions, up to 2022' [web page, accessed September 2024], EUDA, Lisbon. Available from www.euda.europa.eu/media-library/edr/2023/infographicnumber-european-countries-implementing-harm-reduction-interventions-2022_en#edr23-harm-reduction-table1.
2 European Union Drugs Agency, 'Women and drugs: health and social responses' [web page, accessed September 2024], EUDA, Lisbon. Available from www.euda.europa.eu/publications/mini-guides/women-and-drugs-health-and-social-responses_en.
3 European Union Drugs Agency, 'Migrants and drugs: health and social responses' [web page, accessed September 2024], EUDA, Lisbon. Available from http://www.euda.europa.eu/publications/mini-guides/migrants-and-drugs-health-and-social-responses_en.
4 European Monitoring Centre for Drugs and Drug Addiction, (2022), *Prison and drugs in Europe: current and future challenges*, Publications Office of the European Union, Luxembourg.
5 Jeziorska, I., et al., (2023), *Essential Harm Reduction Services: Report on policy implementation for people who use drugs. Civil Society Monitoring of Harm Reduction in Europe 2023*, Correlation – European Harm Reduction Network, Amsterdam.
6 Rigoni, R. and A. Pomfret, (2024), 'Global State of Harm Reduction 2024 survey response, Correlation – European Harm Reduction Network', 2024.
7 Harm Reduction International, (2022), *Harm reduction services in Switzerland*, HRI, London.
8 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
9 Guardiola, J.R., (2024), 'Global State of Harm Reduction 2024 survey response, Spain'.
10 Barrett, D., et al., (2022), 'Child-centred harm reduction', *International Journal of Drug Policy*, vol. 109, e103857.
11 Harm Reduction International, (2022), *Harm reduction services in Switzerland*, HRI, London.
12 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
13 Schäffer, D., (2024), 'Global State of Harm Reduction 2024 survey response, Germany'.
14 Barrett, D., F. Petersson and R. Turner, (2022), 'Best interests and low thresholds: legal and ethical issues relating to needle and syringe services for under 18s in Sweden', *Harm Reduction Journal*, vol. 19, no. 1, p.15.
15 Hawkinson, D.E., T.C. Witzel and M. Gafos, (2024), 'Exploring practices to enhance benefits and reduce risks of chemsex among gay, bisexual, and other men who have sex with men: A meta-ethnography', *International Journal of Drug Policy*, vol. 127, e104398.
16 Harm Reduction International and APCOM, (2021), *Chemsex and harm reduction for gay men and other men who have sex with men*, HRI, London. 2021.
17 Jeziorska, I., et al., (2023), *Essential Harm Reduction Services: Report on policy implementation for people who use drugs. Civil Society Monitoring of Harm Reduction in Europe 2023*, Correlation – European Harm Reduction Network, Amsterdam.
18 Coronado-Muñoz, M., et al., (2024), 'Sexualized Drug Use and Chemsex among Men Who Have Sex with Men in Europe: A Systematic Review and Meta-Analysis', *Journal of Clinical Medicine*, vol. 13, no. 6, p.1812.
19 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
20 European Union Drugs Agency, 'Migrants and drugs: health and social responses' [web page, accessed September 2024], EUDA, Lisbon. Available from www.euda.europa.eu/publications/mini-guides/migrants-and-drugs-health-and-social-responses_en.
21 Jeziorska, I., et al., (2023), *Essential Harm Reduction Services: Report on policy implementation for people who use drugs. Civil Society Monitoring of Harm Reduction in Europe 2023*, Correlation – European Harm Reduction Network, Amsterdam.
22 van Selm, L., et al., (2023), 'Drug use and access to drug dependency services for vulnerable migrants who use drugs in the European Union: Consensus statements and recommendations from civil society experts in Europe', *International Journal of Drug Policy*, vol. 118, e104087.
23 van Selm, L. et al., (2024), 'A call to create integrated services to better address the needs of migrants who use drugs in Europe', *Harm Reduction Journal*, vol. 21, no. 1, p.9.
24 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
25 Guardiola, J.R., (2024), 'Global State of Harm Reduction 2024 survey response, Spain'.
26 Schäffer, D., (2024), 'Global State of Harm Reduction 2024 survey response, Germany'.
27 Bafi, I., (2024), 'Global State of Harm Reduction 2024 survey response, Greece'.
28 Rogialli, A., R.P. Gayo and I. Jeziorska, (2023), *Adequate drug-related responses for migrants in Berlin. Recommendations for policy and practice from the SEMID-EU project*, Correlation – European Harm Reduction Network, Amsterdam.
29 van Selm, L. et al., (2024), 'A call to create integrated services to better address the needs of migrants who use drugs in Europe', *Harm Reduction Journal*, vol. 21, no. 1, p.9.
30 Rogialli, A., R.P. Gayo and I. Jeziorska, (2023), *Adequate drug-related responses for Migrants in Europe. Policy recommendations from the SEMID-EU project for evidence-informed social & health policies*, Correlation – European Harm Reduction Network, Amsterdam.
