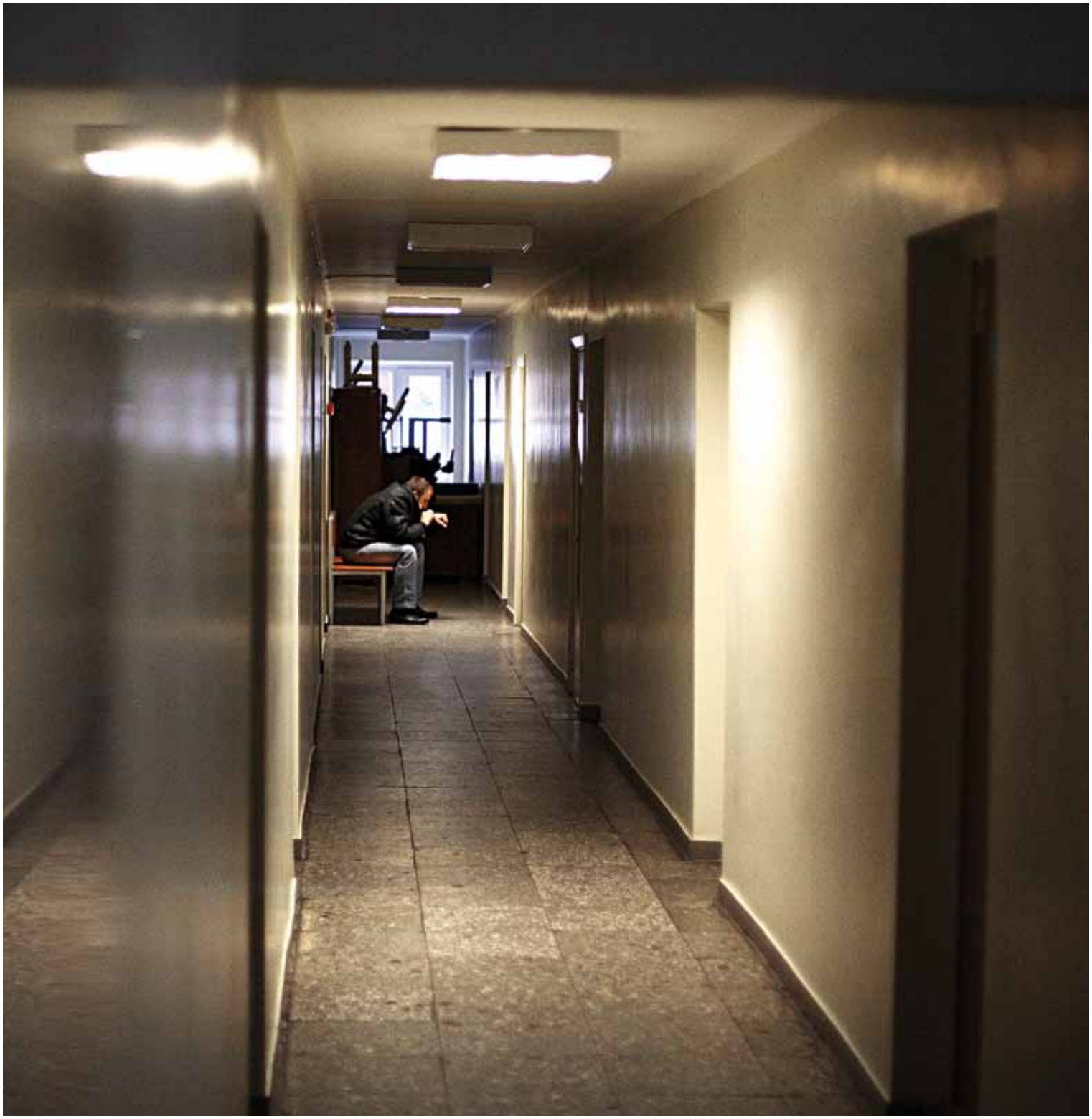

IFRC Advocacy Report

Out of harm's way

Injecting drug users and harm reduction

December 2010

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Saving lives, changing minds.

International Federation
of Red Cross and Red Crescent Societies

Phnom Penh, 2000 – Street children are often at high risk of becoming future injecting drug users. UNAIDS. S. Noorani

In this edition

In this last edition for 2010, the *IFRC Health Advocacy Report* depicts the stark reality of what it means to be an injecting drug user and living with HIV. It examines the prevention, treatment, care and support needs of this most at-risk population and the International Federation of Red Cross and Red Crescent Societies (IFRC) response to their plight.

It also offers National Societies and the reader an advocacy tool that can be used for years to come. The aim? To remind governments and National Societies of the obligation to respect the human rights of injecting drug users at risk of, or living with, HIV. Although our focus is global, we place a special emphasis on Eastern Europe and Central Asia where the situation is becoming increasingly dire.

Executive summary

- Harm reduction refers to a range of pragmatic and evidence-based public health policies and practices aimed at reducing the negative consequences associated with drug use and other related risk factors such as HIV and AIDS. These interventions exemplify human rights in action by seeking to alleviate hazards faced by the injecting drug users, where needed, without distinction and without judgement. The IFRC advocates harm reduction for one very simple reason: It works.
- The United Nations estimates that approximately 15.9 million people living in 148 countries regularly inject drugs. Known as injecting drug users, these individuals are particularly vulnerable to HIV, Hepatitis C and B infections owing to risky behaviours such as sharing syringes and needles, unsafe sex practices and a general lack of health-seeking behaviour. Worldwide, an estimated three million injecting drug users are now living with HIV.
- Injecting drug use thus constitutes a serious public health concern that can only be addressed through the rational application of non-moralistic public health interventions that emphasize harm reduction programming over punishment and censure.
- In this context, the IFRC recommends that scientific evidence and a humanitarian spirit should guide the HIV response. Injecting drug users, who routinely face harassment, stigmatization, violence and social exclusion, require not only care but compassion as well. Stigma only further marginalizes already vulnerable individuals and directly impedes efforts to halt the spread of HIV. Reducing marginalization also reduces the transmission of HIV and other infectious diseases.

A call to action

The International Federation of Red Cross Red Crescent Societies (IFRC) advocates on behalf of the individuals suffering most from exclusion within an already marginalized group—injecting drug users living with, or at risk of, HIV and AIDS. In this report, the IFRC challenges policymakers, governments and donors to move beyond their own prejudices to work with stakeholders, multi-lateral organizations, civil society and those living with HIV to provide prevention, treatment, care and support to injecting drug users and their families.

IFRC's recommendations

- Governments need to engage in country-specific data collection, research, analysis and education to more accurately guide policy and the implementation of programmes. This would also assist them to adopt the necessary strategic measures to adequately respond to drug-related epidemics.
- To deny injecting drug-users access to lifesaving comprehensive services could potentially trigger a public health disaster. Universal access to evidence-based public health interventions for drug users constitutes a fundamental right to health and is an urgent public health priority.[1]
- Governments need to put in place supportive policies and regulations that promote the implementation of harm reduction programmes.
- Currently available strategies can largely control and mitigate the harm caused by HIV epidemics among injecting drug users. To be effective, harm reduction programmes must be tailored to local contexts. Effective responses can:
    a) Decrease the social marginalization and the subsequent vulnerability of injecting drug users;
    b) Increase access to health care and social services. These include harm reduction programmes and a comprehensive package of HIV prevention, treatment, care and support interventions.
    c) Promote a non-repressive approach based on human rights and public health principles.
- The dangers of inaction include the continued transmission of HIV and other infectious diseases to new populations and regions, more complex HIV epidemics in addition to a high rate of mortality and socio-economic destabilization. The IFRC strongly recommends that governments establish supportive policies that respect human rights and support the implementation of harm reduction programmes.
- Red Cross and Red Crescent volunteers and health professionals need to advocate and take action with, and on behalf of, individuals who use drugs—both within the health-care and criminal justice sectors.
- All stakeholders need to empower and listen to those who use drugs: Their voices need to be heard and their participation—in all aspects of decision and policymaking, planning and implementation—is absolutely critical.
- Repressive laws, which include imprisonment and harassment, drive many drug users underground, away from health and social support services. This makes providing HIV prevention, treatment, care and support almost impossible and exposes the general population to more harm.
- Policy change and justice system reform is an integral component of harm reduction. Injecting drug use should not be seen as a criminal act but as a major public health issue. The IFRC calls for the decriminalisation of drug users, access to due legal process and health services for those who use drugs both within, and outside, of all types of detention centres.

Advocacy, fearless political will and commitment are absolutely imperative if the actions called for in this report are to be realized. The evidence unequivocally shows that inaction drives HIV transmission. Limiting access to HIV prevention and treatment programmes, and imprisoning drug users is an abuse of human rights and a threat to public health.[2]

1. *Wolfe D, et al., 'Treatment and care for injecting drug users with HIV infection: a review of barriers and ways forward'. The Lancet, published online July 2010. PubMed*
2. *Beyrer Ch, et. al. 'Time to act: a call for comprehensive responses to HIV in people who use drugs', The Lancet, Volume 376, Issue 9740, Pages 551 - 563, 14 August 2010, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960928-2/fulltext*

Introduction

Almost thirty years have passed since scientists at the Pasteur Institute identified HIV as the causative agent behind a mysterious pandemic that has since claimed the lives of millions of people worldwide. Today–thanks in no small part to the advent of anti-retrovirals combined with earlier treatment–HIV and AIDS has evolved from a death sentence into a chronic, albeit treatable, disease.

Nevertheless, even as science is shedding light on how HIV can be contained–and possibly even eliminated[3], governments and donors continue to drag their heels. Every day an estimated 7,400 people are newly infected, while epidemiologists now pin the total infection rate at 33.4 million worldwide with a yearly mortality rate of 2 million.[4]

Stigma also continues to takes its toll–and nowhere is this more evident than with respect to injecting drug users. Today, HIV remains concentrated in the nine highest-prevalence countries in sub-Saharan Africa where the mode of transmission remains primarily heterosexual. Elsewhere however, statistics tell a darker tale.

The *United Nations Reference Group on HIV and Injecting Drug Use* estimates that 15.9 million people living in 148 countries regularly inject drugs. Known as injecting drug users, these individuals are particularly vulnerable to HIV, hepatitis C and B infections owing to risk behaviours such as sharing syringes and needles, unsafe sex practices and a general lack of health-seeking behaviour. Worldwide, an estimated three million injecting drug users are now living with HIV[5] **(See part 1: The magnitude of the epidemic)**.

Quite apart from the devastation such behaviour wreaks on the individual user and his or her loved ones, injecting drug use constitutes a serious public health concern that can only be addressed through the rational application of non-moralistic public health interventions that emphasize harm reduction programmes over punishment and censure.

In this report, we focus primarily on Eastern Europe and Central Asia because that is where the injecting drug use/HIV epidemic is worsening and where policies continue to criminalize and stigmatize users–thus jeopardizing attempts to address the epidemic based on sound, evidence-based and effective public health interventions.

Throughout the document we illustrate the Red Cross and Red Crescent responses with case histories taken from the highest HIV/injecting drug user prevalence countries in the world. These are featured at the beginning of each chapter.

- In **Part 1**, we show the magnitude of the problem with an at-a-glance situation analysis.
- In **Part 2**, we outline our advocacy messages that address the inhumane conditions injecting drug users and their families all too often find themselves trapped in—gravely ill, stigmatized and alone.
- In **Part 3**, we summarize the Red Cross and Red Crescent's harm reduction response which is based on the 2003 'Spreading the light of science'[6] guidelines on injecting drug use.
- In **Part 4**, we explore how all stakeholders can work together to adjust policies, establish programmes and reduce harm among some of the world's most disenfranchised and disadvantaged populations.

Exactly who injects drugs? Although drug users come from all walks of life, nationalities and socio-economic strata, most injecting drug users are young, male and sexually active. Many will acquire and transmit the HIV virus, not only by sharing injecting equipment, but also through sexual intercourse with regular or casual partners. Injecting drug use also overlaps with the sex trade, with users often buying sexual services or selling sex to finance their drug dependency.

3. *Granich R M, et al. "Universal Voluntary HIV testing with immediate antiretroviral therapy as a strategy for the elimination of HIV transmission: a mathematical model." The Lancet , Nov 26, 2008*
4. *2009 AIDS Epidemic Update, UNAIDS http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp*
5. *Beyrer C et al, 2010.*
6. *http://www.ifrc.org/what/health/tools/harm_reduction.asp.*

part 1

THE MAGNITUDE OF THE EPIDEMIC

Case study

The province of Yunnan lies huddled in the southwest border area in China, curved up against Vietnam, Laos and Burma, and linked to Thailand and Cambodia via the Mekong River (otherwise known as Lancang River in China).

Owing to its location near "The Golden Triangle", Yunnan's population is 'drowning' in heroin and other illicit drugs. In 1989, the first HIV infection case was reported among injecting drug users living along the borderlands.

By the end of 2005, authorities reported that 40,157 citizens were living with HIV while 1,541 had already died. Experts estimate that the actual number of those individuals living with HIV has already exceeded 80,000. Province-wide, all 16 regions are affected, three of which have entered into the 'highly prevalent' stage.

In Yunnan, the Red Cross Society of China relies on volunteers to reach out to communities and families. HomeAIDS, a counselling service centre, plays a key role in preventing the transmission of HIV. A cooperative effort involving the Yunnan Red Cross branch and the Hong Kong and Macao Salvation Army, the centre works with HIV and AIDS experts, other NGO staff, medical workers, police officers, young volunteers, journalists, taxi drivers, and hotel employees.

The aim is to provide harm reduction services that save lives and slow the transmission of HIV and other blood-borne and sexually-transmitted infections.

In four years, HomeAIDS has already established two locations and eleven volunteer branches and has mobilized and deployed more than 800 volunteers. It raises awareness, supports communities, offers training, advocates for policy change, and builds an effective and sustainable model of HIV prevention, treatment, care and support.

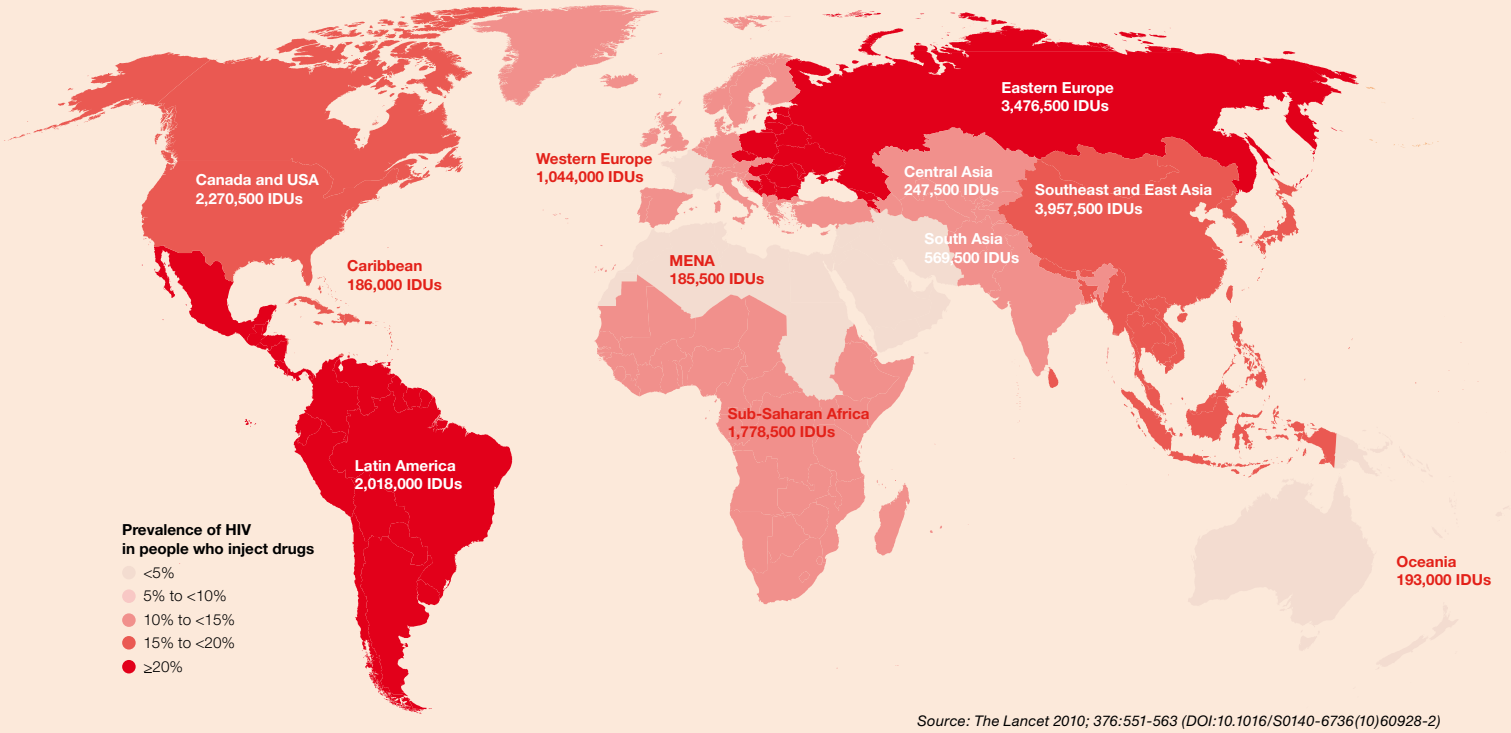
Key to this is providing a 'safe place' for injecting drug users who are living with HIV. In order to do so HomeAIDS places a special emphasis on peer education, which supports injecting drug users, commercial sex workers and other at-risk groups to support themselves.

In addition to medical referrals for treatment and care, HomeAIDS offers participants a wide array of skills building and occupational training that includes peer education, elementary first aid, computer, electronics, knitting and cosmetology.

—Zhang Ran, Red Cross Society of China: Harm Reduction Project

01. The magnitude of the epidemic

HIV and injecting drug users (IDUs) worldwide



Source: The Lancet 2010; 376:551-563 (DOI:10.1016/S0140-6736(10)60928-2)

The *Reference Group to the UN on HIV and Injecting Drug Use* estimates that three million injecting drug users were living with HIV in 2007. Although some countries have managed to contain the spread of HIV infection among injecting drug users by deploying the package of harm reduction interventions jointly recommended by WHO, UNAIDS, and the UN Office on Drugs and Crime (UNODC), many have not.

This represents a major concern particularly given evidence that shows that, where injecting drug users enjoy good access to these services, HIV incidence remains stable and low for years and even decades (Australia, Brazil, France, Germany, Hong Kong, the United Kingdom and several US cities).

With rare exceptions, studies also consistently show that needle and syringe programmes result in marked decreases in HIV transmission–by as much as 33 to 42 per cent in some settings.[7] Indeed, these experiences reveal that public health efforts are effective and that controlling HIV infection in people who use drugs can be accomplished fairly easily and at low cost.

Nevertheless, it appears that the successes experienced by these countries are not enough to trump stigma and bad policy. In 2010, hundreds of thousands of injecting drug users and their intimate partners continue to be infected, particularly in Eastern Europe, in East, Southeast, and Central Asia, and in the southern cone of South America.

Five countries in particular (China, Malaysia, Russia, Ukraine, and Vietnam) are characterized as "mega-epidemics" in terms of people who inject drugs. Taken together, these countries account for an estimated 2 to 4 million cases of HIV infection and constitute the largest concentration of injecting drug users living with HIV worldwide.[8]

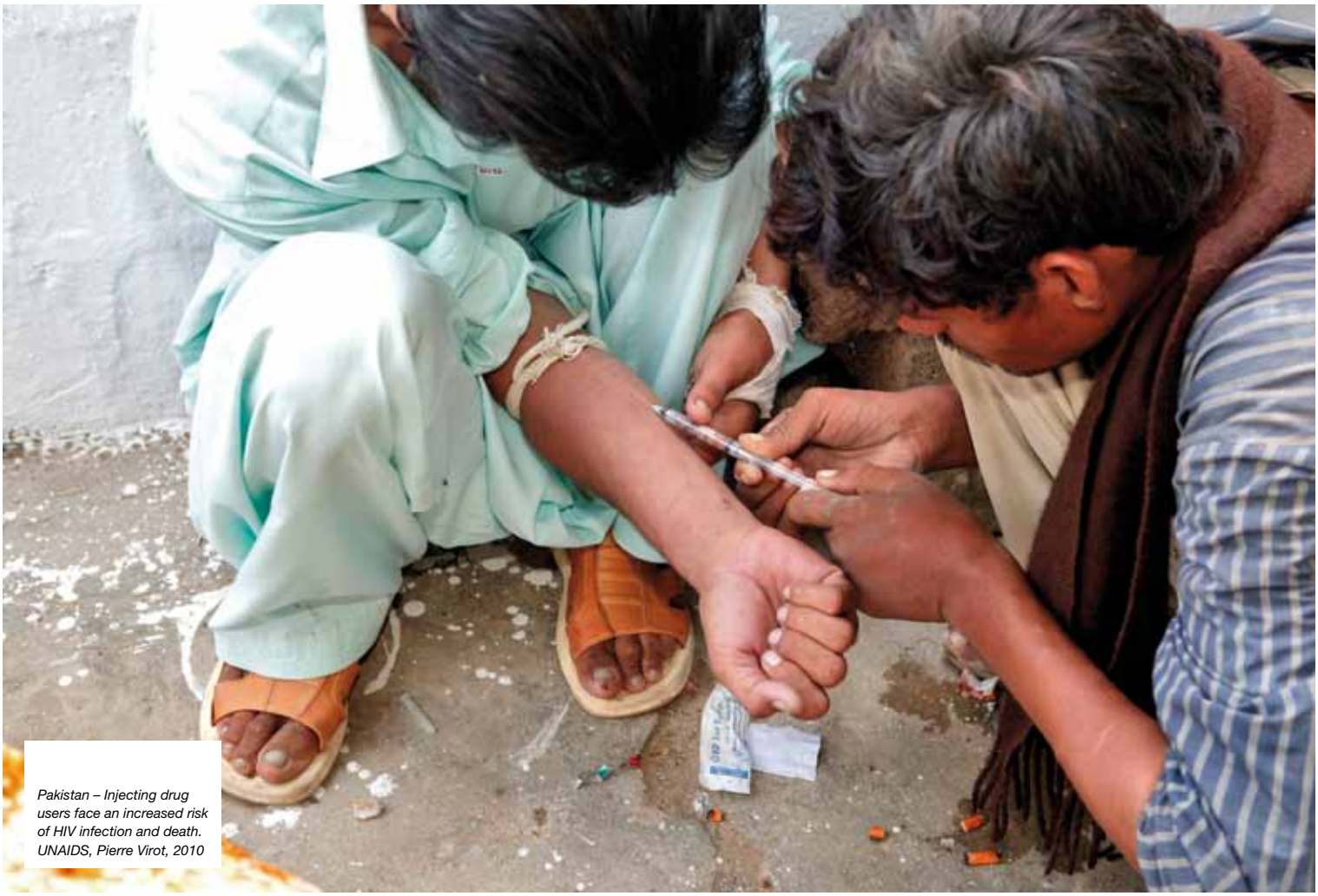
In Eastern Europe and Central Asia the situation is particularly worrisome. Injecting drug users account for more than 60 per cent of all HIV infections in Belarus, Georgia, Iran, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine, Tajikistan, and Uzbekistan.[9]

01. The magnitude of the epidemic

In sub-Saharan Africa, new epidemics among injecting drug users are beginning to emerge. An estimated 221,000 injecting drug users are now HIV-positive. Survey-based estimates of HIV prevalence among injecting drug users in other African countries range from 12.4 per cent in South Africa to 42.9 per cent in Kenya.[10] In Kenya, transmission attributable to injecting drug use accounted for an estimated 3.8 per cent of new HIV infections in 2006.[11] In Ghana, researchers report that injecting drug users had an estimated four per cent annual HIV-positive rate in 2008.[12] In 2007, 10 per cent of injecting drug users surveyed in the Kano region of Nigeria tested HIV-positive (Federal Ministry of Health, 2007).

Moreover, researchers predict that injecting drug use will likely be the cause of several emerging epidemics in formerly low-prevalence Muslim communities in the Middle East and North Africa–as has occurred in western China, Indonesia, Iran and Malaysia.[13]

7. *WHO, UNODC, UNAIDS Technical guide (2009)*
8. *Wolfe et al., 2010.*
9. *Beyrer C et al. 2010.*
10. *Mathers et al., 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review'. Lancet 2008; 372: 1733-1745.*
11. *UNAIDS, 2010.*
12. *Bosu et al., 2009.*
13. *Strathdee SA, Hallett TB, Bobrova N, et al. HIV and risk environment for injecting drug users: the past, present, and future. Lancet 201010.1016/S0140-6736(10)60743-X. published online July 20. PubMed*



Pakistan – Injecting drug users face an increased risk of HIV infection and death. UNAIDS, Pierre Virot, 2010

01. The magnitude of the epidemic

Double the risk and double the neglect

(Extracted and rewritten from: El-Bassel N et al. 2010)

HIV and women who use drugs

Many women who use drugs lack the power to negotiate safer sex. Nevertheless, most HIV-prevention strategies place the onus on women to insist on safe sex, which increases the likelihood of physical and sexual abuse.

Drug-involved women often rely on their partners to procure the drugs. Because women are often injected by their partners, they are "second on the needle". This increases their risk of being infected with HIV and other pathogens. Refusing to share needles and syringes means female injecting drug users risk physical and sexual intimate partner violence–which also increases the likelihood of HIV infection.

The prevalence of lifetime sexual and physical intimate partner violence among drug-involved women, particularly among crack-cocaine users, is three times higher than in women who do not use drugs. Intimate partner violence is a major risk factor for HIV infection.[14] [15] However, very few evidence-based HIV-prevention strategies address these complex interactions holistically.

Odessa, Ukraine – Women who use drugs are doubly at risk for HIV infection via unprotected sex and unsafe injections. UNAIDS. John Spaull

Reproductive health and injecting drug users

Most strategies ignore the plight of women who suffer intimate partner violence and sexual trauma, and fewer still emphasize the need for reproductive health–particularly with respect to sex workers and women who are in prison.

In many countries, pregnant drug users are unable to access HIV prevention and treatment services. Most programmes do not educate clients on the effects of drug use on pregnancy, while many women risk criminal sanctions if they continue to use drugs while pregnant.

The stigma and criminalization of drug use during pregnancy drives women to conceal their addictions from healthcare providers, which also puts their unborn infants at risk because their mothers are unable to access mother-to-child transmission prevention services.

A lack of child-care facilities or programmes makes it even more difficult for drug-dependent mothers to access the services they so desperately need. The failure to address the needs of pregnant drug-involved women will ensure that the cycle of addiction and HIV infection is passed on to the next generation.

14. *Wechsberg WM, et al., 'Substance use and sexual risk within the context of gender equality in South Africa'. Subst use misuse 2008;43: 1186-1201. CrossRef PubMed*

15. *El Bassel N, et al., 'HIV and intimate partner violence among methadone-maintained women in New York City'. Soc Sci Med 2005; 61: 171-183. Cross Ref PubMed*

01. The magnitude of the epidemic

'Problem' drug users: Stigmatization matters[16]

In September 2010,the *United Kingdom Drug Policy Commission* released a report that dealt specifically with 'problem' drug users–those who engage in injecting drug use and/or the regular long-term use of opioids, cocaine, and/or amphetamines.

The report, entitled *Sinning and sinned against: The stigmatisation of problem drug users*, concluded that drug users are so strongly stigmatised that their ability to escape addiction is compromised. This can take the form of discrimination with respect to treatment, housing, and employment. The Commission excluded "recreational" drugs, such as alcohol, cannabis, and ecstasy, but acknowledged that users of those drugs carry different stigmatising labels. "Stigmatisation matters", the Commission noted. "We feel stigma exquisitely because we are fundamentally social in our make-up."

The Commission also pointed out that the vote-catching rhetoric of the "war on drugs" or "tough on drugs" means politicians and policy makers are simply paying lip service to the compassionate "road to recovery". It advised politicians and policy makers to think more carefully before using such language, which impedes outreach efforts by naming and shaming the most vulnerable and marginalized.

The Commission also calls for the public, the health professionals–and particularly the media–to become more aware of the destructive consequences of stigmatising drug users. It also lauded former California Governor Arnold Schwarzenegger for supporting Recovery Month, an annual observance that takes place every September. The aim is to raise awareness and support the efforts of those involved with the treatment, recovery and care of drug users.

16. *Extract from: The Lancet, Volume 376, Issue 9743, Page 744, 4 September 2010*

Drug-dependent prisoners

In many countries, a substantial proportion of prisoners are drug dependent with reported incarceration rates of between 56 to 90 per cent. Threatened with such punitive measures is it any wonder that drug-dependent injecting drug users avoid public health authorities? Needless to say, this holds serious consequences both for themselves and the public at large.

Detention centres have a poor record with respect to preventing drug use and reducing harm.

People who used drugs before will continue to do so while imprisoned. They simply cannot withdraw overnight. Others will begin using drugs for the very first time–usually as way of coping with overcrowding, boredom and violence. Prisoners who inject drugs are also more likely to share equipment than individuals outside prison.[17] Unsafe sex–including sexual violence–can result in the transmission of HIV and other sexually transmitted infections.[18] [19]

Although needle and syringe programmes and substitution treatment can reduce HIV at-risk behaviour, only a few prisoners have access to these. Many are also denied drug-dependency treatment and HIV prevention information. This, despite the fact that research undertaken in Russia and China unequivocally shows that a scarcity of prevention services in prison increases the likelihood that HIV-positive prisoners will transmit the virus following release.[20] [21]

In some countries 40% of self-injecting drug users have HIV. Timo Luege/IFRC

17. *WHO, UNODC, UNAIDS. 'Interventions to address HIV in prisons: drug dependence treatments'. Evidence for Action Technical Papers. Geneva: WHO/UNODC/UNAIDS, 2007.*
18. *Taylor A, Goldberg D, Emslie J, et al. 'Outbreak of HIV infection in a Scottish prison'. BMJ 1995; 310: 289-292. PubMed*
19. *Hughes R, Huby M. 'Life in prison: perspectives of drug injectors'. Deviant Behav 2000; 21: 451-479. PubMed*
20. *Sarang A, Rhodes T, Platt L. 'Access to syringes in three Russian cities: implications for syringe distribution and coverage'. Int J Drug Policy 2008; 19 (suppl 1): S25-S36. PubMed*
21. *Cohen JE, Amon JJ. 'Health and human rights concerns of drug users in detention in Guangxi Province', China. PLoS Med 2008; 5: e234. CrossRef | PubMed*

part 2

THE CALL TO ACTION

Case study

Nikolay and Irina spend all their money on 'semechki', a home-made poppy-seed paste, the drug of choice in the drab town of Slutsk (pop. 70,000, levelled in the Second World War), two hours' drive south of the Belarusian capital, Minsk. Their families have long since kicked them out. They work, they live, they use. Sober hours are spent wishing they had never started, till the rats start scratching in their brains and the only thing they can focus on is their next 'hit'—their next 'shot'. Release is immediate: the bliss, the love… until it wears off and the 'hate-it-need-it-love-it' cycle starts up all over again.

To the casual observer, Nikolay and Irina are just another couple of junkies, human refuse floating on the post-Soviet sea of despair. But they have a purpose. Nikolay and Irina are saving lives, needle by needle. Every day, they commute to a shabby apartment crouched under the shadow of two massive chimneystacks on the edge of town and begin their work.

Each has 40 clients who inject several times a day. Nikolay and Irina bring them clean needles and take back the used needles (coated with a residue of narcotics, which, without a special agreement between the Red Cross and the police, could carry a jail term), package them for destruction and then head back out: back to the alleys and tower blocks where their fellow addicts are waiting.

"No one I work with uses a dirty needle now, but we all used to," says Nikolay. "We know what AIDS can do and we don't want to catch it." In addition to running the needle and syringe exchanges, the couple handout needles, swabs, condoms, vitamins and specially fortified chocolate bars that help nourish those who are too ill, too poor and too drug-dependent to feed themselves properly.

Nikolay and Irina know the streets, know the users, know the risks. They are trusted in a way no police, partner, parent or religious leader could ever be. That's why they go to schools and tell children what it is like to be a user: how tough, ugly and dangerous it can be. We don't say, "just say no", we say, "this is how it is. You choose".

—Joe Lowry, IFRC Budapest
Belarus: IFRC Harm Reduction Project

02. The call to action

Dealing with the problem of drug users by denying their existence, or by repression, neglect, defunding, detention or forced treatment, has not been successful.

Despite this, many governments continue to adopt discriminatory, judgemental and punitive policies and incarceration regimes. Today, the IFRC reports that patients struggling with drug dependency are still being discriminated against, their rights restricted and proven evidence-based interventions either limited or withheld altogether.

A number of Red Cross and Red Crescent National Societies–although well-placed to advocate for harm reduction in general–are still reluctant to even entertain the notion that attitudes need to change, let alone actively advocate on behalf of drug users and their human rights.

But there has been some progress. During the XVIII International AIDS Conference in Vienna (18-23 July 2010) political, civil society and development leaders from around the world, together with the Red Cross and Red Crescent, renewed commitments and pushed to secure universal access to HIV prevention, care, treatment and support–including harm reduction.

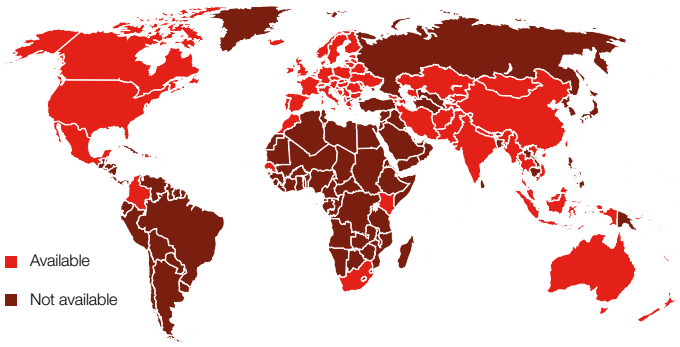
Representatives from 36 Red Cross and Red Crescent National Societies and the IFRC Secretariat acknowledged that HIV and AIDS remains one of the biggest public health crises ever to affect the lives of millions of impoverished and marginalized individuals living in low- and middle-income countries. They also committed to addressing the catastrophic situation of injecting drug users by invoking the seven fundamental principles of the International Movement of the Red Cross and Red Crescent. Three of these–humanity, impartiality and neutrality–are particularly relevant and need to be applied to the prevention, treatment, care and support of injecting drug users living with HIV.

Nevertheless, although HIV research and programming has expanded, the financial crisis means fewer resources for greater numbers of people in need of treatment. Conference participants also noted the need for greater attention to human rights and the expansion of evidence-based programming **(See page 14: What we are spending, what it will cost)**

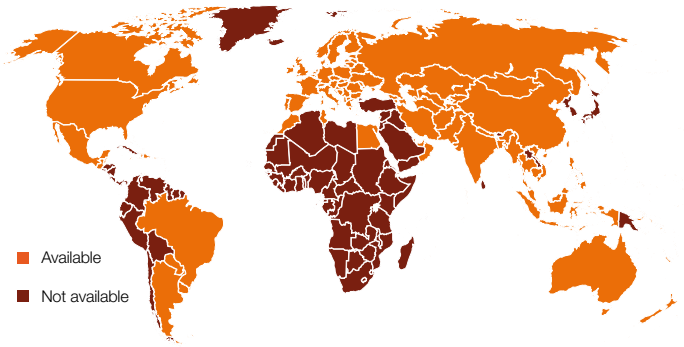
To that end the IFRC is actively supporting needle and syringe exchange programmes, drug substitution treatment, condom distribution, education and psychosocial support. These efforts need to be tailored to specific country contexts in order to have the greatest impact possible over the long-term.

The IFRC also emphasizes that scientific evidence and a humanitarian spirit should guide the response to the transmission of HIV. Injecting drug users, who routinely face harassment, stigmatization, violence and social exclusion, require not only care but compassion as well. Stigma only further marginalizes already vulnerable individuals and directly impedes efforts to halt the spread of HIV. Reducing marginalization also reduces the transmission of HIV and other infectious diseases.

Global availability of opioid substitution therapy



Global availability of needle and syringe programmes



Source: Cook, C (2010) Global State of Harm Reduction 2010 at a glance. International Harm Reduction Association, London, UK. For more information see www.ihra.net

02. The call to action

Injecting drug users and HIV transmission

Sharing and re-using contaminated injection material is the easiest and most effective way to transmit HIV and other blood-borne diseases–particularly hepatitis C. Once in the bloodstream, HIV spreads rapidly and relentlessly. When an HIV–positive injecting drug user shares a needle, transmission is pretty much 'guaranteed'. One HIV-positive drug user can transmit the virus to thousands of people, via contaminated equipment and into the general population through sexual contact with spouses and other intimate partners.

In many countries, drug users rely on sex work to support their addiction and ensure basic survival. This magnifies the risk. Many countries–particularly those in Eastern Europe and Central Asia–are reporting an epidemic that is transitioning from one heavily concentrated among drug users to one that is increasingly characterized by significant sexual transmission.[22] Moreover–if not properly diagnosed and treated–pregnant injecting drug users run the risk of transmitting the virus to their children.

22. *UNAIDS Outlook 2010: http://data.unaids.org/pub/Outlook/2010/20100713_outlook_report_web_en.pdf*

Do no harm: A public health issue

Despite the fact that injecting drug use has led to the widespread transmission of HIV worldwide, the provision of HIV prevention, treatment, and care services to IDU populations remains dismally low. In 2009, only 8 per cent of injecting drug users worldwide enjoyed access to HIV prevention services of any kind, while substitution therapy–i.e. offering users methadone instead of heroin–is permitted in only 70 countries. Needle and syringe exchange programmes are available in only 82 countries.[23]

Up until 2009, the US government–the world's leading HIV donor–steadfastly refused to fund comprehensive harm reduction programmes. In other countries–some of which have the highest proportion of injecting drug users in the world–policy-makers continue to limit the availability of clean syringes and needles and forbid methadone as a substitution therapy for people who are opiate-dependent. In Eastern Europe and Central Asia–home to an estimated 3.7 million injecting drug users–substitution therapy was only available to 3, 746 patients by 2008.[24]

The determination to criminalize and withhold services to those who are drug-dependent can lead to serious consequences–socially, economically and from a public safety perspective. Where opioid substitution therapy and needle and syringe programmes are illegal or unavailable, HIV infections can spiral rapidly out of control. In Russia, where substitution treatment is banned, HIV transmission from male injecting drug users to their female sex partners appears to be a major factor behind a spike in the numbers of newly-infected women.[25]

Although a number of countries are expanding substitution treatment–including China, Iran, Kyrgyzstan and Vietnam–poor quality of care and the continued stigmatization of clients is undermining outreach efforts. In Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine, Tajikistan, Uzbekistan, Iran, and Indonesia, injecting drug users are denied the package of essential services and receive, on average, no more than two needles per user per month.[26]

In 2008, only eight percent of opioid users were accessing substitution treatment, and only four percent of injecting drug users living with HIV were receiving antiretroviral therapy.[27]

23. *Mathers et al., 2010*
24. *UN Declaration of commitment 2007, UNAIDS PCB report 09.*
25. *Niccolai LM et al., 'The potential for bridging of HIV transmission in the Russian Federation: sex risk behaviors and HIV prevalence among drug users (DUs) and their non-DU sex partners'. J Urban Health 2009; 86 (suppl 1): 131-143. CrossRef | PubMed*
26. *UNAIDS. AIDS epidemic update.*
27. *Mathers et al., 2010*

02. The call to action

Do no harm: A human rights issue

The widespread abuse of human rights continues to fuel the HIV epidemic among injecting drug users. At stake are: the denial of harm reduction services, discriminatory medical practices–especially with respect to accessing antiretroviral treatment–abusive law enforcement, disproportionate criminal penalties, and coercive and abusive drug dependence treatment. Governments are still not adequately targeting vulnerable groups such as women and young people.

Moreover, stigma associated with both drug use and HIV infection is likely the main reason why policymakers continue to disavow the evidence and oppose harm reduction programming. In all but a handful of nations, injecting drugs is illegal. Public attitudes toward drug users are rarely anything but hostile–not only because users are engaging in an illegal activity but because such behaviour is deemed morally suspect.

Assumptions that drug users are more likely to engage in criminal and delinquent behaviour also fuel public fears, and injecting drug users are thus isolated and shunned. Stigma and fear of arrest discourage millions from contacting health and social services, no matter how great their need.

The response to HIV in people who inject drugs has been especially poor in many of the countries in which harm-reduction measures are needed most. Access to antiretroviral therapy for HIV–positive injecting drug users is also unacceptably low. Worldwide, only four out of 100 HIV–positive injecting drug users receive anti-retroviral treatment.[28]

Until the mid-1990s, human rights were rarely mentioned or discussed in the context of HIV and injecting drug use. In most countries, policies focused overwhelmingly on criminalization and the imposition of harsh penalties rather than on the public health response. Not a single provision of international human rights law names people who inject drugs, let alone identifies them as being worthy of protection. Nevertheless, existing human rights law applies to all people–regardless of whether they use drugs or not.

The right to the highest attainable standard of physical and mental health includes the right to obtain health services without fear of punishment. Policies that are likely to result in unnecessary morbidity and preventable mortality are breaches of a governmental obligation to respect the right to health. This right–as with any other–is inherently guaranteed under international law and without discrimination.

People who use drugs also have the right to life, liberty, bodily integrity, privacy, education, equality before the law, freedom of movement, assembly and association, and information. *The International Covenant on Civil and Political Rights* protects all people from arbitrary arrest or detention.

28. *Beyrer C, et al, 2010, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960928-2/fulltext*

Most targeted regions

In 2009, the *United Nations Joint Programme on AIDS (UNAIDS)* estimated that almost 40 per cent of all injecting drug users live in China, the Russian Federation and the US. However, it is in Eastern Europe and Central Asia where HIV prevalence is continuing to rise, with injecting drug use the primary route of transmission.

In Ukraine for example, researchers believe that between 38.5 and 50.3 per cent of injecting drug users are living with HIV.[29] In August 2010, researchers reported 1.3 percent of the adult population as HIV–positive–making Ukraine home to the largest numbers of those living with HIV in all of Europe and pushing it dangerously close to the status of a 'generalized' epidemic.

Injecting drug users can deposit used syringes, and get food and counselling. UNAIDS, Pierre Virot, 2010

29. *Kruglov et al, 'The most severe HIV epidemic in Europe: Ukraine's national HIV prevalence estimates for 2007', in Sex Transm Infect 2008;84:i37-i41 doi:10.1136/sti.2008.031195*

02. The call to action

India, Kohima, Nagaland – Injecting rooms provide drug users with a safe and controlled environment. Sanjit Das

HARM REDUCTION: WHAT WE ARE SPENDING, WHAT IT WILL COST

UNAIDS maintains that at USD 160 million, the spending on harm reduction in 2007 was only 7 per cent of the USD 2.13 billion that they estimated was needed for HIV prevention for drug users in 2009 and only 5 per cent of the USD 3.2 billion required in 2010–or spending on harm reduction was 14 and 20 times greater than what is currently allocated.

According to UNAIDS calculations,[30] this amounts to as little as three US cents per day per user. HIV-related harm reduction spending should instead average between USD 170 and USD 256 per injector per year. Therefore, the actual spending represents only a very small proportion of what is required. Indeed, a huge resource gap exists between what is being spent and what is needed.

Current spending on harm reduction is also disproportionately low in terms of what is currently being spent on overall HIV and AIDS programming at a negligible 1.4 per cent of the total (USD 11.3 billion).[31]

30. *85. UNAIDS (2007) Financial Resources op. cit.*
31. *Stimson G V, et al, 'Three cents a day is not enough, resourcing HIV-related harm reduction on a global basis', IHRA 2010*

part 3

RED CROSS RED CRESCENT RESPONSE

FERNANDO NUÑO/IFRC

VILLA MARAINI


VILLA MARAINI

Case study

"I started to take drugs quite young, when I was about 14 or 15 years old. They were light drugs like cannabis and alcohol, but over the years I started to take heavy drugs like heroin.

Then, to get the same effect, I had to take bigger quantities... which caused money problems, so I started to deal.

Then that little world I had created, it was so artificial and it just collapsed... I found myself in jail, having heroin withdrawal. I had even forgotten what it was, because it had been years since I had a withdrawal. When you are a drug consumer, you almost always manage not to be in need. It's then that I got to know the Villa Maraini Foundation – a joint venture of the Italian Red Cross.

I knew about methadone but I had never taken it. I talked to them and they invited me. As soon as I got out of the court, I went directly to Villa Maraini. There is also a place where you can see doctors and psychologists so you can talk to them.

I was convinced of what I wanted to do, and I was convinced that I needed help, but I was really surprised by the welcoming (attitude) of the people working there, full of humanity, smiles. You arrive there and the first thing that they ask you is if you want a coffee, if you want food. After that it took one-year-and-a half to reintegrate into society.

I was lucky that when I started this programme in Villa Maraini and the Italian Red Cross Detoxication and Harm Reduction Centre, they were thinking of creating an office for fundraising with the EU (European Union), not only in Italy but also elsewhere. I have a degree, and I speak English, so they offered me the job. I accepted instantly, because it was easier for me to stay inside than to go out. I do a job that I really like. I'm proud of what I have done... I have a new relationship with my parents, which I never had before.

I have been talking to them for years now, I mean really talking. It's paradoxical, but on the emotional side, the way I live my life everyday... I feel better, much more positive than before. Before I had to use heroin to feel positive. That's impressive and it's everyday—Everyday I am telling myself this. Basically that's it."

—Philippe Garcia, former drug addict working for the Italian Red Cross at Villa Maraini in Rome, Italy

03. Red Cross Red Crescent response

Harm reduction adopts a morally neutral stance to drug use, neither condoning nor opposing it. It focuses on the actual harm caused by injecting drugs—i.e. HIV, and hepatitis B and C infection—and operates on the assumption that some people will continue to inject drugs despite government repression.

Harm reduction also takes into account the fact that many users are drug-dependent and that addiction is exactly that: a condition that should be dealt with humanely and compassionately, as a public health issue and not as a criminal activity. Thus, if injecting drug users are to persist in their activities, they should be offered the option of doing so in a way that reduces the risks and causes the least harm to themselves and others.

When implemented properly, harm reduction offers a menu of services that also include de-toxification, rehabilitation, counselling and access to services such as health care, housing, occupational training and other social supports. For many users, harm reduction represents the only opportunity to access these vital services and often, their only contact with the public health system.

In 2002, the IFRC governing board adopted harm reduction as integral to a comprehensive AIDS policy and strategy focusing on drug users. Key to this is the implementation of a set of evidence-based and pragmatic interventions that support prevention, offer treatment, encourage social inclusion and provide assistance.

While many governments, organizations and individuals would like to see a society free of drugs, the aim of harm reduction programming lies elsewhere. Harm reduction strategies do exactly that: reduce risk and thus reduce harm.

Demand reduction is a separate strategy, which seeks to reduce the use of drugs. Harm reduction acknowledges the existence of drug use without condoning or opposing it and seeks to minimize the harm to the individual and by extension, the society as a whole.

THE HIERARCHY OF HARM REDUCTION OBJECTIVES IS:

- Enter into drug dependence treatment. Those offering long-term medications such as methadone maintenance are more effective.
- If drug dependence treatment is not an option, switch from injecting to non-injecting drug use.
- If injecting continues, always use sterile injecting equipment and do not share equipment or drug solutions.
- If it is not possible to use sterile injecting equipment clean and reuse your own equipment and do not share it.
- If sharing does occur, clean injecting equipment between each use (using bleach, for example). Do not share 'cookers', drug containers or filters used for injecting, and do not use or share water for rinsing or mixing.
- Avoid unprotected sex. Always use condoms.

PRINCIPLES BEHIND RED CROSS RED CRESCENT INVOLVEMENT IN HARM REDUCTION ACTIVITIES

(IFRC *Spreading the light of science*, 2003)

The International Red Cross and Red Crescent Movement is the largest humanitarian organization in the world. In 1919, the IFRC was established with the objective of preventing and alleviating human suffering without judgement–regardless of geographic location, socioeconomic status, ethnicity or gender.

In keeping with its mandate and based on the IFRC Strategy 2020, *Saving Lives and Changing Minds*, the IFRC advocates on behalf of injecting drug users by improving access to treatment, calling on governments to implement effective measures to reduce exposure to HIV and AIDs and promoting social inclusion.

To that end, the IFRC is "*guided by sound public health and humanitarian principles, to promote and where appropriate, facilitate, harm reduction strategies for high risk behaviours and traditional practices, including advocacy for law reform as necessary.*" This is consistent with Millennium Development Goal 6, which advocates 'halting and beginning to reverse the spread of HIV and AIDS by 2015'.

Key to this is education and awareness raising—particularly when it comes to the 50 million Red Cross and Red Crescent youth volunteers. In 2009, Red Cross and Red Crescent youth drafted a declaration in Solferino, Italy, in which they committed to: "*promote the 'right to know' about substance-related harm, by increasing peer education and community participation*" and to "*Act to eliminate stigma and discrimination associated with tuberculosis, HIV and drug use.*"

The *Declaration of the United Nations General Assembly Special Session on HIV and AIDS* (UNGASS, 2001) acknowledged the work of the IFRC as a whole, including Red Cross and Red Crescent Societies. It also made specific reference to harm reduction, drug-using behaviour, and stigma and discrimination.

In April 2002, the European Red Cross and Red Crescent Societies Conference in Berlin unanimously supported implementing harm reduction strategies as a major step forward to addressing the rapid increase in HIV infection in the region. Similarly, the *Manila Action Plan*, adopted at the Manila Conference in December 2002, requires all Red Cross and Red Crescent Societies in the Asia, Pacific and Middle East regions to develop culturally appropriate harm reduction programmes.

The IFRC Guideline *Spreading the light of science*, published in 2003, details the rationale for harm reduction programmes. It outlines generic approaches that Red Cross and Red Crescent Societies can adapt to the realities of their countries in the development and implementation of harm reduction programmes. It also supports them in how to conduct advocacy for harm reduction.

Several National Red Cross and Red Crescent Societies have already initiated harm reduction strategies in collaboration with governments and other multilateral and nongovernmental organizations. The Red Cross societies of Australia, Belarus, Croatia, Kenya, Italy, Portugal, Russia, Spain Lithuania, Latvia, Kazakhstan, Kyrgyzstan, Ukraine and Uganda are undertaking injecting drug use programmes, and the Vietnamese and Chinese Red Cross Societies are making good progress. Many other National Red Cross and Red Crescent Societies are tapping into existing networks, which can be utilized to support injecting drug users and advocate for the acceptance, introduction and maintenance of harm reduction programmes.

part 4

OBSTACLES OPPORTUNITIES

Case study

A pit stop on the heroin highway (Extracts)[32]

Deep in the industrial heartland of Urumqi city in north-west China, alongside the coal mine, the paper mill and the chemical plant, live Arkin* and his six-year-old daughter. In this bustling city of two million, appearances can be deceiving: For Arkin and his kind there is no work, not even at the coalmine, a few blocks from his door. To take the edge off the boredom and poverty Arkin started using heroin in 1993.

Heroin pours into the Xinjiang Uyghur Autonomous Region via the heroin highway from nearby Afghanistan and up from Yunnan province, near the notorious golden triangle of South-East Asia. There's a ready market among ethnic Uyghurs–a Muslim minority comprising eight of the 20 million people living in the region. An estimated eight in 10 injecting drug users are from this group.

Heroin is easy to get, but at around 50 rmb a bolaq (USD 7 a shot) it isn't cheap, particularly if the only source of income is a monthly government benefit of 150rmb. Since the first diagnosis in 1995, more than 18,206 people in Xinjiang Uyghur Autonomous Region have tested positive for HIV. About 77 percent of these are injecting drug users, according to the government health agency, the *Centre for Disease Prevention and Control* (CDC).

As Arkin's habit grew, he took to crime, and over 14 years, the drugs nearly consumed him. His relationships, his self-worth and his health all broke down. He discovered he was HIV-positive in 2001 after a free blood test at the CDC. Shocked, but incapable of giving up heroin, the best he could do was to start using clean syringes.

Arkin first learned of the Red Cross and its HIV awareness, nutrition and self-care programme on television. The Red Cross has recently conducted six self-care workshops in the neighbourhood and in the rest of Urumqi more than 380 people have attended 25 workshops, the majority of which were conducted in Uyghur language.

The Xinjiang Red Cross HIV and AIDS programme first began home visits in 2001, with funding and support from Australian Red Cross. Awareness projects are slowly finding an audience in communities around Urumqi, but Arkin, and those just like him, are still wary of revealing their drug use and HIV status for fear of discrimination.

"At the beginning, everyone ran away from me. Even children wouldn't play with my child. Now, everyone is learning what HIV is. The awareness is increasing and everyone is starting to understand," says Arkin.

One of the 38 syringe exchanges sites in Urumqi opened up around the corner a year ago, and the methadone clinic opened six months ago. Today, there are four. Arkin says methadone is good medicine. He's now clean, living a normal life and seeing the world through different eyes.

Now that he's off heroin, it's easier for Arkin to find the money to pay for the nutritious food and to care for his family. "It is good that I found out about the Red Cross so I can stay healthy," he says. "The Red Cross rescued me, it saved me, taught me how to eat good food and stay safe."

—Xinjiang Uyghur Autonomous Region: Red Cross Society of China Harm Reduction Project with support from Kelly Chandler, Australian Red Cross

32. *http://www.redcross.org.au/ourservices_aroundtheworld_development-programs_ntheastasia_china_HIV_feature1.htm*

04. Obstacles and opportunities

Tackling HIV and AIDS is a shared responsibility–no single donor, government, multilateral institution or NGO can overcome it alone. Partnership is critical and so too is innovation and imagination. Nevertheless, the global financial crisis means the donor climate is changing rapidly and is threatening to derail more than two decades of progress.

According to a new report by UNAIDS, UNICEF and WHO (September 2010) a global funding shortage means the achievement of universal access to prevention, treatment and care is extremely unlikely. Although the Millennium Development Goals deadline is in 2015, it is becoming increasingly apparent that Goal 6–halting and reversing HIV transmission–will likewise be missed.

In 2009, 70 Red Cross and Red Crescent Societies managed to mobilize 36 million Swiss francs for the implementation of HIV and AIDS programmes–22 per cent less than funds raised in 2008. This shortfall is likely due to the global financial crisis. Globally, UNAIDS estimates the funding shortfall for the overall HIV and AIDS response to be USD 10 billion. This is affecting the implementation of many national programmes.

UNAIDS

We can do more and better

Red Cross Red Crescent should:

- Strengthen the technical and management capacities of staff and volunteers to enable them to implement effective programmes.
- Develop, implement and expand comprehensive HIV programmes including harm reduction strategies targeting at-risk populations, including prisoners.
- Promote dialogue with the aim of persuading governments to develop and establish supportive policies and legal frameworks through discussions with key community members and other stakeholders. The aim is to encourage them to observe and respect human rights and promote and implement harm reduction programmes targeting injecting drug users
- Use public forums—and in particular—the mass media to explain what harm reduction programmes are, their benefits, their underlying rationale and cost effectiveness.
- Disseminate information through the media to the general public about harm reduction programmes during national, regional or global events such as conferences or special days—i.e. World AIDS Day, World Red Cross and Red Crescent Day etc.

In order to support Red Cross and Red Crescent Societies to implement harm reduction activities, the IFRC will pursue its humanitarian diplomacy efforts to raise awareness and try to change the mindset of relevant stakeholders with regard to harm reduction.

The way forward

For the Red Cross and Red Crescent, universal access to treatment and respect for human rights means doing everything we can to give a voice to the voiceless–i.e. providing drug users living with, and at risk of, HIV with an opportunity to raise their concerns with governments and donors and to participate in decision-making and policy debate.

The IFRC, working closely with civil society organisations, international organizations, and donors, is committed to encouraging governments to develop supportive, evidence-based policies and harm reduction practices that are in conformity with public health humanitarian and human rights rationales.

Harm reduction is pragmatic, cost-effective and evidence-based.

From a public health perspective, it safeguards the well-being of drug users by allowing them to minimize harm to themselves and others by offering a menu of services–i.e. needle and syringes exchange, opioid substitution and condoms, education, nutrition and vocational training–designed to halt HIV transmission. It also provides users with the treatment necessary to maintain their health and to reduce viral load to the point where they cannot transmit the virus to others.

As we noted earlier, from a humanitarian perspective, repressive laws that imprison and harass drug users merely serve to drive them away from health and social support services. This not only violates humanitarian principles and human rights legislation, but makes providing HIV prevention, treatment, care and support all but impossible and exposes the general population to more harm.

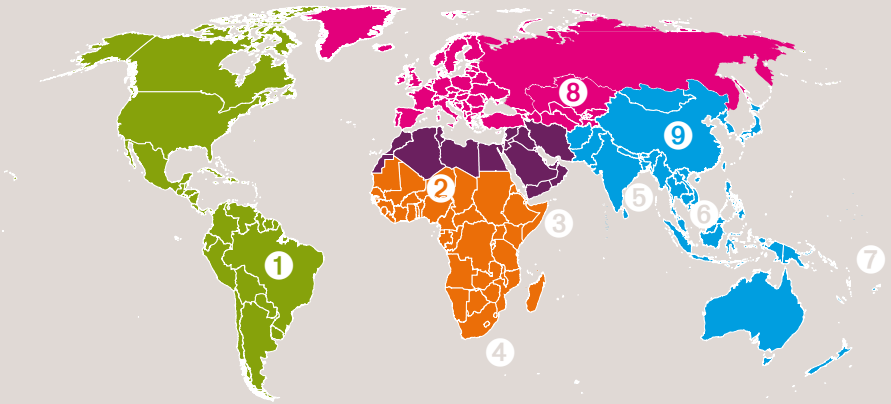
Changing policies and reforming the justice system are central to harm reduction. Injecting drug use should not be seen as a criminal act but as a major public health issue. The IFRC is calling for the decriminalisation of drug users, as well as access to due legal process and health services for those who use drugs both within, and outside detention centres.

Ultimately, the issue of harm reduction is not about breaking the law and it is not about morality. It is about respecting basic human rights so that we can prevent, treat, care and support our sisters and brothers, mothers, fathers, sons and daughters, friends and acquaintances living with drug dependencies and with HIV. By extending help and compassion to our most vulnerable and marginalized fellow human beings, we assist our communities and we assist ourselves.

annexes

THE GLOBAL ALLIANCE ON HIV

56 RED CROSS AND RED CRESCENT SOCIETIES HAVE DEVELOPED GLOBAL ALLIANCE HIV PROGRAMME DOCUMENTS



On World AIDS Day 2006 (01 December), the Federation Secretariat launched the Global Alliance on HIV in order to more effectively address the challenges posed by HIV and AIDS. Based on a conventional public health approach, it provides a mechanism for the development and implementation of Federation-wide, standardized and comprehensive HIV programmes.

1	2	3	4	5	7	8	9
Argentina	Burkina Faso	Ethiopia	Angola	Bangladesh	Cook Islands	Armenia	China
Belize	Central African Republic	Djibouti	Botswana	India	Kiribati	Belarus	Mongolia
Colombia	Democratic Republic of Congo	Kenya	Lesotho	Nepal	Micronesia	Kazakhstan	
Ecuador	Guinea	Madagascar	Malawi	Sri Lanka	Samoa	Russia	
El Salvador	Nigeria	Rwanda	Mozambique	6		Ukraine	
Guatemala		Somalia	Namibia	Cambodia		Uzbekistan	
Guyana		Sudan	South Africa	Indonesia		Kyrgyzstan	
Haiti		Tanzania	Swaziland	Myanmar			
Honduras		Uganda	Zambia	Philippines			
Jamaica			Zimbabwe	Laos			

Chart indicating National Societies active in HIV programming in 2009

In 2009, a total of 18, 644,009 persons including IDU's were reached with prevention messages and received psycho-social support. 119,370 volunteers were empowered and engaged in HIV interventions, investing 17,5 million volunteer hours to deliver services.

HIV programme performance by Red Cross and Red Crescent societies globally in 2008

Service rendered	Africa 31 NSs	Middle East 3 NSs	Asia 14 NSs	Americas 10 NSs	Europe 8 NSs	Pacific 4 NSs	Global total 70NSs
Number of people reached with prevention messages	9,079,764	59,985	7,284,135	1,439,991	433,458	63,800	18,361,133
Number of PLHIV supported	125,616	16	15,148	4090	2,822	8	147,700
Number of orphans supported	131,054	-	2,775	843	504	-	135,176
Total population reached and served	9,336,434	60,001	7,302,058	1,444,924	436,784	63,808	18,644,009
No of volunteers trained and engaged in the work	17,479	213	95,882	3052	2,643	101	119,370
Volunteer hours mobilized for action in a year	10,440,768	116,668	5,784,844	612,908	585,024	32,712	17,572,924
% of NS staff participating in work place programs	23.5% (average)	7% (average)	9.2% (average)	-	12% (average)	-	
Resource mobilized for HIV programme in CHF	26,308,581	665,366	4,597,144	2,057,944	2,086,575	402,366	36,117,976

XVIII International AIDS conference
Vienna Federation satellite meeting

Expression of commitment

On the eve of the 18th International AIDS Conference we, the representatives from 36 National Societies and the Secretariat of the International Federation of Red Cross and Red Crescent Societies, acknowledge that the HIV epidemic remains one of the biggest public health problems in low and middle income countries affecting the lives of millions of poor and marginalized populations.

During two days of meetings in Vienna on the 17th and 18th of July 2010, we developed better insight on the global magnitude of injecting drug use and its role in the transmission of HIV, as well as the devastating impact of TB as the main cause of increased mortality among people living with HIV and AIDS. Similarly, we found useful the experience shared and lessons learned on the implementation of comprehensive HIV programmes within the framework of the Federation Global Alliance on HIV in 56 countries around the world. The findings of the midterm evaluation of the comprehensive HIV programmes implemented in the last three years in southern Africa are helpful for improving our programming, expediting management and enabling us to do better and reach more.

We renew our commitment to:

1) Reach more people with information on prevention using appropriate strategies.
2) Do better and further scale up efforts to reach out to more people in need of care and support.
3) Continue using the Global Alliance approach for designing comprehensive HIV and TB programmes while refining it from lessons learned.
4) Make the utmost efforts to scale–up programme implementation and support the efforts of governments in rolling out antiretroviral therapy through enhancing adherence to treatment and by providing psychosocial support to people infected and affected by HIV and TB.
5) Scale up harm reduction programmes related to injecting drug use in countries where the problem is prevalent.
6) Exert all possible efforts to systematically integrate TB and HIV programmes at service delivery levels and support Planning, Monitoring, Evaluation and Reporting.
7) Work actively to support National Societies to enable them access resources at the country level. In addition, to make all possible efforts to mobilize resources at regional and global levels.
8) Ensure workplace programmes are developed.
9) Finally, we admire the important role played by members of the RCRC+ Network in promoting awareness and fighting stigma and discrimination within National Societies and commit ourselves to support their efforts in all possible ways.

We are happy that HIV is well captured as a priority agenda in Federation Strategy 2020 and we encourage the Federation Secretariat to continue strengthening efforts for addressing the challenges of HIV and TB. Moreover, Federation Secretariat must support and encourage all National Societies to report programme delivery through Secretariat zone offices in accordance to the set time frame.

Global State of Harm Reduction 2010
At A Glance

Guide to Reading the Table

This table lists the countries and territories around the world that support harm reduction in policy or practice. Please note that inclusion in this table does not indicate the scope, quality or coverage of services.

It is also important to recognise that the explicit supportive reference to harm reduction in national policy may not necessarily equate to the existence of quality and high coverage services.

Furthermore, in many countries harm reduction services, Needle and syringe programmes (NSP) in particular, are NGO-driven and may be operating without government support.

Explicit supportive reference to harm reduction in national policy documents: Countries and territories which have an explicit reference to harm reduction in national health or drug-related policy.

Needle and syringe exchange programmes (NSP) operational: Countries and territories which have one or more operational NSP sites.

Opioid substitution therapy programmes (OST) operational: Countries and territories which have one or more sites which provide opioid substitution therapy as maintenance (not for detoxification only).

Drug consumption rooms: Countries and territories which have one or more operational drug consumption rooms (or safer injecting facilities)

Needle exchange in prisons: Countries and territories which have one or more prisons with operational NSP.

Opioid substitution therapy in prisons: Countries and territories which have one or more prisons with opioid substitution therapy as maintenance (not for detoxification only)

Country or territory (93)	Explicit supportive reference to harm reduction in national policy documents (79)	Needle and syringe exchange programmes operational (82)	Opioid substitution therapy programmes operational (73)	Drug consumption rooms (8)	Needle exchange in prisons (10)	Opioid substitution therapy in prisons (39)
ASIA						
Afghanistan	✓	✓	✓			
Bangladesh	✓	✓	✓			
Cambodia	✓	✓				
China	✓	✓	✓			
Hong Kong	✓		✓			
India	✓	✓	✓			✓
Indonesia	✓	✓	✓			✓
PDR Laos	✓					
Malaysia	✓	✓	✓			✓
Maldives			✓			
Mongolia		✓				
Myanmar	✓	✓	✓			
Nepal	✓	✓	✓			
Pakistan	✓	✓				
Philippines	✓	✓				
Taiwan	✓	✓	✓			
Thailand	✓	✓	✓			
Vietnam	✓	✓	✓			
CARIBBEAN						
Puerto Rico		✓	✓			✓
Trinidad and Tobago	✓					
CENTRAL AND EASTERN EUROPE AND CENTRAL ASIA						
Albania	✓	✓	✓			✓
Armenia	✓	✓	✓		✓	
Azerbaijan		✓	✓			
Belarus	✓	✓	✓		✓	
Bosnia and Herzegovina	✓	✓	✓			
Bulgaria	✓	✓	✓			
Croatia	✓	✓	✓			✓
Czech Republic	✓	✓	✓			✓
Estonia	✓	✓	✓			
Georgia	✓	✓	✓			✓
Hungary	✓	✓	✓			✓
Kazakhstan	✓	✓	✓			
Kosovo		✓				
Kyrgyzstan	✓	✓	✓		✓	
Latvia	✓	✓	✓			
Lithuania	✓	✓	✓			
Macedonia FYR	✓	✓	✓			✓
Moldova	✓	✓	✓		✓	✓
Montenegro	✓	✓	✓			✓
Poland	✓	✓	✓			✓
Romania	✓	✓	✓		✓	✓
Russia		✓				
Serbia	✓	✓	✓			✓
Slovakia	✓	✓	✓			
Slovenia	✓	✓	✓			✓
Tajikistan	✓	✓	✓			
Turkmenistan		✓				
Ukraine	✓	✓	✓			
Uzbekistan	✓	✓				

Country or territory (93)	Explicit supportive reference to harm reduction in national policy documents (79)	Needle and syringe exchange programmes operational (82)	Opioid substitution therapy programmes operational (73)	Drug consumption rooms (8)	Needle exchange in prisons (10)	Opioid substitution therapy in prisons (39)
LATIN AMERICA						
Argentina	✓	✓				
Brazil	✓	✓				
Colombia	✓		✓			
Mexico	✓	✓	✓			
Paraguay	✓	✓				
Uruguay	✓	✓				
MIDDLE EAST and NORTH AFRICA						
Egypt		✓				
Iran	✓	✓	✓		✓	✓
Israel	✓	✓	✓			
Lebanon	✓	✓	✓			
Morocco	✓	✓	✓			
Oman		✓				
Palestine		✓				
Tunisia		✓				
NORTH AMERICA						
Canada	✓	✓	✓	✓		✓
United States	✓	✓	✓			✓
OCEANIA						
Australia	✓	✓	✓	✓		✓
New Zealand	✓	✓	✓			✓
SUB-SAHARAN AFRICA						
Kenya	✓		✓			
Mauritius	✓	✓	✓			✓
Senegal			✓			
Seychelles						
South Africa			✓			
Tanzania	✓					
Zanzibar	✓					
WESTERN EUROPE						
Austria	✓	✓	✓			✓
Belgium	✓	✓	✓			✓
Cyprus	✓	✓	✓			
Denmark	✓	✓	✓			✓
Finland	✓	✓	✓			✓
France	✓	✓	✓			✓
Germany	✓	✓	✓	✓	✓	✓
Greece	✓	✓	✓			
Iceland			✓			
Ireland	✓	✓	✓			✓
Italy	✓	✓	✓			✓
Luxembourg	✓	✓	✓	✓	✓	✓
Malta	✓	✓	✓			✓
Netherlands	✓	✓	✓	✓		✓
Norway	✓	✓	✓	✓		✓
Portugal	✓	✓	✓		✓	✓
Spain	✓	✓	✓	✓	✓	✓
Sweden	✓	✓	✓			✓
Switzerland	✓	✓	✓	✓	✓	✓
United Kingdom	✓	✓	✓			✓

Source: Cook, C (2010) Global State of Harm Reduction 2010 at a glance. International Harm Reduction Association, London, UK. For more information see www.ihra.net

The Fundamental Principles

International Red Cross and Red Crescent Movement

Humanity
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality
In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service
It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity
There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality
The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

Out of harm's way

Injecting drug users and harm reduction

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Cover photo: *Lithuania – At the Vilnius Centre, social workers, rather than doctors, manage the patients' files. This frees up doctors to focus on treating patients, while social workers use their expertise to connect patients with appropriate health services. Patients can also take advantage of vocational training and a host of other municipal services.*

www.ifrc.org
Saving lives, changing minds.

International Federation
of Red Cross and Red Crescent Societies