31 Jeziorska, I., et al., (2023), *Essential Harm Reduction Services: Report on policy implementation for people who use drugs. Civil Society Monitoring of Harm Reduction in Europe 2023*, Correlation – European Harm Reduction Network, Amsterdam.
32 Westenberg, J.N., et al., (2023), 'Feasibility, safety, and acceptability of intranasal heroin-assisted treatment in Switzerland: protocol for a prospective multicentre observational cohort study', A*ddiction Science & Clinical Practice*, vol. 18.
33 International Network of People who Use Drugs, (2023), *Harm Reduction Best and Worst Practice*, INPUD, London.
34 Trans European Drug Information, 'Drug checking' [web page, accessed June 2024], TEDI Network, Poland. Available from: www.tedinetwork.org/drug-checking/.
35 Trans European Drug Information, (2023) *Drug Checking services as an answer to shifting drug markets*, TEDI Network, Poland.
36 Jones, G., et al., (TEDI network), (2023), *European Drug Checking Trends 2018-2023. Civil Society Monitoring of Harm Reduction in Europe 2023*, Correlation – European Harm Reduction Network, Amsterdam.
37 Magnolini, R. et al., (2023), 'Substances from unregulated drug markets – A retrospective data analysis of customer-provided samples from a decade of drug checking service in Zurich (Switzerland)', *International Journal of Drug Policy*, vol. 114, e103972.
38 European Union Drugs Agency, 'Drug checking data from the Trans-European Drug Information (TEDI) network' [web page, accessed September 2024], EUDA, Lisbon. Available from www.euda.europa.eu/publications/data-factsheet/drug-checking-data-trans-european-drugs-information-tedi-network_en.
39 Oomen, P.E., et al., (2022) 'Cannabis adulterated with the synthetic cannabinoid receptor agonist MDMB-4en-PINACA and the role of European drug checking services', *International Journal of Drug Policy*, vol. 100, e103493.
40 Various respondents, (2024), 'Global State of Harm Reduction 2024 survey responses, Western Europe'.
41 Trans European Drug Information, 'About - The Trans-European Drug Information project website' [web page, accessed September 2024], TEDI Network, Poland. Available from www.tedinetwork.org/about/.
42 Bafi, I., (2024), 'Global State of Harm Reduction 2024 survey response, Greece'.
43 Duffin, T., (2024), 'Global State of Harm Reduction 2024 survey response, Ireland'.
44 Maghsoudi, N., et al., (2022), 'Drug checking services for people who use drugs: a systematic review', *Addiction*, vol. 117, no. 3, p.532–44.
45 Ibid.
46 Various respondents, (2024), 'Global State of Harm Reduction 2024 survey responses, Western Europe'.
47 Measham, F. and G. Turnbull, (2021), 'Intentions, actions and outcomes: A follow up survey on harm reduction practices after using an English festival drug checking service', *International Journal of Drug Policy*, vol. 95, e103270.
48 Valente, H., et al., (2023), 'A longitudinal study of behavioural outcomes following a visit to the Boom Festival 2018 drug checking service: individual and group level results', *Drugs: Education, Prevention and Policy*, vol. 30, no. 4, p.373–82.
49 Maghsoudi, N., et al., (2022), 'Drug checking services for people who use drugs: a systematic review', *Addiction*, vol. 117, no. 3, p.532–44.
50 Valente, H., et al. (2023), 'A longitudinal study of behavioural outcomes following a visit to the Boom Festival 2018 drug checking service: individual and group level results', *Drugs: Education, Prevention and Policy*, vol. 30, no. 4, p.373–82.
51 Ibid.
52 Ibid.
53 van der Linden, N., (2024), 'Global State of Harm Reduction 2024 survey response, Belgium'.
54 Dahm, G., et al., (2023), 'Consumer expectations, drug effects, price and purity of heroin and cocaine purchased at drug consumption rooms', *Harm Reduction Journal*, vol. 20, no. 1, p.106.
55 Personal communication with Busz, M., Netherlands for the Global State of Harm Reduction 2024.
56 Holland A., et al., (2024), 'Nitazenes—heralding a second wave for the UK drug-related death crisis?' *The Lancet Public Health*, vol. 9, no. 2, e71–2.
57 European Union Drugs Agency, 'EU Drug Market: Heroin and other opioids — Trafficking and supply' [web page, accessed July 2024], EUDA, Lisbon. Available from www.euda.europa.eu/publications/eu-drug-markets/heroin-and-other-opioids/trafficking-and-supply_en.
58 Falzon, D., et al., (2024), 'Planning and implementing community-based drug checking services in Scotland: a qualitative exploration using the consolidated framework for implementation research', *Substance Abuse Treatment and Prevention Policy*, vol. 19, no. 1, p.7.

THE GLOBAL STATE OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL