

# Syringe exchange programs around the world: The global context



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## I. Introduction and Overview

Injection drug use is a dangerously effective—and increasingly prevalent—means for spreading blood-borne viruses such as Human Immunodeficiency Virus (HIV); indeed, risky injection practices like needle sharing can easily result in transferring HIV directly from the bloodstream of one intravenous/injection drug user (IDU) to that of another.<sup>1</sup> Consequently, as injection drug use has become more widespread throughout the globe in the last three decades, needle sharing has become a significant factor in fueling the HIV/AIDS epidemic.<sup>2</sup>

In the late 1980s and early 1990s, countries began implementing harm reduction programs to reduce the spread of HIV infections among IDUs.<sup>3</sup> One of the key elements of these programs was the development of needle exchange programs or syringe exchange programs (SEPs)—outlets where IDUs could safely dispose of used needles and obtain sterile injecting equipment.<sup>4</sup> As of 2008, there were at least 77 countries worldwide that had introduced SEPs to curb the spread of HIV/AIDS.<sup>5</sup>

As the U.S. Congress considers repealing the ban on using federal funds to support SEPs in the United States, this paper examines the global context for this effective HIV prevention technique. Section I surveys global rates of injection drug use and HIV infection and discusses the development of SEPs as a mechanism to reduce HIV infections among IDUs. Section II contains a region-by-region analysis of SEP development, discusses the challenges that certain countries have faced in implementing effective SEPs and analyzes countries' efforts to establish SEPs, formulating general recommendations on establishing an

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<sup>1</sup> INT'L HARM REDUCTION ASS'N, GLOBAL STATE OF HARM REDUCTION 2008: MAPPING THE RESPONSE TO DRUG-RELATED HIV AND HEPATITIS C EPIDEMICS 12 (2008), <http://www.ihra.net/Assets/1396/1/GSHRFullReport1.pdf> [hereinafter IHRA, GLOBAL STATE OF HARM REDUCTION 2008].

<sup>2</sup> *See id.* at 10.

<sup>3</sup> *See* discussion *infra* Sections II.B (Asia) and II.C (Australia and New Zealand).

<sup>4</sup> While differences exist between these two types of programs, the term SEP will be used throughout this paper for internal consistency.

<sup>5</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 10, 15 (providing a chart identifying countries worldwide with SEPs).

effective system of SEPs.<sup>6</sup> Section III then discusses those recommendations, emphasizing the ways in which the United States may tailor a domestic SEP to best serve the IDU population by drawing on lessons learned from SEPs worldwide. In particular, this paper highlights five policy lessons from the review of global SEPs: (1) SEPs are most often community-based programs supported by governmental funds and regulatory oversight, with this support and oversight playing a critical role in the success of any SEP; (2) governments should flexibly structure SEPs to meet national goals as well as the particular needs of domestic IDUs; (3) laws may be tailored to regulate and legalize SEPs, without legalizing drug use or possession; (4) social and religious mores disapproving of drug use do not preclude SEPs from operating effectively; and (5) SEPs can promote rehabilitation and actually reduce incidences of injection drug use.

#### **A. Injection Drug Use and the Development of SEPs**

Prior to 1970, widespread injection of drugs, such as cocaine and heroin, took place primarily in North America and Europe.<sup>7</sup> By 1992, however, injection drug use had spread to 80 countries and territories, and to 121 countries and territories by 1995.<sup>8</sup> By 2008, researchers located 158 countries and territories worldwide with evidence of injection drug use.<sup>9</sup> From the data available, researchers estimate that in 2008, there were 11.6 million IDUs worldwide, down

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<sup>6</sup> This paper provides an overview of how global regions have implemented SEPs, and in so doing, it derives lessons that may be of use to the United States in implementing its own program. Where scientific studies have been performed on SEP effectiveness, the paper attempts to document those studies, but it is by no means exhaustive. Because there are varying amounts and qualities of data demonstrating the effectiveness of SEPs, this paper does not aim to compare the effectiveness of individual country programs as a numerical matter.

It should also be noted that this paper focuses squarely on SEPs and their effectiveness in preventing HIV infections. While SEPs have also been proven effective against the spread of other blood-borne diseases, this paper focuses on HIV, both because the spread of HIV has motivated the creation of SEPs generally and because less data exists on how effectively SEPs have curbed the spread of other blood-borne diseases. Much as this paper focuses on HIV to the exclusion of other viruses, it also focuses on SEPs to the exclusion of other harm reduction measures, such as opioid substitution therapy or methadone maintenance treatment.

<sup>7</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 10.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.* Another 2008 study estimated that there was evidence of injection drug use in 148 countries worldwide. Mathers et al., *Global Epidemiology of Injecting Drug Use and HIV among People who Inject Drugs: A Systematic Review*, 372 THE LANCET 1733 at \*4 (2008). However, it is difficult to pinpoint the precise number of countries where injection drugs are used because data on injection drug use is not available in many countries—particularly countries located throughout Africa, Latin America and the Caribbean. *Id.* at \*1, \*4.

from a 2004 estimate of 13.2 million.<sup>10</sup> Of this population, estimates suggest that 3.3 million, or more than one quarter of the worldwide population of IDUs, has HIV or AIDS.<sup>11</sup>

Countries first began responding to the spread of HIV through injection drug use in the mid-1980s, when nations determined that they could prevent the further outbreak and spread of HIV by promoting safer injection practices among IDUs. In 1984, IDUs in the Netherlands established the first SEP,<sup>12</sup> and in 1987, the government of New Zealand established the first national SEP.<sup>13</sup> Governments worldwide began to develop SEPs in the 1990s and the early 2000s, largely through the help of community-based nongovernmental organizations (NGOs) and the support of the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC).<sup>14</sup> Some countries, such as Mauritius and Paraguay, have introduced smaller-scale SEPs to combat HIV only in the last several years.<sup>15</sup>

Today, there are at least 77 countries and territories that provide some form of sterile syringe and/or needle distribution.<sup>16</sup> These countries operate many different kinds of SEPs, with varying structures and aims. Some countries, such as Australia and Brazil, operate SEPs with comprehensive services, such as needle exchange (both disposal of used needles and distribution of sterile needles), distribution of injection supplies such as alcohol and swabs, and referrals for

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<sup>10</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 12. The Mathers study provides a slightly larger range of IDUs worldwide, 11 million to 21.2 million, and a higher mid-range estimate of 15.9 million IDUs worldwide. Mathers et al., *supra* note 9, at \*1, \*4.

<sup>11</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 12; *cf.* Mathers et al., *supra* note 9, at \*1, \*4 (estimating a range of 0.8 million to 6.6 million, with a mid-range estimate of 3.0 million IDUs infected with HIV).

<sup>12</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 10.

<sup>13</sup> History, New Zealand Needle Exchange Programme, <http://www.needle.co.nz/fastpage/fpengine.php/templateid/5>.

<sup>14</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 14, 16.

<sup>15</sup> Nasseem Ackbarally, *Mauritius Starts Needle Exchange Program to Stem AIDS*, THE BODY, Mar. 7, 2007, <http://www.thebody.com/content/news/art40199.html> (Mauritius); *Harm Reduction in Paraguay*, INTERCAMBIANDO NO. 6 (Intercambios), June 2004, <http://www.intercambios.org.ar/english/boletin/intercambiando6.htm> (Paraguay).

<sup>16</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 10.

medical and social services.<sup>17</sup> Those countries with the most sophisticated programs, such as Australia and New Zealand, also have syringe vending machines that permit IDUs to obtain clean needles day or night.<sup>18</sup> Some countries, such as India and Ukraine, have mobile services whereby volunteers travel directly to IDUs in order to exchange or distribute sterile needles and/or injecting equipment.<sup>19</sup> Other countries, such as China, France, Kyrgyzstan, Slovenia, as well as Ukraine, perform needle exchange at least in part through pharmacy-based SEPs.<sup>20</sup> Depending upon the nature of their SEPs, countries may use needle exchange services to promote cessation of drug use, or, as with a vending machine or pharmacy-based SEP, they may simply seek to contain HIV infection without directly reducing the overall incidence of drug use.

Funding and oversight arrangements for SEPs vary widely from country to country, but typically SEPs involve some degree of regulatory oversight by the government, coupled with community-implemented programs.<sup>21</sup> In addition, the success of SEPs is affected by whether needle exchange services are fee-based or provided free-of-charge. A recent study in New Zealand, for example, hypothesized that Australia had achieved a significantly higher rate of needle

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<sup>17</sup> KATE DOLAN ET AL., AUSTRALIAN DEP'T OF HEALTH AND AGEING, NEEDLE & SYRINGE PROGRAMS: A REVIEW OF THE EVIDENCE 10-11 (2005), <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-needle-syringe-kit-cnt.htm> (follow "Needle and Syringe Program: A review of the evidence"); Waleska Teixeira Caiaffa et al., *Practices Surrounding Syringe Acquisition and Disposal: Effects of Syringe Exchange Programmes from Different Brazilian Regions—the AjUDE-Brasil II Project*, 14 INT'L J. DRUG POL'Y 365, 369 (2003).

<sup>18</sup> DOLAN ET AL., *supra* note 17, at 11; Press Release, New Zealand Ministry of Health, Needle and Syringe Exchange Programme Saves Lives (Dec. 20, 2002), *available at* <http://www.beehive.govt.nz/node/15790>.

<sup>19</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, LEGAL AND POLICY CONCERNS RELATED TO IDU HARM REDUCTION IN SAARC COUNTRIES 70 (2007) (discussing India); IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 38 (discussing Ukraine). As will be discussed later in this paper, this strategy helps to overcome one of the largest obstacles to successful SEPs—access to SEP services.

<sup>20</sup> Sheena G. Sullivan & Zunyou Wu, *Rapid Scale Up of Harm Reduction in China*, 18 INT'L J. DRUG POL'Y 118, 123 (2006) (discussing China); IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 38, 51 (discussing Kyrgyzstan, Slovenia, Ukraine and France).

<sup>21</sup> *See, e.g.*, IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 38-39, 43 (discussing financial, regulatory and operational controls throughout Eastern Europe and Eurasia).

exchange because Australia's SEPs are available gratis, while New Zealand's SEP charges a nominal \$1.00 fee to IDUs for clean needles.<sup>22</sup>

Beyond SEPs, it is possible for individuals in many countries to legally purchase sterile injecting equipment directly from pharmacies. Unlike pharmacy-based SEPs, pharmacies that simply sell needles do not also provide needle disposal services; however, IDUs may, in theory, purchase clean needles for injection drug use independent of whether the country has established or allows the operation of SEPs.<sup>23</sup>

## **B. Current Trends: Drug Use, HIV Infections and SEPs**

SEPs, where they exist, have proven effective in reducing rates of HIV infection among IDUs. One study in India suggested that SEPs had contributed to a reduction in HIV seroprevalence among IDUs from 80.7% to 58% over a three-year period.<sup>24</sup> The Australian Ministry of Health projected that its SEPs had prevented approximately 25,000 HIV infections among IDUs by 2000, and reported that in cities with SEPs, HIV infection rates fell by 8.1% annually, while in cities without SEPs, HIV infection rates increased by 18.6% annually.<sup>25</sup> Brazil reported a 62% reduction in HIV infection rates among IDUs after implementing a harm reduction program that included SEPs.<sup>26</sup> UNAIDS has reported that HIV

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<sup>22</sup> What's New: Questions and Answers regarding the Needle and Syringe Exchange Programme and One-for-One Exchange, New Zealand Needle Exchange Programme, <http://www.needle.co.nz/fastpage/fpengine.php/templateid/26> (noting that Australia's free-of-charge SEPs provide equipment for 27% of annual injection incidents while New Zealand's fee-based system covers 10-11% of such incidents).

<sup>23</sup> See, e.g., IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27, 102, 112 (referencing Afghanistan, Bangladesh, the Republic of Korea, Malaysia, Myanmar, Taiwan, Thailand, Vietnam, Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, Syria, Angola, Botswana, Burkina Faso, Kenya, Lesotho, Malawi, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania and Uganda).

<sup>24</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 71.

<sup>25</sup> HEALTH OUTCOMES INT'L, RETURN ON INVESTMENT IN NEEDLE & SYRINGE PROGRAMS IN AUSTRALIA 14, 29 (2002), <http://www.drugpolicy.org/docUploads/ROIfinal.pdf> (see Table 2.1).

<sup>26</sup> Ministry of Health of Brazil, Declaration by the Brazilian Government on Harm Reduction as a Public Health Strategy, Presented at the United Nations Economic and Social Council 49th Session of the Commission on Narcotic Drugs (Mar. 15, 2006), <http://www.aids.gov.br> (follow "Documents and Publications," "Documents Search," keyword "declaration harm reduction").



infection rates throughout Western Europe have fallen, in part as a result of harm reduction programs such as SEPs.<sup>27</sup>

Recent studies conducted in Asia, Sub-Saharan Africa, and Central and Eastern Europe suggest that injection drug use may be increasing worldwide.<sup>28</sup> In 2008, the International Harm Reduction Association (IHRA) reported that 10% of new HIV infections worldwide are the result of unsafe injection practices.<sup>29</sup> However, while injection drug use is on the rise, fewer than 5% of IDUs worldwide have access to harm reduction services such as SEPs.<sup>30</sup> Indeed, numerous geographic regions have very few SEPs to service their IDU populations: the Middle East, Central and South America, the Caribbean and Sub-Saharan Africa, in particular, tend to have few countries that have organized or allow for the operation of SEPs.<sup>31</sup>

In some countries where even limited harm reduction services are available, particularly throughout Africa, IDUs are largely ignorant of the dangers of sharing needles.<sup>32</sup> Many countries' penal codes still criminalize the possession of injecting equipment for illegal drug use, thus deterring IDUs from admitting their drug use to social workers and preventing social workers from distributing clean needles.<sup>33</sup> Even where possession of injecting equipment is not a crime,

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<sup>27</sup> EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, ANNUAL REPORT 2008: THE STATE OF THE DRUGS PROBLEM IN EUROPE 78 (2008), [http://www.emcdda.europa.eu/attachements.cfm/att\\_64227\\_EN\\_EMCD\\_DA\\_AR08\\_en.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_64227_EN_EMCD_DA_AR08_en.pdf) [hereinafter EMCDDA, ANNUAL REPORT 2008]; JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, AIDS EPIDEMIC UPDATE 33-34 (2007), [http://data.unaids.org/pub/EPISlides/2007/2007\\_epiupdate\\_en.pdf](http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf) [hereinafter UNAIDS, AIDS EPIDEMIC UPDATE].

<sup>28</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 12.

<sup>29</sup> *Id.* at 3.

<sup>30</sup> *Id.*

<sup>31</sup> *See id.* at 15-16 (providing charts detailing the paucity of SEPs in these regions). Notably, many of the countries without SEPs are also the same countries that have not produced national estimates of an IDU population or the occurrence of HIV infection among IDUs—a fact that makes it difficult to compare their HIV infection rates with those of countries that *have* created SEPs.

<sup>32</sup> *See, e.g., id.* at 27, 101, 111, 113 (referencing low awareness of safe injection practices in Asia, North Africa, the Middle East and Sub-Saharan Africa as a barrier to effective SEP functioning).

<sup>33</sup> *See, e.g., id.* at 27 (referencing the Philippines and Sri Lanka), *id.* at 80 (discussing the United States); Narcotic Drugs and Psychotropic Substances Control Act, Act No. 4 at Section 5(1)(4) (1994, as amended Mar. 9, 2006) (Kenya); Narcotic Drugs and Psychotropic Substances Act, Act No. 37 at Section 15 (Aug. 26, 1993) (Zambia).

such as in Brazil, IDUs may avoid SEPs for fear of police harassment or arrest.<sup>34</sup> Moreover, IDUs worldwide frequently report that IDUs experience stigma or discrimination from pharmacists and healthcare workers which prevent them from being able to access clean needles.<sup>35</sup> Perhaps most importantly, countries with little funding for SEPs or little governmental support to provide services for IDUs are unlikely to prioritize the development of SEPs in the fight against HIV/AIDS.<sup>36</sup>

## II. Analysis of Syringe Exchange Programs on a Region-by-Region Basis

### A. Africa

#### 1. North Africa and the Middle East

##### *Levels of Injection Drug Use and Current Trends*

With an estimated 185,000 IDUs, Iran has the highest number of IDUs of any country in the Middle East and North Africa.<sup>37</sup> It is estimated that there are roughly 88,618 IDUs in Egypt, 40,961 IDUs in Algeria and 34,673 IDUs in Iraq.<sup>38</sup> IDUs in the Middle East and North Africa are overwhelmingly male.<sup>39</sup> Heroin is the most commonly injected drug in the region, although various other injection drugs are also used.<sup>40</sup>

Injection drug use appears to be on the rise in several countries in the region, including Kuwait, Bahrain, Egypt, Iran, Syria and Yemen.<sup>41</sup> In Egypt,

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<sup>34</sup> *Id.* at 17; Caiaffa, *supra* note 17, at 369.

<sup>35</sup> See, e.g., IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27, 69-70, 112 (discussing Nepal, South America and Sub-Saharan Africa); CANADIAN HIV/AIDS LEGAL NETWORK, INJECTION DRUG USE AND HIV/AIDS: NEEDLE EXCHANGE PROGRAMS (Info Sheet No. 9) (2005), <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=769> (discussing Canada) [hereinafter Info Sheet No. 9].

<sup>36</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 17.

<sup>37</sup> *Id.* at 99 (noting that some studies estimate the number of IDUs to be closer to 240,000).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.* at 99-100 (noting that in Oman, “it is reported that over 90% of people who inject drugs are male”).

<sup>40</sup> *Id.* (citing reports of buprenorphine, opium and benzodiazepines being injected in Iran, rare cases of barbiturates being injected in Oman, other opiates being injected in Qatar and the United Arab Emirates, and diazepam being injected in Syria).

<sup>41</sup> *Id.*

while the HIV infection rate among IDUs is relatively low, the rate of needle sharing among IDUs is very high.<sup>42</sup> In Lebanon and Morocco, evidence indicates that injection drug use is decreasing.<sup>43</sup>

### *History of SEPs and Status of Current SEPs*

The first SEPs in Iran were established in the late 1990s, bringing SEPs to the Middle East and North Africa for the first time.<sup>44</sup> Prior to 1997, Iran's strict drug policy, which emphasized "supply reduction and punishing drug use," resulted in a high level of HIV prevalence among prisoners.<sup>45</sup> However, Iran's current drug policy manages to maintain a policy of supply reduction, but complements that policy with a focus on harm reduction and treatment of IDUs.<sup>46</sup> Iran is the only country in the Middle East and North Africa to offer needle exchange services in some of its prisons.<sup>47</sup>

SEPs currently operate in six countries in the Middle East and North Africa, outside of Iran: Israel, Oman and Morocco, with smaller-scale SEPs operating in Egypt, Lebanon and Palestine.<sup>48</sup> NGOs have been in the process of developing outreach strategies for SEPs to further their expansion and development within these countries, as well as in neighboring nations.<sup>49</sup> For

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<sup>42</sup> *Egypt: Needle Sharing Rife among Drug Users*, IRIN, June 21, 2009, <http://www.irinnews.org/report.aspx?ReportID=84927> (noting concern that Egypt is "sitting on a ticking bomb").

<sup>43</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 100.

<sup>44</sup> Int'l Ctr. for Journalists, *Change from the Bottom Up*, PAYVAND, Sept. 20, 2008, <http://www.payvand.com/news/08/sep/1236.html>.

<sup>45</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 103 (stating that as many as "60% of prisoners were incarcerated due to drug convictions, and mandatory sentencing was the predominant approach.").

<sup>46</sup> *Id.* (noting that "[t]his policy change was cataly[z]ed by advocacy and evidence from successful NGO and university-led harm reduction [programs], as well as close cooperation and common understanding between key stakeholders from various government departments" and that Iran now boasts a "national harm reduction committee, which has representatives from various ministries, academic institutions and NGOs").

<sup>47</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 103 (referencing the operation of SEPs in five of the 200 adult prisons in Iran, but noting that these SEP services are rarely used).

<sup>48</sup> *Id.* at 101.

<sup>49</sup> *See id.*

example, in 2006, three Israeli cities served as hosts to pilot SEPs, while Morocco and Oman each hosted one SEP site.<sup>50</sup>

In Egypt, Iran, Iraq, Jordan, Lebanon, Morocco and Syria, sterile injecting equipment may be sold at pharmacies, but similar to the experience in other nations, stigma and criminal penalties for IDUs limit the effectiveness of this method of distribution.<sup>51</sup> The sale of sterile injecting equipment in pharmacies in Yemen is prohibited, and despite a similar ban being lifted in Oman in 2003, no pharmacy there sells injecting equipment.<sup>52</sup>

### *Obstacles to the Establishment of Effective SEPs*

One challenge to the establishment and efficiency of SEPs is the fact that drug-related offenses result in severe penalties in [the Middle East and North Africa], including the death penalty in nine countries.<sup>53</sup>

Additionally, many IDUs in the region are prevented from accessing SEPs for a variety of reasons, including “limited access due to few outlets and outreach teams, lack of awareness [among members of the IDU community] of the risks associated with sharing injecting equipment, lack of awareness of available services, inconvenience of regular attendance at services[, and] fear of becoming registered as someone who injects drugs and having this information shared with police.”<sup>54</sup>

While the NGO sector typically plays a major role in the organization and funding of SEPs in other regions, in Iran and Oman, restrictive regulations limit the extent to which NGOs and other actors may provide services.<sup>55</sup>

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<sup>50</sup> *Id.* at 102.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.* at 101 (observing that Egypt, Iran, Kuwait and Saudi Arabia have carried out executions for drug-related offenses).

<sup>54</sup> *Id.* at 101-02. “In Iran, those who are also receiving drug treatment from a Drug Intervention Centre (DIC) are given a card to show that they are accessing harm reduction services. This card can be used to protect from arrest for being an illegal ‘addict.’” *Id.* at 102.

<sup>55</sup> *Id.* at 102.

### *Spotlight on Iran*

Although Iran has the highest number of IDUs in the region, it is actively working to reduce both the number of IDUs and the transmission of HIV/AIDS within the IDU community by developing numerous addiction treatment facilities and an extensive SEP. Iran's SEP not only distinguishes itself from other countries in the Middle East and North Africa, but has been touted as a standard to which other countries should aspire. Iran's growing openness towards harm reduction strategies appears to have come just in time, as illegal drug use, including injection drug use, has been growing at a rapid pace.<sup>56</sup>

Dr. Arash Alaei is credited with developing this two-pronged approach. First, he guided Iran's institution of a nationwide SEP. Second, he oversaw the establishment of methadone treatment centers in each province.<sup>57</sup> Dr. Alaei began developing his program during a period when the Iranian government viewed HIV/AIDS and drug addiction as Western evils.<sup>58</sup> However, his work ultimately caught the attention of Iran's health minister, and by 2003, the program had expanded across Iran.<sup>59</sup> By 2006, Iran had SEPs in 67 cities as well as 57 prisons.<sup>60</sup>

Iran's support for SEPs and its current drug policy represent departures from the predominantly anti-trafficking focuses of many other nations, and reflect a shift to a profound recognition of the potential of an injection-driven HIV epidemic in the absence of a public health approach to addiction.<sup>61</sup>

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<sup>56</sup> Int'l Ctr. for Journalists, *supra* note 44; *The Age of AIDS: Iran, A Pragmatic Approach*, PBS.ORG, May 30, 2006, <http://www.pbs.org/wgbh/pages/frontline/aids/countries/ir.html> (noting that "Iran has the highest rate of drug use in the world, and more than 60 percent of HIV infections are among [IDUs].").

<sup>57</sup> David Ignatius, *In Iran, Searching for Common Ground*, WASH. POST, Sept. 6, 2006, at A15, available at <http://www.washingtonpost.com/wpdyn/content/article/2006/09/05/AR2006090501134.html> (noting that Iran's public health program in this area "looks more enlightened than what we have in America").

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> See Emran M. Razzaghi et al., *Profiles of Risk: A Qualitative Study of Injecting Drug Users in Tehran, Iran*, 3 HARM REDUCTION J. (2008), <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1431517&blobtype=pdf> (emphasis added).

Over the course of the past decade, Iran’s efforts have included: (i) the expansion of “therapeutic communities, Narcotics Anonymous, and outpatient clinics”; (ii) sponsorship of methadone and buprenorphine substitution treatment programs and support of their expansion (including enacting enabling legislation); (iii) “implementation of outreach programs and enlarging the network of existing outreach mechanisms, such as the more than sixty ‘Triangular Clinics’ that are devoted to the health concerns of high-risk individuals like sex workers and drug users”; (iv) “support of needle exchange and pharmacy-sold syringe programs to operate and vend syringes legally to [IDUs]”; and (v) piloting prison-based SEPs.<sup>62</sup> In a letter to prosecutors, Justice Minister Ayatollah Mohammad Esmail Shoshtari urged them to “ignore the current laws on the books and to defer to Iran’s Health Ministry to counter the spread of AIDS and [HCV].”<sup>63</sup> Observers have noted that “[t]he openness to many of these individual and social structural responses indicates that there is a unique window of opportunity for remarkable reduction in drug-related harm in Iran, provided that the momentum can be maintained and that rigorous evaluations are undertaken to objectively gauge effectiveness.”<sup>64</sup>

## 2. Sub-Saharan Africa

### *Levels of Injection Drug Use and Impact of SEPs on HIV Infection Rates*

Little information has been collected on injection drug use and the prevalence of HIV among IDUs in Sub-Saharan Africa.<sup>65</sup> Studies show that HIV prevalence among IDUs ranges from 22.9 to 50% in Kenya, 19.4% in South Africa, 8.9% in Nigeria and less than 1% in Zambia, and some recent studies suggest that injection drug use is increasing, particularly along the coasts.<sup>66</sup>

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<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.*

<sup>65</sup> *See id.*; Mathers et al., *supra* note 9, at \*4.

<sup>66</sup> Theo Smart, *PEPFAR: HIV Prevention for Injection Drug Users in Africa a Growing Issue*, AIDS MAP, June 27, 2006, <http://www.aidsmap.com> (search title of article); Tara Carney, *An Audit of Harm Reduction Strategies to Address Drug-Related HIV and AIDS in Southern Africa*, SAHRN UPDATE (Sub-Saharan Harm Reduction Network), Sept. 2008, at 3, <http://www.ihra.net/Assets/1318/1/SAHRNUpdateNewsletter1.pdf> (also reporting that HIV prevalence among IDUs is 0-25.5% in Malawi and 5-20% in South Africa).

Mauritius, a nation of approximately 1.3 million people, has approximately 17,000 to 18,000 IDUs.<sup>67</sup> In 2006, the year that Mauritius began its SEPs, an estimated 25-50% of IDUs shared needles and 75-90% used condoms “seldom” or “never.”<sup>68</sup> This population has an unknown incidence of HIV, but a 95% incidence of HCV.<sup>69</sup>

Mauritius has not yet announced data on how its SEPs have affected HIV infection rates. Nevertheless, in 2008, Mauritius reported that its SEPs had made progress in treating IDUs, and in particular, that the HIV/AIDS Act had assisted IDUs in obtaining treatment by reducing stigma and decriminalizing the possession of injecting equipment.<sup>70</sup>

### *History of SEPs*

Among the 754 million people living in Sub-Saharan Africa, an estimated 22.5 million have HIV/AIDS. Of the 47 countries in the region, many of which are among the poorest in the world, only one—the island nation of Mauritius, off the eastern coast—operates an SEP.<sup>71</sup>

Mauritius’ implementation of an SEP in 2006 arose when it was determined that the vast majority of HIV infections were caused by injection drug use.<sup>72</sup> The Mauritian parliament enacted the HIV and AIDS Act, which established a national response to the HIV/AIDS epidemic, including creating SEPs and rehabilitation services for IDUs.<sup>73</sup> In late 2006, Mauritius opened several community-based SEPs around its capital city of Port Louis, and within several weeks the SEPs had exchanged 2,000 needles.<sup>74</sup>

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<sup>67</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 110.

<sup>68</sup> Rey Chad Abdool et al., *The Injecting Drug Use and HIV/AIDS Nexus in the Republic of Mauritius*, 5 AFRICAN J. DRUG & ALCOHOL STUD. 108, 108 (2006).

<sup>69</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 108.

<sup>70</sup> JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, NATIONAL COMPOSITE POLICY INDEX 2007, EAST AND SOUTHERN AFRICA: MAURITIUS at 13, 16 (2008), [http://data.unaids.org/pub/Report/2008/mauritius\\_2008\\_ncpi\\_en.pdf](http://data.unaids.org/pub/Report/2008/mauritius_2008_ncpi_en.pdf).

<sup>71</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 109-10, 112.

<sup>72</sup> Ackbarally, *supra* note 15 (stating that by 2005, 92% of HIV infections in Mauritius occurred due to injection drug use).

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*; Nasseem Ackbarally, *Injection Drug Use Fueling Spread of HIV in Mauritius*, MED. NEWS TODAY, Feb. 26, 2007, <http://www.medicalnewstoday.com/articles/63658.php>.

### *Status of Current SEPs*

The expansion of Mauritius' SEP has been inhibited, however, by scarce funding, limited human resources and IDUs' fear of arrest in connection with accessing services.<sup>75</sup> In addition, while legislation enacted in 2006 explicitly decriminalized needle possession,<sup>76</sup> individuals in Mauritius may still be arrested for drug possession and use.<sup>77</sup>

In practice, Mauritius' existing SEPs are operated by social workers around the capital of Port Louis.<sup>78</sup> Typically, social workers visit locations frequented by IDUs to distribute clean needles, collect used ones, educate IDUs on HIV/AIDS and encourage rehabilitation.<sup>79</sup>

It bears noting that although other countries in Sub-Saharan Africa do not fund or operate SEPs themselves, IDUs can purchase sterile injecting equipment from pharmacies in at least 13 countries in the region: Angola, Botswana, Burkina Faso, Kenya, Lesotho, Malawi, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania and Uganda.<sup>80</sup>

### *Obstacles to the Implementation of SEPs*

Sub-Saharan countries face numerous obstacles to implementing effective SEPs. Some countries, such as Kenya and Zambia, continue to classify the possession of needles for injection drug use as a crime.<sup>81</sup> Others, such as Botswana, provide the police with broad discretion to investigate drug possession, which would likely deter IDUs from visiting SEPs for fear of exposing themselves as IDUs.<sup>82</sup>

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<sup>75</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 112.

<sup>76</sup> The HIV and AIDS Act, Act No. 31 at Section 16 (Dec. 22, 2006) (Mauritius).

<sup>77</sup> The Dangerous Drugs Act, Act No. 41 at Section 34(1)(c) (Dec. 29, 2000) (Mauritius) (noting that Mauritius once criminalized needle possession in and of itself).

<sup>78</sup> Nasseem Ackbarally, *Syringes and Needles Now Part of Anti-AIDS Arsenal*, INTER PRESS SERV., Feb. 20, 2007, <http://ipsnews.net/africa/nota.asp?idnews=36646>.

<sup>79</sup> *Id.*

<sup>80</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 112.

<sup>81</sup> *See, e.g.*, Narcotic Drugs and Psychotropic Substances Control Act, Act No. 4 at Section 5(1)(4) (1994, as amended Mar. 9, 2006) (Kenya); Narcotic Drugs and Psychotropic Substances Act, Act No. 37 at Section 15 (Aug. 26, 1993) (Zambia).

<sup>82</sup> *See, e.g.*, Drugs and Related Substances Act, Act No. 18 at Section 17 (Sept. 8, 1992) (Botswana).



Still another problem is the degree to which legislatures lack the political will to prioritize creating SEPs to fight HIV/AIDS. South Africa, for example, has an estimated 16,000 IDUs, of whom 1-20% have HIV/AIDS.<sup>83</sup> Nevertheless, in 2008, when the National Assembly considered a bill to prevent and treat substance abuse, the bill's language contained not a single reference to IDUs or providing IDUs with treatment for HIV/AIDS.<sup>84</sup> Even if South Africa's National Assembly did not intend the substance abuse bill in particular as a step in the country's fight against HIV/AIDS, the National Assembly has not passed separate legislation to prevent the spread of HIV/AIDS through IDUs, demonstrating the lack of priority that South Africa has placed thus far on SEPs.

Sub-Saharan Africa also faces practical and social constraints to establishing SEPs. Many Sub-Saharan countries are very poor and politically unstable, creating an unfavorable environment for governments to create, fund and oversee the establishment of SEPs.<sup>85</sup> Moreover, these countries of few resources face an epidemic that is largely (except in Mauritius) spread by sexual contact,<sup>86</sup> and thus, countries not surprisingly choose to allocate their scarce resources more directly to the prevention of sexual transmission of HIV. Additionally, there is the problem of a lack of information concerning the risks of HIV transmission from sharing needles and IDUs are often unaware of these risks.<sup>87</sup> More generally, little information exists on injection drug use in many Sub-Saharan countries, making it difficult to tailor SEPs to meet the needs and demands of an unknown population of IDUs.<sup>88</sup> Finally, pharmacists and healthcare workers may discriminate against IDUs.<sup>89</sup>

## **B. Asia**

### ***Levels of Injection Drug Use and Current Trends***

Injection drug use has spread rapidly in Asia over the last fifty years. The development of local opiate production in Thailand and Myanmar, and the

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<sup>83</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 108.

<sup>84</sup> Prevention of and Treatment for Substance Abuse Bill, Bill No. B-12 (Proposed Section 76) (2008) (South Africa).

<sup>85</sup> See IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 109, 113 (describing the need for revised legislation and policy on SEPs).

<sup>86</sup> See *id.* at 111.

<sup>87</sup> See *id.*

<sup>88</sup> See *id.* at 113.

<sup>89</sup> See *id.* at 112.

opening of opiate export routes to China, India, Nepal, Vietnam, and more recently Cambodia and Laos, have increased access to opiates.<sup>90</sup> At the same time, as the cost effectiveness of heroin has become increasingly apparent, opiate drug users in Asia have shifted dramatically from smoking opium to injecting heroin.<sup>91</sup> While the population of IDUs is thought to be very high in many Asian countries, accurate data is extremely difficult to find. For instance, cited statistics range from estimates of 356,000 to 3.5 million IDUs in China.<sup>92</sup> IDUs are an increasing population in “at least ten countries”—Afghanistan, India, Indonesia, Japan, PDR Laos, Myanmar, Nepal, Pakistan, the Philippines and Sri Lanka—while decreasing in only two—Taiwan and Hong Kong.<sup>93</sup>

Among IDUs, HIV/AIDS prevalence is much higher than in the general population.<sup>94</sup> Indeed, it is estimated that nearly half of those living with HIV/AIDS in China were infected through injecting drugs, while more than two-thirds of those infected with HIV/AIDS in Malaysia are IDUs.<sup>95</sup> And, according to a 2008 Kaiser Family Foundation Report, in Afghanistan, Bangladesh, India, Pakistan and Vietnam, injection drug use “plays a major role in the [HIV/AIDS] epidemic[.]”<sup>96</sup> “The level of involvement in sex work among female [IDUs] is reported to be increasing, and in Guangxi [(an autonomous region of the People’s Republic of China),] it is estimated that 80% of female sex workers inject drugs.”<sup>97</sup>

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<sup>90</sup> *Id.* at 12.

<sup>91</sup> *See id.* at 24 (noting that “[i]n several countries . . . heroin is cheaper than other drugs and this appears to be contributing to an increase in its use.”). However, it should be noted that opium use, including the injection of “blackwater opium” continues at high levels in Southeast Asia, with methadone, benzodiazepines, valium, methamphetamine and cocaine, among others, used as injection drugs. *Id.* at 24-25.

<sup>92</sup> *See id.* at 25 (observing that “numbers as high as ten million have been reported in Chinese media.”).

<sup>93</sup> *See id.* at 24.

<sup>94</sup> An International Harm Reduction Association report cites a wide range of estimates of prevalence rates among IDUs: Vietnam (0-89.4%), China (0-80%), India (1.3-68.4%), Myanmar (37.1-63%), Nepal (45-60%), Thailand (20-56%), Indonesia (15-47%) and Malaysia (10-40%). *See id.* at 25.

<sup>95</sup> THE HENRY J. KAISER FOUND., HIV/AIDS POLICY FACT SHEET: THE HIV/AIDS EPIDEMIC IN ASIA 2 (2008), <http://www.kff.org/hiv/aids/upload/7825.pdf>.

<sup>96</sup> *Id.*

<sup>97</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 25 (noting that in the Philippines, injection drug use is “closely linked with the sex industry”).

### *History of SEPs*

The use of opiates as injection drugs is more widespread in Asia than in any other region in the world.<sup>98</sup> Close to one half of the IDUs in the world reside in Southeast Asia and the Western Pacific Regions,<sup>99</sup> and IDUs make up a significant number, and in some cases a majority, of the national populations currently living with HIV/AIDS.<sup>100</sup> SEPs emerged in some countries in response to this crisis, although at a pace too slow to prevent the rapid spread of HIV among IDUs in the late 1990s. China and Bangladesh, for instance, which are currently home to a significant number of SEPs, did not implement pilot SEPs until the late 1990s, well after HIV prevalence among IDUs had begun to increase dramatically.<sup>101</sup> Nepal implemented an SEP in 1991, but the program covered such a small population of IDUs that, although it was successful for those IDUs able to access it, Nepal was unable to prevent a rapid explosion of HIV infections among IDUs in the late 1990s.<sup>102</sup> Other countries have failed to implement any SEPs at all, or have SEPs that provide such minimal coverage that there is little hope of affecting HIV/AIDS prevalence.<sup>103</sup>

The response to HIV/AIDS prevalence among IDUs in Asia, while almost universally inadequate, has been extraordinarily varied. Some countries in the region, including China, have established progressive harm reduction programs including SEPs and methadone substitution therapy programs.<sup>104</sup> Other countries, like Bangladesh, tacitly accept a small presence of SEPs operated and funded by international NGOs, but ultimately stop short of officially supporting such policies.<sup>105</sup> Other countries, like Thailand, have adopted a starkly different approach, eschewing harm reduction policies in favor of stricter enforcement

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<sup>98</sup> *Id.* at 23.

<sup>99</sup> Gary Reid et al., *Harm Reduction Programmes in the Asia-Pacific Region*, 27 *DRUG & ALCOHOL REV.* 95, 96 (2008).

<sup>100</sup> *See supra* note 95 and accompanying text.

<sup>101</sup> Sullivan & Wu, *supra* note 20, at 124; LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 35-36 (2007).

<sup>102</sup> CAROL JENKINS & DAVID A. ROBALINO, WORLD BANK, *HIV/AIDS IN THE MIDDLE EAST AND NORTH AFRICA: THE COSTS OF INACTION* 6 (2003).

<sup>103</sup> *See* IHRA, *GLOBAL STATE OF HARM REDUCTION 2008*, *supra* note 1, at 27 (stating that from 2003 to 2005, Southeast Asia was the only region that reported a decrease in harm reduction coverage to IDUs).

<sup>104</sup> *See generally* Sullivan & Wu, *supra* note 20.

<sup>105</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 36-37.

through a “war on drugs.”<sup>106</sup> Finally, although enforcement practices vary, many countries prohibit and even criminalize the distribution and possession of injection paraphernalia.<sup>107</sup> These varied practices present useful case studies of the different approaches to SEPs, the obstacles faced and the impact of SEPs on HIV transmission.

### *Status of Current SEPs*

As of the date of this publication, SEPs operate in at least 13 Asian countries.<sup>108</sup> These programs vary substantially in scope, type and degree of national or international support. The most aggressive harm reduction strategy has been implemented in China, which has at least 775 fixed SEP sites in the 17 provinces that operate SEPs, funded and administered in large part by government agencies.<sup>109</sup> China plans to expand this coverage to 1,400 SEP sites.<sup>110</sup> On the other side of the spectrum, only two NGOs in Cambodia have supported pilot SEPs that provide limited needles to only a few users in Phnom Penh, despite a rising HIV/AIDS threat.<sup>111</sup> Hong Kong, despite its aggressive harm reduction strategy in the form of methadone maintenance treatment,<sup>112</sup> does not permit the operation of SEPs.<sup>113</sup>

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<sup>106</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 30.

<sup>107</sup> Philippines, Sri Lanka, Thailand, Myanmar, Malaysia, Laos, Japan, Hong Kong, Bhutan and Bangladesh. *Id.* at 27. Some of these countries, like Thailand, Malaysia and Bangladesh, have SEPs, but they operate in a “quasi-legal” environment of general nonenforcement. However, the specter of prosecution clearly discourages the growth of these SEPs. *Id.* at 27.

<sup>108</sup> Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Malaysia, Myanmar, Nepal, Pakistan, Taiwan, Thailand and Vietnam all have some form of SEP coverage. Hong Kong used to have a program run by Medecins Sans Frontieres, but this was shut down by the government. *Id.* at 27 note d.

<sup>109</sup> *Id.* at 12.

<sup>110</sup> Sullivan & Wu, *supra* note 20, at 123. Taiwan currently has 427 sites; India, 120 sites; Myanmar, 24 sites; and Nepal, 9 sites. IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27.

<sup>111</sup> MACFARLANE BURNET INST. FOR MED. RESEARCH AND PUB. HEALTH, FINAL REPORT: BASELINE ASSESSMENT OF THE CURRENT STATUS OF RESOURCES, POLICIES, AND SERVICES FOR INJECTING DRUG USE AND HIV/AIDS IN SOUTH AND SOUTH EAST ASIA, ANNEX 1: CAMBODIA 14 (2007).

<sup>112</sup> Dave Burrows, *Advocacy and Coverage of Needle Exchange Programs: Results of a Comparative Study of Harm Reduction Programs in Brazil, Bangladesh, Belarus, Ukraine, Russian Federation, and China*, 22 CADERNOS DE SAÚDE PÚBLICA 871, 872 (2006).

<sup>113</sup> Reid et al., *supra* note 99, at 96.

With some exceptions, the vast majority of funding for and implementation of SEPs in Asia comes from international NGOs that support program implementation by local organizations, mostly without government support.<sup>114</sup> CARE Bangladesh is the paradigmatic example. An international health and development aid agency, CARE Bangladesh established a pilot SEP in 1998 that has grown to reach 23 districts with “cautious acceptance” from the government.<sup>115</sup> In contrast, while roughly half of China’s SEP funding comes from international NGOs, the implementation of the program is run exclusively by the Chinese government, which imposes extremely tight restrictions on the registration of NGOs.<sup>116</sup>

SEPs in Asia also vary considerably in the type of services provided. While most SEPs use community outreach exchange programs,<sup>117</sup> SEPs in the region differ in the mode of dispensing injecting equipment. China, for instance, uses fixed locations, such as pharmacies, hospitals or designated needle exchange centers.<sup>118</sup> India, however, uses both fixed site drop-in centers and mobile vans to target more diffusely located IDUs.<sup>119</sup> In addition to clean needles, Pakistan’s drop-in centers offer comprehensive services to IDUs holding registration cards, including medical care, condom distribution, shelter and a place to bathe.<sup>120</sup> Clean needles and syringes are available to be purchased at pharmacies in Afghanistan, Bangladesh, the Republic of Korea, Malaysia, Myanmar, Taiwan, Thailand and Vietnam.<sup>121</sup>

As of 2008, there was no available evidence that any Asian country operates SEPs in its prisons.<sup>122</sup>

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<sup>114</sup> Examples include the Asian Harm Reduction Network, *Medicins du Mondes* and the International Federation of the Red Cross and Red Crescent Societies. Multilateral institutions also provide considerable support and funding to Asian harm reduction programs and SEPs. These include UNESCO, UNAIDS, the World Bank and the largest funder in developing countries, the Global Fund.

<sup>115</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 35-36.

<sup>116</sup> Sullivan & Wu, *supra* note 20, at 124.

<sup>117</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27.

<sup>118</sup> Sullivan & Wu, *supra* note 20, at 123.

<sup>119</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 70.

<sup>120</sup> *Id.* at 116.

<sup>121</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27.

<sup>122</sup> *Id.* at 29.

The majority of SEPs in Asia embrace strict one-for-one needle exchange policies to avoid creating a new market for injecting paraphernalia.<sup>123</sup> This strategy, however, necessarily decreases the potential for distribution of clean needles by requiring IDUs to visit SEPs more frequently.

### *Impact of SEPs on HIV/AIDS Prevalence*

Generally, harm reduction programs in Asia have lacked adequate coverage to have a measurable impact on HIV/AIDS prevalence. Even in China, which has seen the most rapid and widespread increase in SEP coverage, access to SEP services is only available to 7% of IDUs, and only approximately 110 needles are distributed annually per IDU—a figure well short of what is required to curb HIV/AIDS prevalence.<sup>124</sup> However, there has been some indication that SEPs have contributed to diminishing or stabilizing the risk of HIV infection in specific regions.

In India, for example, while data about the success of SEPs has not generally been comprehensive, studies in the states of Manipur and Kolkata suggest that SEPs have reduced or stabilized HIV/AIDS prevalence among IDUs.<sup>125</sup> The operation of the “Rapid Intervention and Care Project” in Manipur, which provided sterile needles and syringes over a three-year period, correlated with an HIV prevalence reduction among IDUs from 80.7% to 58%.<sup>126</sup> In Kolkata, HIV prevalence rates have stabilized after the introduction of an SEP.<sup>127</sup> Studies in China and northern Vietnam indicate that SEPs have contributed to stabilizing HIV prevalence rates over a 24-month period after their establishment.<sup>128</sup>

While we have found no data quantifying the effect of SEPs on the prevalence of HIV/AIDS in Bangladesh, studies have shown that there, too, SEPs have reduced needle-sharing behavior among IDUs.<sup>129</sup> Similarly, in Pakistan, while studies on prevalence have not been conducted, the drop-in center distribution system has led “significant numbers of [IDUs] . . . to [seek]

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<sup>123</sup> *Id.* at 36, 70.

<sup>124</sup> *Id.*

<sup>125</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 71.

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> Theodore M. Hammett et al., *Patterns of HIV Prevention Interventions in Northern Vietnam and Southern China*, 18 AIDS EDUC. & PREVENTION 97 (2006).

<sup>129</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 36.

enrollment in detoxification and drug treatment centres,” debunking the commonly held belief by those opposing SEPs that needle exchange encourages and increases drug use.<sup>130</sup> However, a report commissioned by the United Nations Office on Drugs and Crime noted that a critical evaluation of the SEP in Pakistan had never been conducted despite Pakistan’s robust SEP infrastructure. Indeed, the lack of such studies has fueled criticism of the effectiveness of SEPs in reducing prevalence without more intervention.

Nepal’s experience with SEPs, while largely unsuccessful, provides a good example of the potential of SEPs, as well as the risks associated with inadequate implementation. In the early 1990s, surveys noted the presence of a low rate of HIV/AIDS infections among IDUs.<sup>131</sup> Believing people who share needles to be a generally small and insular community with little risk of spreading viruses to non-IDUs, the Nepalese response was a small pilot SEP in Katmandu. Those who elected to participate in the needle exchange program initially had a zero prevalence rate and showed declining needle-sharing behavior.<sup>132</sup> However, in the late 1990s, Nepal experienced “an explosive increase in HIV infections in about one half of all IDUs.”<sup>133</sup> A limited study in Katmandu concluded that IDUs that used the SEP had lower rates of HIV infection than the larger IDU population. The spike of HIV infection rates generally, coupled with lower HIV infection rates for IDUs who accessed the limited SEP services, demonstrates the pitfalls associated with failing to fully develop and support an SEP.

### ***Obstacles to the Implementation and Effectiveness of SEPs***

#### *Legal and Law Enforcement*

Legal and regulatory regimes that prohibit or impede the distribution of clean needles and syringes represent enormous obstacles to the successful implementation of SEPs as a harm reduction strategy in parts of Asia. Where police are less tolerant, SEP sites and programs can be used by law enforcement as easy targets of routine harassment or narcotics roundups. This undermines client confidence in SEPs and drives the distribution of clean needles underground, leading to an increase in the reuse and sharing of needles. In Bangladesh, for example, police regularly interfere with SEPs through “harassment, raids and spot evictions” of IDUs.<sup>134</sup> Not surprisingly, the IDU

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<sup>130</sup> *Id.* at 117.

<sup>131</sup> JENKINS & ROBALINO, *supra* note 102, at 6.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 36.

community's response has been less frequent attendance at SEP sites, resulting in decreases in the distribution of needles.

Many countries in Asia have criminal laws against possessing or distributing drug paraphernalia, including clean syringes.<sup>135</sup> The Philippines, Sri Lanka, Thailand, Myanmar, Malaysia, PDR Laos, Japan, Hong Kong, Bhutan and Bangladesh all prohibit the provision of needles and syringes.<sup>136</sup> While most of the countries do not aggressively enforce these laws, especially against government-sanctioned SEPs, the legal ambiguity in which SEPs function operates as an impediment to more open and robust needle exchange and distribution. For example, Thailand's aggressive "war on drugs" and the prohibition on the distribution of needles has largely forced clean needle distribution by NGOs to go underground.<sup>137</sup> In such situations, not only the IDUs, but also the distributors and social workers are deterred from participating in SEPs.

Ambiguous laws also open the door for police harassment, which can drive IDUs away from needle exchange centers. Lower level police in India, for example, often harass outreach workers and IDUs themselves on the basis of a widely held view that SEPs enable, rather than reduce, illicit drug use.<sup>138</sup> In addition, the applicability of India's drug paraphernalia laws to the distribution of needles is uncertain, further deterring participation.<sup>139</sup> A World Bank report issued in 2003 concluded that expansion of SEPs in Nepal was difficult because of drug enforcement opposition and the lack of a coherent national policy.<sup>140</sup> Significantly, in Bangladesh, a criminal statute provides that "[s]upplying equipment like needles/syringes to IDUs that facilitate illicit drug use constitutes 'abetment.'"<sup>141</sup> Although no one has been tried under this criminal provision, the statute has been invoked by police when arresting outreach workers at SEP locations.<sup>142</sup>

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<sup>135</sup> Despite having SEPs, Thailand, Myanmar, Malaysia and Bangladesh all have laws that at least technically prohibit the provision of syringes without a prescription. IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27.

<sup>136</sup> *Id.*

<sup>137</sup> *Id.* at 30.

<sup>138</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 72.

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* at 36.

<sup>142</sup> *Id.*



By contrast, where the police support, or at the very least tolerate, SEPs, IDUs feel more confident in coming forward and enrolling in programs to receive sterile needles. In Pakistan, for example, the nation's principle drug enforcement agency, the ANF, has formally endorsed needle exchange as one solution to reducing the harms associated with injection drug use, including HIV infection.<sup>143</sup> Further, a local NGO, Nai Zindagi, has established an aggressive campaign to secure local police assistance and acceptance of an SEP in Lahore.<sup>144</sup> In-depth studies of SEPs in China have shown that positive police attitudes toward and support for SEPs result in increases in clean needle distribution.<sup>145</sup>

### *Funding*

As previously noted, the vast majority of funding for and implementation of SEPs in Asia comes from international NGOs that support SEP implementation by local organizations.<sup>146</sup> Many Asian SEPs depend on Global Fund grants, which provide financing to programs to prevent and fight HIV/AIDS. Once developing countries become wealthy enough to no longer qualify for Global Fund grants, state-sponsored programs must contribute in order to prevent a gap in coverage. Asian governments, with some exceptions, have shown considerable reluctance to support SEPs (both financially and even politically).<sup>147</sup> Currently, international NGOs make up the lion's share of SEP funding, and this level of funding is insufficient to supply IDUs with enough clean needles to meaningfully control HIV infection rates.<sup>148</sup>

### *Local Communities*

Community acceptance or tolerance of an SEP is critical to its success. Preexisting stigma associated with IDUs can be exacerbated by SEPs when the objectives of the SEP are not adequately understood by the surrounding community. Community disapproval comes from several sources: religious

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<sup>143</sup> *Id.* at 116.

<sup>144</sup> *Id.* at 116-17.

<sup>145</sup> Bo Liu et al., *An Evaluation of Needle Exchange Programmes in China*, 21 AIDS S123, S127 (2007).

<sup>146</sup> See *supra* note 114 and accompanying text. The most prominent exception is China, which has aggressively pursued a state-sponsored, nationwide SEP. China's stringent registration requirements have largely repressed the growth and influence of NGOs.

<sup>147</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 27.

<sup>148</sup> One obvious funding obstacle is the United States' ban on federal funds to support international SEPs, as funding from organizations through PEPFAR directed at needle exchange must exclude United States money.

opposition, local resident resistance to SEPs attracting IDUs and other criminals to the neighborhood and a community sense that SEPs simply facilitate illegal drug use and distribution. Another expression of community resistance common to many Asian countries is the reluctance of pharmacists to distribute clean needles, where available, to people whom they suspect to be IDUs.<sup>149</sup> This reluctance deters IDUs who could otherwise lawfully purchase safe injecting equipment from doing so.

Asian SEPs have had varied levels of success in securing community acceptance. Active outreach by the Nai Zindagi NGO in Pakistan, for instance, despite a mostly Muslim population and use of Shariat (Islamic law), has helped to diffuse local disapproval.<sup>150</sup> In contrast, SEPs in some regions of India have faced extensive community resistance and stigma where needle exchange is believed only to encourage drug use.<sup>151</sup>

### **C. Australia and New Zealand**

#### ***Levels of Injection Drug Use and Current Trends***

New Zealand, which has a population of approximately 4.3 million people, is home to an estimated 31,000 IDUs, which account for less than 1% of the population. IDUs in New Zealand exhibit only a 2% prevalence for HIV.<sup>152</sup>

Australia, which has a national population of 21.8 million people, has an estimated 163,000 IDUs, including 73,800 IDUs believed to have injected drugs within the past twelve months.<sup>153</sup> This rate may be falling due to evidence that the number of young people using injection drugs has decreased over time. HIV

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<sup>149</sup> For example, in Nepal, needles can be lawfully purchased from pharmacies; however, pharmacists are unlikely to sell needles and syringes to people they suspect to be “drug addicts.” LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 98.

<sup>150</sup> *Id.* at 116. Similarly, the Malaysian government, in a predominantly Muslim country, initially opposed SEPs but switched its policy in 2006. The government relied on a justification grounded on a provision in Islam that an individual harm can be tolerated to eliminate a greater harm. INST. OF MED. OF THE NAT’L ACADS., PREVENTING HIV INFECTION AMONG INJECTING DRUG USERS IN HIGH RISK COUNTRIES: AN ASSESSMENT OF THE EVIDENCE 214 (2006), *available at* [http://books.nap.edu/openbook.php?record\\_id=11731&page=214](http://books.nap.edu/openbook.php?record_id=11731&page=214).

<sup>151</sup> LAWYERS COLLECTIVE HIV/AIDS UNIT, *supra* note 19, at 72.

<sup>152</sup> *Id.* at 88, 90 (noting that 70% of IDUs in New Zealand have HCV).

<sup>153</sup> *Id.*

infection rates among IDUs in Australia are very low (roughly 1%), but IDUs exhibit a 41-60% prevalence for HCV.<sup>154</sup>

### *History of SEPs*

Australia and New Zealand have both operated SEPs since the late 1980s. However, SEPs do not currently operate in the many Pacific Island nations surrounding them, including Vanuatu, Tuvalu, Papua New Guinea and the Solomon Islands.<sup>155</sup>

In 1987, when New Zealand enacted health regulations legalizing its SEP, the country created the first national SEP in the world.<sup>156</sup> New Zealand's SEP includes exchange and distribution of sterile injecting equipment through general practitioners and pharmacies, complemented by peer-based groups that provide evening and weekend exchanges and educational programs.<sup>157</sup>

As a legal matter, New Zealand's 1987 regulations decriminalized the sale of needles and syringes to IDUs, but not the possession of needles and syringes.<sup>158</sup> After 1987, therefore, it was no longer a crime to sell a syringe to an IDU (and thus SEPs could operate legally), but it remained a crime for IDUs to possess syringes. New Zealand did, however, permit defendants charged with possession of needles and syringes to claim the SEP as a defense to criminal charges.<sup>159</sup> Therefore, defendants charged with possession of syringes for illicit drug use could defeat a criminal charge with the affirmative defense that they obtained the needle from the SEP. While possession of needles and syringes remains a crime in New Zealand, following revisions to the SEP regulations in 1998 and 2005, the government now bears the burden to prove beyond a reasonable doubt that the needles in question did not come from the SEP.<sup>160</sup>

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<sup>154</sup> *Id.*

<sup>155</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 88, 92.

<sup>156</sup> History, New Zealand Needle Exchange Programme, *supra* note 13.

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

<sup>159</sup> *Id.*

<sup>160</sup> CAMPBELL AITKEN, THE CENTRE FOR HARM REDUCTION, NEW ZEALAND NEEDLE AND SYRINGE EXCHANGE PROGRAMME REVIEW 11 (2002), [http://www.ndp.govt.nz/moh.nsf/pagescm/1026/\\$File/needlesyringeexchange.pdf](http://www.ndp.govt.nz/moh.nsf/pagescm/1026/$File/needlesyringeexchange.pdf); *see also* History, New Zealand Needle Exchange Programme, *supra* note 13.

Needle exchange in Australia grew out of the country's efforts in the mid-1980s to develop a National Drug Strategy to control drug use through a multilayered approach involving supply reduction, demand reduction and harm reduction.<sup>161</sup> Australia first legalized a needle and syringe exchange program as part of its first National HIV/AIDS Strategy in 1989.<sup>162</sup> Begun initially as a trial project in Sydney in 1986, SEPs became government policy in all Australian states and territories by 1993.<sup>163</sup> As of 2005, there were approximately 3,000 SEP sites throughout Australia.<sup>164</sup>

Unlike New Zealand, Australia does not criminalize either the acquisition or possession of syringes obtained from SEPs for injection drug use (with the exception of Western Australia, which criminalizes possession).<sup>165</sup>

### *Status of Current SEPs*

New Zealand operates its SEP through a regulatory system whereby the country's Ministry of Health contracts with nongovernmental charitable groups to run individual needle exchanges.<sup>166</sup> The Ministry of Health supplies its SEP with over \$1 million New Zealand dollars in public funding annually.<sup>167</sup> An oversight board, Needle Exchange New Zealand, provides regulatory oversight and national coordination among individual needle exchange outlets.<sup>168</sup>

There are approximately 200 needle exchange outlets throughout New Zealand.<sup>169</sup> At last estimate, these outlets included over 185 pharmacies (which sell a range of popular needles and syringes), as well as a dozen needle exchanges.<sup>170</sup> These needle exchanges are purchase-based exchanges run by

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<sup>161</sup> DOLAN ET AL., *supra* note 17, at 6.

<sup>162</sup> *Id.* at 8.

<sup>163</sup> *Id.* at 10; Paul Sendziuk, *Harm Reduction and HIV-Prevention among Injecting Drug Users in Australia: An International Comparison*, 24 CANADIAN BULL. OF MED. HIST. 113, 119-20 (2007).

<sup>164</sup> DOLAN ET AL., *supra* note 17, at 10.

<sup>165</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 92; DOLAN ET AL., *supra* note 17, at 21.

<sup>166</sup> AITKEN, *supra* note 161, at 23.

<sup>167</sup> *Id.* at 82 (see Appendix 5, Table 5).

<sup>168</sup> *Id.* at 23.

<sup>169</sup> Press Release, New Zealand Ministry of Health, *supra* note 18.

<sup>170</sup> *Id.*

IDUs for IDUs, where IDUs can discard used needles and purchase, for a nominal fee, needles, syringes and injection accessories, such as sterile water and swabs.<sup>171</sup> IDUs may also obtain advice about safer drug use and referrals for health services. In addition, New Zealand operates several syringe vending machines for around-the-clock access to clean needles. Typically, IDUs may obtain clean needles from any of these outlets for approximately \$1.00 in local currency.<sup>172</sup>

Australia's SEPs arose directly out of harm reduction goals set in the mid-1980s by the country's National Drug Strategy<sup>173</sup> and, like New Zealand's program, receives federal funding for its operation of over 3,300 needle exchange sites around the country.<sup>174</sup> However, unlike New Zealand's centralized regulatory system, states throughout Australia operate their SEPs using their own models, methods and funding arrangements, which sometimes differ markedly from one another. For example, some states primarily use government-run SEPs, and some use nongovernmental "peer-based" programs, comparable to New Zealand's needle exchanges.<sup>175</sup> Moreover, regulatory oversight and educational programs vary from one state to another.<sup>176</sup> SEPs throughout Australia, however, do include pharmacy outlets, mobile and outreach services, primary medical care and referral services, and syringe vending machines for around-the-clock access to clean needles.<sup>177</sup> Unlike New Zealand's purchase-based access to clean needles, Australia often distributes needles free of charge.<sup>178</sup>

### ***Obstacles to the Implementation and Effectiveness of SEPs***

Although both Australia and New Zealand implemented SEPs over two decades ago, IDUs still face various social, practical and legal challenges in accessing SEP services. As a social matter, IDUs sometimes experience

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<sup>171</sup> AITKEN, *supra* note 160, at 24.

<sup>172</sup> Press Release, New Zealand Ministry of Health, *supra* note 18.

<sup>173</sup> HEALTH OUTCOMES INT'L, *supra* note 25, at 9.

<sup>174</sup> Sendziuk, *supra* note 164, at 120; DOLAN ET AL., *supra* note 17, at 10; *see* HEALTH OUTCOMES INT'L, *supra* note 25, at 10-11 (Table 2.1, providing a detailed chart of public and consumer expenditures on SEPs by state).

<sup>175</sup> HEALTH OUTCOMES INT'L, *supra* note 25, at 9.

<sup>176</sup> *See id.* at 58-72 (Appendix A, providing a detailed state-by-state commentary on funding, services and access barriers for SEPs).

<sup>177</sup> DOLAN ET AL., *supra* note 17, at 10-11.

<sup>178</sup> What's New: Questions and Answers regarding the Needle and Syringe Exchange Programme and One-for-One Exchange, New Zealand Needle Exchange Programme, *supra* note 22.

discrimination or stigma from pharmacy staff, adding to concerns about maintaining anonymity. More practically, some IDUs find cost a barrier to the service, as well as the lack of around-the-clock exchange services, lack of services in prisons and lack of services in rural areas—a particular problem in New Zealand, which has a low population density. Additionally, despite the legality of the SEPs and attempts to prevent individuals from being searched for drugs near SEPs, some IDUs fear police harassment or view police searches as an impediment to using SEP services.<sup>179</sup>

### ***Impact of SEPs on HIV Infection Rates***

There is a strong correlation between Australia's establishment of SEPs and its HIV infection rates among IDUs. In a 2002 study, the Australian government determined that in cities without SEPs, HIV infection rates rose 8.1% annually, while in cities with SEPs, HIV infection rates fell by 18.6% annually.<sup>180</sup> Based on this data, the government estimated that SEPs prevented approximately 25,000 HIV infections among IDUs between their founding and the year 2000.<sup>181</sup> In addition, the same study found that cities without SEPs had a 75% prevalence of HCV among IDUs, while cities with SEPs had a 60% HCV prevalence among IDUs, leading the government to conclude that SEPs had helped prevent 21,000 HCV infections by the year 2000.<sup>182</sup> The report consequently concluded that the government's investment in preventative SEPs reduced medical costs to treat HIV and HCV and represented an "effective financial investment" for the country.<sup>183</sup> Another study estimated the Australian government's financial savings from its SEP at \$2.4 billion in public health funding.<sup>184</sup>

Researchers have also found New Zealand's SEP effective at reducing HIV and HCV infection rates, although less so than Australia's SEPs. For example, New Zealand has estimated that its pay-per-use SEP system covers only 10-11% of drug injections per year, while Australia's SEPs (which distribute

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<sup>179</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 92.

<sup>180</sup> HEALTH OUTCOMES INT'L, *supra* note 25, at 1-2.

<sup>181</sup> *Id.* Beyond reducing the actual incidence of HIV in the country, researchers have also found SEPs effective in achieving their most immediate goal of reducing the practice of needle-sharing. In 1986, when Sydney established the first trial SEP, almost 100% of IDUs shared needles; needle-sharing fell to 28% by 1996 and 13% by 2001. DOLAN ET AL., *supra* note 17, at 14.

<sup>182</sup> DOLAN ET AL., *supra* note 17, at 14.

<sup>183</sup> *Id.* at 6.

<sup>184</sup> Paola Totaro, *Needle Schemes Stop Thousands of HIV Cases*, SYDNEY MORNING HERALD, Oct. 23, 2002, available at <http://www.smh.com.au/articles/2002/10/22/1034561495439.html>.

injecting equipment free of charge) cover 27% of drug injection incidents.<sup>185</sup> However, one government-sponsored 2002 study concluded that New Zealand had effectively prevented over 1,000 HIV infections and almost 1,500 HCV infections among IDUs by the year 2001, although the study did not attribute these prevented infections to its SEP in particular.<sup>186</sup> New Zealand's Ministry of Health did, however, observe in connection with the report's release that there was a continuous decline in the prevalence of needle-sharing practices among IDUs and that the SEP reduced HIV and HCV transmission rates, saving lives as well as \$35 million in treatment costs for the diseases.<sup>187</sup>

## **D. Europe**

### **1. Eastern Europe**

#### ***Levels of Injection Drug Use, HIV Infection Rates and Current Trends***

Illicit drug use has generally increased in the Eurasian region since the end of the Cold War, and especially during periods of conflict in the Balkans and parts of Central Asia and Caucasus.<sup>188</sup> In recent years, injection drug use has increased rapidly in Eastern Europe and is currently reported in all Eastern European countries.<sup>189</sup> Estimates suggest that there are approximately 3.4 million IDUs across the region, with the highest numbers in Russia (2 million),<sup>190</sup> Ukraine (325,000-425,000)<sup>191</sup> and Kazakhstan (186,000).<sup>192</sup> While injection drug use is

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<sup>185</sup> What's New: Questions and Answers regarding the Needle and Syringe Exchange Programme and One-for-One Exchange, New Zealand Needle Exchange Programme, *supra* note 22.

<sup>186</sup> AITKEN, *supra* note 160, at 27-32; Press Release, New Zealand Ministry of Health, *supra* note 18.

<sup>187</sup> AITKEN, *supra* note 160, at 27-32; Press Release, New Zealand Ministry of Health, *supra* note 18.

<sup>188</sup> See UNITED NATIONS OFFICE ON DRUGS AND CRIME, WORLD DRUG REPORT 268 (2007), [http://www.unodc.org/pdf/research/wdr07/WDR\\_2007.pdf](http://www.unodc.org/pdf/research/wdr07/WDR_2007.pdf); see also EURASIAN HARM REDUCTION NETWORK, *supra* note 202, at 6-7.

<sup>189</sup> See IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 36. It is notable, however, that precise estimates of injection drug use are not available for all countries within the region.

<sup>190</sup> *Id.*; see also RUSSIAN FED'N, COUNTRY REPORT OF THE RUSSIAN FEDERATION ON THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV/AIDS 16-19 (2008), [http://data.unaids.org/pub/Report/2008/russia\\_2008\\_country\\_progress\\_report\\_en.pdf](http://data.unaids.org/pub/Report/2008/russia_2008_country_progress_report_en.pdf).

<sup>191</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 36; UKRAINIAN AIDS CTR. ET AL., REPORT ON THE NATIONAL CONSENSUS ESTIMATES ON HIV AND AIDS IN UKRAINE AS OF END OF 2005 7 (2006), [http://msmandhiv.org/documents/EasternEurope/HIVAIDS/natinal\\_estimates.pdf](http://msmandhiv.org/documents/EasternEurope/HIVAIDS/natinal_estimates.pdf).

reported to be increasing in most countries in the region, levels are reported to be stable in several countries<sup>193</sup> and even decreasing in three others.<sup>194</sup> However, commentators have noted that these apparent decreases may, in fact, be a result of countries' improved ability to develop reliable estimates of the numbers of people injecting.

The increasing population of IDUs in Eastern Europe also appears to have a significant incidence of HIV infection. "During 2006, almost two-thirds of new HIV diagnoses in Eurasia were attributable to injection drug use."<sup>195</sup> According to the IHRA, "[y]oung injectors, who constitute a large proportion of the injecting population, are particularly vulnerable to HIV. . . and other health and social harms related to injection drug use."<sup>196</sup> This increased vulnerability is largely because they are neglected by public policies and under-served by current harm reduction and drug treatment services."<sup>197</sup> Prisoners also constitute an identifiable proportion of the IDU population susceptible to HIV infection. Indeed, the lack of harm reduction and drug treatment programs in prisons leave prisoners, many of whom are current or former injectors, particularly vulnerable.

The incidence of HIV among IDUs appears to be increasing in Russia in particular. UNAIDS recently noted that "[a]nnually reported (rather than estimated)" data confirmed that "new infections in the Russian Federation have been growing again in recent years, but at a lower rate than at the turn of the century."<sup>198</sup> According to UNAIDS, injection drug use remains the primary mode

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(continued...)

<sup>192</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 36.

<sup>193</sup> Stable levels are reported in Croatia, the Czech Republic (although injection drug use may be increasing among young people), FYR Macedonia, Montenegro and Russia. *Id.*

<sup>194</sup> Decreases in injection drug use were reported in Latvia, Poland and Slovakia. *See id.*

<sup>195</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 37; *see also* UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 27, at 26.

<sup>196</sup> *See* IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 36. For example, in Kosovo in 2005, the average age was below 20 years. *Id.* In Romania, it is estimated that 80% of people injecting are aged under 29 years, and in 2004 the average age for initiating injection drug use was between 17 and 19 years. ILIUTA ET AL., *infra* note 208, at 6, 11. In FYR Macedonia, a 2002 UNICEF rapid assessment among young people who inject drugs found the age for drug use to be decreasing, with a growing number of 12 and 13 year olds using drugs. NORA STOJANOVIK & BRANKO DOKUZOVSKI, THE FYR OF MACEDONIA; MOST AT RISK ADOLESCENTS AND YOUNG PEOPLE, HIV AND SUBSTANCE USE 18 (2006), [http://www.aidsactioneurope.org/uploads/tx\\_windpublications/225.pdf](http://www.aidsactioneurope.org/uploads/tx_windpublications/225.pdf).

<sup>197</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 37.

<sup>198</sup> UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 27, at 8.



of HIV transmission in the Russian Federation. Of the newly registered HIV cases in 2006 where the mode of transmission was known, two-thirds were due to injection drug use, while about one-third were due to unprotected heterosexual intercourse.<sup>199</sup>

### *Status of Current SEPs*

Of the nearly thirty countries in Eastern Europe and Eurasia,<sup>200</sup> all except for Turkmenistan and Kosovo have some form of SEP. While many governments reference harm reduction in their national policies, in practice, NGOs have largely taken the lead in implementing regional SEPs with support from international agencies. Throughout Eastern Europe, the availability of SEP services varies from country to country; for example, the International Harm Reduction Association (IHRA) has reported that “129 sites provide [SEP services] in Kazakhstan, 69 sites serve the vast country of Russia and there are 362 sites in Ukraine (107 fixed sites, 207 street-based programs and 48 mobile units).”<sup>201</sup> However, despite this profusion of SEPs, the Global Fund to Fight AIDS, Tuberculosis and Malaria estimates that programs targeting HIV prevention among IDUs currently service only 2% of the IDUs living in Eastern Europe and Central Asia.<sup>202</sup> Eastern Europe thus proves instructive as a region that has numerous SEPs, but has nevertheless been ineffective in reaching and aiding IDUs.

Only three countries in Eastern Europe currently operate pharmacy-based SEPs: Kyrgyzstan, Slovenia and Ukraine.<sup>203</sup> Pharmacy-based SEPs provide more comprehensive services to IDUs.<sup>204</sup> In Ukraine, for example, 22 pharmacies in 8 different cities distribute syringes to IDUs in addition to condoms and educational materials.<sup>205</sup> Other countries, such as Hungary and Slovenia, distribute sterile

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<sup>199</sup> *Id.* at 26 (commenting that “[t]he latter proportion [of one-third of HIV infections attributable to heterosexual intercourse] . . . has been increasing steadily since the late 1990s.”).

<sup>200</sup> Including Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Kosovo, Latvia, Lithuania, FYR Macedonia, Moldova, Montenegro, Poland, Romania, Russia, Serbia, Slovakia, Slovenia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

<sup>201</sup> See IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 38.

<sup>202</sup> See EURASIAN HARM REDUCTION NETWORK, THE IMPACT OF DRUG POLICY ON HEALTH AND HUMAN RIGHTS IN EASTERN EUROPE 17 (2009), [http://www.harmreduction.org/images/stories/documents/ungass\\_report\\_2009\\_03\\_04\\_en.pdf](http://www.harmreduction.org/images/stories/documents/ungass_report_2009_03_04_en.pdf).

<sup>203</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 38.

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

injecting equipment through syringe vending machines, which have the advantage of providing an anonymous, around-the-clock method of obtaining sterile injecting equipment.<sup>206</sup>

SEP services are not widely available in prisons in the region. In fact, SEPs are only located in prisons in Armenia (3 prisons), Kyrgyzstan (11 of 12 prisons) and Moldova (7 of 18 prisons).<sup>207</sup> In Romania, legislation allowing the implementation of pilot SEPs has been endorsed by the National Prison Administration and National Antidrug Agency, and in 2008, the Romanian National Prison Administration planned pilot SEPs in two prisons with international technical and financial assistance.<sup>208</sup> However, in the majority of prisons in Eastern Europe, sterile injecting equipment is not currently available.

### *Sources of Funding*

SEPs receive funding from a variety of sources throughout Eastern Europe, including “national funding (the Czech Republic), the Global Fund grants (Albania, Bosnia and Herzegovina, Kazakhstan, Montenegro and Romania) and a combination of international and national funding (Estonia, Latvia and Lithuania).”<sup>209</sup> The governments of and NGOs operating in some countries receive support for harm reduction programs through the provision of financial and/or technical assistance by multilateral agencies, although this support is not consistent across the region.<sup>210</sup> In Central Europe, for example, countries mainly rely on national resources for developing and maintaining services for IDUs. By contrast, in Eastern Europe, the majority of financial support for general harm reduction services is provided by the Global Fund, which although not a technical support provider, “plays a key role in strengthening harm reduction service provision in the region[,]” by providing financial support.<sup>211</sup> Harm reduction responses to HIV are also supported throughout the region by a variety of organizations, including UNODC, The United Nations Children’s Fund

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<sup>206</sup> *Id.*

<sup>207</sup> *See id.* at 41.

<sup>208</sup> *See id.* (citing CATALENA ELENA ILIUTA ET AL., ROMANIAN HARM REDUCTION NETWORK, ROMANIA: MOST-AT-RISK ADOLESCENTS AND YOUNG PEOPLE, HIV AND SUBSTANCE USE (2006), [http://www.aidsactioneurope.org/uploads/tx\\_windpublications/226.pdf](http://www.aidsactioneurope.org/uploads/tx_windpublications/226.pdf)).

<sup>209</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 39.

<sup>210</sup> *See id.* at 43.

<sup>211</sup> *Id.*

(UNICEF), the World Bank, UNAIDS, WHO, the United Nations Population Fund (UNFPA) and various European Union organizations.<sup>212</sup>

### *Impact of SEPs on HIV Infection Rates*

In some countries that operate SEPs, the rate of HIV infection among IDUs appears to have leveled off. For example, in Belarus, where the HIV epidemic is largely concentrated among IDUs, UNAIDS reported that HIV infection rates appear to be stabilizing.<sup>213</sup> Similarly, in Estonia, Latvia and Lithuania, where injection drug use is the most-reported mode of HIV transmission, the epidemics appear to have stabilized.<sup>214</sup>

There is also evidence, although limited, of the cost-effectiveness of SEPs. A 2000 study in Svetlogorsk, Belarus, estimated that its harm reduction measures for IDUs (including the establishment of an SEP) cost \$144,617 USD over a two-year period (including costs for a media campaign aimed at disease prevention).<sup>215</sup> Although HIV prevalence in Svetlogorsk did not decline substantially as a result of these measures, the program succeeded in “averting HIV infection among IDUs and their non-IDU sexual partners,”<sup>216</sup> and the cost per HIV infection averted ranged from \$240 to \$442.<sup>217</sup>

Other Eastern European countries that operate SEPs (including Moldova, Georgia, Armenia, Azerbaijan, Uzbekistan, Kazakhstan, Tajikistan and Kyrgyzstan), however, have reported that their numbers of HIV infections have been increasing, and in the vast majority of these countries, IDUs make up a large proportion of new HIV infections.<sup>218</sup> Because these countries operate SEPs, the increase in HIV infection rates among IDUs cannot be attributed to an absence of SEPs. However, the increasing rates of HIV infections in these countries suggest that perhaps these countries have not managed to develop effective SEPs that meet their intended goals.

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<sup>212</sup> *See id.*

<sup>213</sup> *Id.* at 27 (noting that the annual number of newly reported HIV diagnoses has varied only slightly since 2003).

<sup>214</sup> *Id.* at 34.

<sup>215</sup> L. KUMARANAYAKE ET AL., JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, THE COST-EFFECTIVENESS OF HIV PREVENTIVE MEASURES AMONG INJECTING DRUG USERS IN SVETLOGORSK, BELARUS 4 (2000), [http://www.ahrn.net/library\\_upload/uploadfile/Belarus.pdf](http://www.ahrn.net/library_upload/uploadfile/Belarus.pdf).

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

<sup>218</sup> UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 27, at 27-28.

### *Obstacles to the Implementation and Effectiveness of SEPs*

Many obstacles exist in Eastern Europe which inhibit access to SEPs. Such obstacles hinder the effectiveness of SEPs in reducing the incidence of HIV infection among IDUs. These obstacles include strict legal policies on drugs, fear of arrest or police harassment, and social stigma against IDUs and SEP social workers.

Criminal codes that forbid SEP operations are a major obstacle in many Eastern European countries. In Montenegro, SEP activity may be construed as “enabling others to consume narcotics”:

Montenegrin legislation states this to be a crime punishable with prison sentences of between six months and five years. Enabling a minor to inject drugs commands prison sentences of between two and ten years, a law that in practice denies young people who inject drugs access to sterile injecting equipment.<sup>219</sup>

The IHRA, citing a report from the Eurasian Harm Reduction Network, related the following account of establishing SEPs in Hungary:

Budapest-based NGOs signed a contract with the police to set up a new [SEP] client identification system in order to ensure that clients possessing needles [were] not harassed by police. However, when they attempted to broaden the scope of this contract to the whole country, the General Prosecutor’s Office issued a statement which called needle exchange provision a crime.<sup>220</sup>

Similarly, Georgia’s official report to UNAIDS on UNGASS indicator data<sup>221</sup> revealed that “the national anti-drug policy climate has inhibited efforts to offer even minimal access to detoxification and drug rehabilitation services.”<sup>222</sup>

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<sup>219</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 42.

<sup>220</sup> *Id.*

<sup>221</sup> UNGASS indicator data are data submitted to UNAIDS by individual countries and used to monitor the progress towards achieving UNAIDS’ goals of universal access to prevention, treatment and care in 2010, and eventually in reaching the Millennium Development Goal of arresting and halting the spread of HIV by 2015. *See* UNAIDS, Much Progress to Report: UNGASS 2008 (Mar. 12, 2008), <http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080312-countryprogress.asp>.

<sup>222</sup> *See* JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC 117 (2008), [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008\\_Global\\_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp) [hereinafter UNAIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC].

In addition, a number of countries, such as Russia, Ukraine, Belarus and FYR Macedonia, have restrictive policies that create fear of arrest or police harassment for IDUs accessing SEP services.<sup>223</sup> For example, a survey of IDUs in FYR Macedonia found that over one-third of respondents had been apprehended and taken to a police station and one-quarter had injection equipment confiscated by the police.<sup>224</sup> Moreover, in Georgia, according to the IHRA, the current “War on Drugs” has led to a significant increase in both police activity and the number of people apprehended for suspected drug use. “In 2007, more than 57,000 [Georgians] were stopped on the streets and taken for drug testing. Those who tested positive for traces of controlled substances were subject to fines and criminal sanctions.”<sup>225</sup>

There are also significant social obstacles to effective implementation of SEPs in Eastern Europe, primarily as a result of stigma and discrimination against IDUs. As in other global regions, some pharmacists decline to sell injecting equipment to suspected IDUs. Citing a small survey in FYR Macedonia, the IHRA reported that 25% of pharmacies in the country declined, as a policy, to sell needles to IDUs.<sup>226</sup> In addition to stigma from pharmacists and other health care workers, police sometimes station themselves at pharmacies that sell injecting equipment, further deterring IDUs from accessing such services.<sup>227</sup> Many SEPs in the region also struggle to employ and retain social workers as staff, as many social workers cease working for SEPs due to the low pay and to the social stigma they themselves experience as a result of providing needle exchange services.<sup>228</sup> In Russia, to open an SEP site, one must take the additional administrative step of applying for a permit with the local branch of the Federal Drug Control Service.<sup>229</sup> The IHRA has reported that “there are limited organi[z]ations willing to provide services due to stigma and a lack of acceptance of harm reduction.”<sup>230</sup>

Despite these obstacles, there is cause for cautious optimism in the region for two reasons: first, Eastern European countries’ membership in the European

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<sup>223</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 39.

<sup>224</sup> *See* STOJANOVIK & DOKUZOVSKI, *supra* note 196.

<sup>225</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 39.

<sup>226</sup> *Id.* at 38.

<sup>227</sup> *Id.*

<sup>228</sup> *Id.* at 39.

<sup>229</sup> *Id.*; *see also* INST. OF MED. OF THE NAT’L ACADS., *supra* note 150, at 216-18.

<sup>230</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 39; *see also* INST. OF MED. OF THE NAT’L ACADS., *supra* note 150, at 216-18.

Union (EU), which has motivated such countries to develop progressive policies concerning SEPs, and second, the involvement of international NGOs in Eastern Europe.

Membership in the EU has had a progressive impact on drug policy in some of the new member states in the Baltics, Central Europe and parts of southeastern Europe. According to the IHRA, EU membership has “facilitated reductions in penalties and prison sentencing for drug use and helped to ‘normaliz[e]’ harm reduction.”<sup>231</sup> In addition, the EU Action Plan on Drugs explicitly states that harm reduction initiatives are a necessity.<sup>232</sup>

Twenty-two countries in Eastern Europe are member states of the Council of Europe, which in 2004 issued the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia (the Dublin Declaration).<sup>233</sup> The Dublin Declaration advocates for the need to increase levels of access to harm reduction services for people who inject drugs, and it “sets a target of reaching 80% of people who inject drugs with HIV prevention, treatment and care by 2010.”<sup>234</sup>

Furthermore, international NGOs have played a critical role in aiding in the reduction of HIV infection rates in Eastern Europe. One such NGO is the International Harm Reduction Development Program of the Open Society Institute, which has “evolved from a key donor to a leading technical support provider and advocate in the region.”<sup>235</sup> In addition, the IHRA has reported that “[t]he International Federation of the Red Cross and Red Crescent Societies has also played a major part in harm reduction service provision through its local partners in several countries.”<sup>236</sup> Finally, several regional organizations, including the Eurasian Harm Reduction Network, the South-Eastern European Adriatic Addiction Treatment Network, the South Eastern European Collaborative on Human Rights and Treatment Network on Drugs and HIV, AIDS Foundation East-West (AFEW), the ENDIPP network (renamed Connections), the Correlation

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<sup>231</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 42.

<sup>232</sup> See COUNCIL OF THE EUROPEAN UNION, EU DRUGS ACTION PLAN (2005-2008) 9 (2005), <http://register.consilium.eu.int/pdf/en/05/st08/st08652-re01.en05.pdf>.

<sup>233</sup> See Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, [http://www.euro.who.int/aids/treatment/20051018\\_1](http://www.euro.who.int/aids/treatment/20051018_1).

<sup>234</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 42.

<sup>235</sup> *Id.*

<sup>236</sup> *Id.*

Network and the International HIV/AIDS Alliance, have all been integral in efforts to promote harm reduction for IDUs.<sup>237</sup>

## 2. Western Europe

### *Levels of Injection Drug Use, HIV Infection Rates and Current Trends*

Injection drug use is reported in twenty-one countries in Western Europe; the largest numbers of IDUs are located in Italy (326,000), the United Kingdom (164,036), Germany (120,000-150,000) and France (122,000).<sup>238</sup> Overall, however, injection drug use is believed to be decreasing in Western Europe.<sup>239</sup> Additional data compiled by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) suggests a decline in injection drug use in Norway and a stable situation in the Czech Republic, Greece, Cyprus and the United Kingdom. The EMCDDA also reported that a large proportion of IDUs are new or young injectors (under age 25), notably in the Central and Eastern European countries of the Czech Republic, Estonia, Lithuania, Austria and Romania, where new or young injectors accounted for more than 40% of injectors.<sup>240</sup> However, the EMCDDA noted that the lack of accurate data makes drawing conclusions on time trends of the prevalence of injection drug use difficult.<sup>241</sup>

According to the EMCDDA, in 2005, 3,500 new HIV diagnoses in the EU were attributable to injection drug use.<sup>242</sup> And “[i]n 2006, the overall rate of newly diagnosed HIV infections among IDUs in the 25 EU Member States for which national data are available was 5.0 cases per million population, down from 5.6 per million in 2005.”<sup>243</sup> By the end of 2006, according to the EMCDDA, “the incidence of diagnosed HIV infection among [IDUs] appear[ed] to have been low

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<sup>237</sup> *Id.*

<sup>238</sup> *See id.* at 50 (citing European Monitoring Ctr. for Drugs and Drug Addiction, Statistical Bulletin, Table PDU-2: Prevalence of Problem Drug Use at National Level (2007); Ingo Ilje Michels et al., *Substitution Treatment for Opioid Addicts in Germany*, 4 HARM REDUCTION J. (2007), <http://www.harmreductionjournal.com/content/pdf/1477-7517-4-5.pdf>).

<sup>239</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 50; *see also* EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, ANNUAL REPORT 2007: THE STATE OF THE DRUGS PROBLEM IN EUROPE 77 (2007), <http://www.emcdda.europa.eu/publications/annual-report/2007> [hereinafter EMCDDA, ANNUAL REPORT 2007].

<sup>240</sup> EMCDDA, ANNUAL REPORT 2008, *supra* note 27, at 73.

<sup>241</sup> *Id.* at 72.

<sup>242</sup> EMCDDA, ANNUAL REPORT 2007, *supra* note 239, at 14.

<sup>243</sup> EMCDDA, ANNUAL REPORT 2008, *supra* note 27, at 78.

in most countries of the [EU], and the overall EU situation appear[ed] relatively positive in a global context.”<sup>244</sup> UNAIDS reported that only 6% of newly diagnosed HIV infections in Western Europe were attributable to injection drug use and that infection rates due to injection drug use were decreasing.<sup>245</sup> This decrease was attributed at least partly to the increased availability of prevention, treatment and harm-reduction measures, including SEPs and substitution treatment. However, the EMCDDA cautioned that in parts of Europe, the data demonstrated that HIV transmission related to injection drug use continued at relatively high rates in 2006, and emphasized “the need to ensure the coverage and effectiveness of local prevention practice.”<sup>246</sup>

### *Status of Current SEPs*

Although at times strictly regulated, SEPs are legal and operate in every country in Western Europe<sup>247</sup> except for Turkey and Iceland.<sup>248</sup> It has been estimated that there are 24,885 SEPs operating in the region, most of which are pharmacy-based, although several countries have community-organized programs as well.<sup>249</sup>

Western European countries provides both pharmacy-based and community-based SEPs to IDUs, as well as syringe vending machines. France, for example, has 18,000 pharmacy-based SEPs.<sup>250</sup> The IHRA has found that throughout Western Europe, “[p]harmacy-based SEPs play a critical role in terms of geographical coverage, but non-pharmacy-based SEPs often distribute more syringes per outlet.”<sup>251</sup> In addition, non-pharmacy-based SEPs provide the

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<sup>244</sup> *Id.*

<sup>245</sup> UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 27, at 33-34 (“Two divergent epidemic trends have been observed in Western Europe. While the number of new HIV diagnoses attributed to unsafe sex between men nearly doubled between 1999 and 2006 (from 2,538 to 5,016), those attributed to injection drug use declined in the same period (from 661 to 581).”); *see also* UNAIDS, REPORT ON THE GLOBAL AIDS EPIDEMIC, *supra* note 222, at 59.

<sup>246</sup> EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, DRUG-RELATED INFECTIOUS DISEASES AND DRUG-RELATED DEATHS, <http://www.emcdda.europa.eu/drug-situation/diseases>.

<sup>247</sup> The nineteen countries that have SEPs are: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the UK. IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 15.

<sup>248</sup> *See id.* at 51.

<sup>249</sup> *Id.*

<sup>250</sup> *Id.*

<sup>251</sup> *Id.*



additional benefit of assisting IDUs with “peer knowledge, support and harm reduction messages, as well as providing links with other services.”<sup>252</sup> In Austria, Denmark, France, Luxembourg, the Netherlands and Norway, clean injecting equipment is distributed via syringe vending machines. According to the IHRA, “[syringe vending machines] provide 24-hour access to sterile injecting equipment for those people who may not access [SEPs] due to fear of stigma, discrimination, lack of anonymity or inconvenient hours of operation.”<sup>253</sup>

Several countries in Western Europe also have SEPs or other harm reduction programs in place in their prisons. Prison-based SEPs exist in Germany (1 prison), Switzerland (7 prisons), Spain (38 prisons, but approved to operate in all prisons) and Luxembourg (1 prison).<sup>254</sup> Several countries also have pilot prison programs in various stages of development, including Ukraine, Portugal, Belgium and the United Kingdom (Scotland).<sup>255</sup> That said, according to the IHRA, in Germany, “the number of [prison-based SEPs] decreased from seven to only one following the election of [center]-right coalition governments with zero-tolerance drug [programs].”<sup>256</sup> This reduction is one illustration of the degree to which SEPs are dependent upon the continued political and regulatory support of the national governments where they exist and operate.

#### ***Sources of Funding and Other Support***

National government agencies provide funding and support for SEPs in Western Europe. The vast majority of Western European governments have declared the reduction of drug-related harm to be a national public health objective.<sup>257</sup> This position is reflected in national policies, strategies and plans concerning both HIV and illicit drug use. In addition, most Western European

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<sup>252</sup> *Id.*

<sup>253</sup> *Id.* at 51-52.

<sup>254</sup> *Id.* at 53 (noting that SEPs in Spanish prisons have been greatly increased in recent years, and they now operate in more than half of the country’s prisons.); *see also* WORLD HEALTH ORG., ET AL., EFFECTIVENESS OF INTERVENTIONS TO MANAGE HIV IN PRISONS—NEEDLE AND SYRINGE PROGRAMMES AND BLEACH AND DECONTAMINATION STRATEGIES 33 (2007), [http://www.who.int/hiv/idu/Prisons\\_needle\\_syringe%20programmes.pdf](http://www.who.int/hiv/idu/Prisons_needle_syringe%20programmes.pdf).

<sup>255</sup> WORLD HEALTH ORG. ET AL., *supra* note 254, at 33; IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 53.

<sup>256</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 53.

<sup>257</sup> *Id.*

governments are explicitly supportive of harm reduction when participating in international forums.<sup>258</sup>

On a broader regional level, international organizations and agencies provide institutional support for SEPs in Western Europe. For example, the EU Action Plan on Drugs articulates the necessity of harm reduction initiatives.<sup>259</sup> In 2003, the European Council put forward its “Recommendation on the prevention and reduction of health-related harm associated with drug dependence,”<sup>260</sup> which encouraged EU member states to adopt harm reduction policies and programs.<sup>261</sup> In 2007, the Commission of the European Communities reported on the implementation of the council’s recommendation.<sup>262</sup> Finally, there is the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, which, among other things, commits its participants to take various steps to reduce HIV infections in their home countries.<sup>263</sup>

### *Impact of SEPs on HIV Infection Rates*

Although there are barriers to accessing SEPs and stigmas associated with visiting SEPs, it has been reported that high distribution rates of sterile injecting equipment—over 140 needles and syringes per person per year—has “averted or

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<sup>258</sup> *Id.* For example, the IHRA reports, “[t]he British Department for International Development (DFID), the German Agency for Technical Cooperation (GTZ) and the Dutch Ministry of Foreign Affairs are all involved in supporting harm reduction initiatives around the world, with financial and/or technical support.” *Id.*

<sup>259</sup> See COUNCIL OF THE EUROPEAN UNION, *supra* note 232.

<sup>260</sup> See COUNCIL OF THE EUROPEAN UNION, RECOMMENDATION ON THE PREVENTION AND REDUCTION OF HEALTH-RELATED HARM ASSOCIATED WITH DRUG DEPENDENCE (2003), [http://europa.eu/legislation\\_summaries/justice\\_freedom\\_security/combating\\_drugs/c11575\\_en.htm](http://europa.eu/legislation_summaries/justice_freedom_security/combating_drugs/c11575_en.htm).

<sup>261</sup> See IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 53; see also TRIMBOS INSTITUTE, PREVENTION AND REDUCTION OF HEALTH-RELATED HARM ASSOCIATED WITH DRUG DEPENDENCE (2006).

<sup>262</sup> COMM’N OF THE EUROPEAN CMTYS., REPORT ON THE IMPLEMENTATION OF THE COUNCIL RECOMMENDATION OF 18 JUNE 2003 (2007), [http://eurlex.europa.eu/LexUriServ/site/en/com/2007/com2007\\_0199en01.pdf](http://eurlex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf) (reporting that “in all Member States, the prevention and reduction of drug-related harm is a defined public health objective at national level” and “[a]ll Member States have established harm reduction services and facilities, some to a lesser extent”).

<sup>263</sup> Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia, *supra* note 233.

reversed HIV epidemics in several Western European countries.”<sup>264</sup> A recent study in Amsterdam pointed to the benefits of the combined availability of methadone maintenance and needle exchange, and argued that involvement with both services, compared to the involvement with only one, was associated with a lower incidence of HIV infections among IDUs.<sup>265</sup>

### *Obstacles to the Implementation and Effectiveness of SEPs*

IDUs seeking to access SEP services in Western Europe face some of the same legal constraints as IDUs face in other regions of the world. For example, some countries have laws that are particularly restrictive of IDUs, and some countries are simply not supportive of investing in harm reduction strategies such as SEPs.<sup>266</sup> The IHRA in particular noted that while SEPs were recently established in Cyprus, the government has not yet officially endorsed the program.<sup>267</sup> Likewise, as discussed above, when Germany elected a center-right leaning government that disapproved of SEPs, the number of prison-based SEPs in the country decreased dramatically.<sup>268</sup>

IDUs also face several practical and social constraints in accessing SEP services. Some SEPs have limited funding and are correspondingly limited in the services they can provide.<sup>269</sup> The difficulties associated with accessing SEP facilities can also inhibit the effectiveness of SEPs. One study in Galicia, Spain, for example, concluded that the IDUs who did not visit local SEPs failed to do so for two primary reasons: a lack of concern for their own health and challenges in accessing SEPs, which were either too far away from some IDUs or not open long

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<sup>264</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 51 (citing Peter Vickerman et al., *Model Projections on the Required Coverage of Syringe Distribution to Prevent HIV Epidemics among Injecting Drug Users*, 42 J. AIDS 355, 355-61 (2006)).

<sup>265</sup> See Charlotte Van Den Berg et al., *Full Participation in Harm Reduction Programmes is Associated with Decreased Risk for Human Immunodeficiency Virus and Hepatitis C Virus: Evidence from the Amsterdam Cohort Studies among Drug Users*, 102 ADDICTION 1454 (2007), available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2040242> (“To provide needles and syringes only or methadone only will not be sufficient to curb the rapid spread of . . . blood-borne infections among [IDUs]. It is essential to offer a comprehensive programme in which both measures are combined, preferably also with social-medical care and counselling.”).

<sup>266</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 51.

<sup>267</sup> *Id.*

<sup>268</sup> See *supra* note 256 and accompanying text.

<sup>269</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 51.

enough to provide the desired services to IDUs.<sup>270</sup> Likewise, Sweden's SEPs, which require all visiting IDUs to be over the age of 20 and make SEP services available for only two hours each weekday, have drawn criticism from the IHRA.<sup>271</sup>

## **E. North America**

### **1. Canada**

#### *Levels of Injection Drug Use*

Similar to the experience in other regions, accurate data regarding IDUs in Canada is difficult to obtain because drug use is an illegal activity.<sup>272</sup> While it was previously thought that injection drug use was limited to Canada's largest metropolitan centers, studies show that injection drug use has spread to urban and rural centers across the country.<sup>273</sup> Recent studies estimate that approximately 286,987 Canadians inject drugs, with HIV prevalence among IDUs at a current rate of approximately 13.4%.<sup>274</sup>

#### *History of SEPs and Status of Current SEPs*

The first unofficial SEPs in Canada were opened in Toronto in 1987,<sup>275</sup> with the first official Canadian SEP established in Vancouver in 1989, and additional SEPs opening in Montreal, Toronto and other Canadian cities soon thereafter.<sup>276</sup> In the early stages of implementing these programs, the Canadian government "shared the cost of pilot outreach programs with five provinces. More recently, funding arrangements have varied widely across Canada; however, many inter-governmental partnerships have been established between provincial

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<sup>270</sup> Amy Smoyer, *Needle Exchange Programs and Public Policy in Spain*, 38-40, [http://cira.med.yale.edu/about\\_us/smoyerspain.doc](http://cira.med.yale.edu/about_us/smoyerspain.doc).

<sup>271</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 51.

<sup>272</sup> John Weekes et al., Canadian Ctr. on Substance Abuse, *Needle Exchange Programs FAQs*, <http://www.ccsa.ca/2004%20CCSA%20Documents/ccsa-010055-2004.pdf>.

<sup>273</sup> *Id.*

<sup>274</sup> Mathers et al., *supra* note 9, at \*10. Other studies have estimated this level of HIV prevalence to range from 2.9 to 23.8%. IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 76.

<sup>275</sup> Weekes et al., *supra* note 272.

<sup>276</sup> Info Sheet No. 9, *supra* note 35.

and municipal governments.”<sup>277</sup> Statistics from 2007 indicate that at that time, “the ministries of health in all ten [Canadian] provinces and two of three territories were providing support for [SEPs].”<sup>278</sup>

In 2003, Canada’s first officially approved Safe Injection Facility (SIF), Insite, opened in Vancouver.<sup>279</sup> In its first year of operation, Insite provided a safe and secure injecting site for approximately 3,000 IDUs, averaging 500-600 injections per day.<sup>280</sup>

“Health Canada reported in 2001 that there were over 200 [SEPs] operating nationally, although the actual number of sites distributing sterile injecting equipment may be significantly higher. For example, in 2007, the Toronto Department of Public Health listed over thirty needle exchange sites in that city alone.”<sup>281</sup> However, only a small portion of IDUs in Canada currently have access to SEPs as a result of various issues, such as: (i) limits on the number of syringes that may be dispensed during a single visit; (ii) the fact that vast rural areas lack SEPs and SEPs in larger metropolitan areas operate from centralized locations, making it difficult for IDUs on the outskirts of such cities to access SEP services; (iii) restricted hours of operation or availability; (iv) the reluctance of pharmacists to dispense injecting equipment to suspected IDUs; and (v) lack of SEPs in federal or provincial prisons.<sup>282</sup> The lack of access to SEP services for IDUs living outside large metropolitan areas has resulted in study results showing higher rates of needle sharing and borrowing in rural areas.<sup>283</sup> Estimates indicate

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<sup>277</sup> Weekes et al., *supra* note 272 (“For example, in Ottawa there is an approximate 50/50 cost sharing partnership between the City of Ottawa and the Province of Ontario to fund [SEP] operations” and “[i]n Québec, [SEPs] are funded by the Régie régionale de la santé publique de Montréal-Centre.”).

<sup>278</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 80.

<sup>279</sup> CANADIAN HIV/AIDS LEGAL NETWORK, INJECTION DRUG USE AND HIV/AIDS: NEEDLE EXCHANGE PROGRAMS (Info Sheet No. 11) (2005), <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=769>.

<sup>280</sup> *Id.* (“In its first year of operation there were over 100 observed overdoses but no fatalities, due to rapid staff interventions . . . . Research has indicated that the opening of the SIF was associated with improvements in public order, including reduced public injection drug use and public syringe disposal.”).

<sup>281</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 80.

<sup>282</sup> *See* Info Sheet No. 9, *supra* note 35.

<sup>283</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 81 (“[t]he survey found that 27.8% of people living in urban settings who inject drugs had lent used syringes to another person during the previous six months, while the figure for those living in rural areas was 36.2%. Similar differences were also found in the number of persons who had borrowed used syringes from another person during the previous six months (urban 32.9%, rural 41%).”).

that in Ontario, approximately 53 syringes are distributed per IDU each year—roughly 5% of the required amount.<sup>284</sup>

### *Obstacles to the Implementation and Effectiveness of SEPs*

Laws in Canada permit the distribution or sale of sterile syringes to IDUs.<sup>285</sup> “Definitions in the Canadian Criminal Code and the Food and Drugs Act exempt the distribution of needles by [SEPs] from laws governing the possession and distribution of drug paraphernalia—as long as the needle is ‘represented for use in preventing’ HIV infection and because HIV infection is considered a ‘disease.’ In short, it is not an offen[s]e under S.462.2 of the Criminal Code to distribute needles to prevent the spread of HIV infection.”<sup>286</sup> While the sale of syringes and other injecting equipment is legal and Health Canada encourages pharmacists to sell syringes, in practice, the decision to sell sterile injecting equipment is left to the individual pharmacist and it is often reported that pharmacists refuse to sell injecting equipment to suspected IDUs (particularly in rural areas where pharmacies may be the only source of clean injecting equipment).<sup>287</sup> While Canada has not implemented SEPs in prisons, separate harm reduction strategies to prevent the spread of HIV have been implemented—more so than in prisons in the United States.<sup>288</sup>

The police community in Canada generally supports the operations of SEPs, leading to a positive working relationship between law enforcement officers and operators of SEPs in Canada.<sup>289</sup> While this is not to say that concern has never been shown by the police and/or local residents that the operation of an SEP in a particular neighborhood might lead to loitering, increased violence and a

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<sup>284</sup> *Id.*

<sup>285</sup> Info Sheet No. 9, *supra* note 35 (“It is theoretically possible that [SEP] staff and drug users may be criminally charged under the *Controlled Drugs and Substances Act* for possessing traces of illegal drugs contained in used syringes. While it is unlikely that such a law would be enforced against [SEP] staff, the risk is probably greater for drug users. However, a policy of enforcing the law in this fashion would undermine the effectiveness of [SEP]s, as well as increase the likelihood that [IDUs] would abandon used injection equipment (instead of disposing of it at an [SEP]).”).

<sup>286</sup> Weekes et al., *supra* note 272.

<sup>287</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 81.

<sup>288</sup> *See id.* at 83 (noting that certain prisons offer anonymous HIV testing, provide condoms and even provide bleach for sterilizing injecting equipment).

<sup>289</sup> *See* Weekes et al., *supra* note 272 (observing that “[i]n 1995, the Canadian Association of Chiefs of Policy (CACP) passed a resolution in support of the National AIDS Strategy, which included a community-based [SEP].”).

host of other unwanted activities, in general, the relationships remain fairly positive.<sup>290</sup>

## 2. Mexico

### *Levels of Injection Drug Use*

“Several of the world’s principal drug production countries are in Latin America, as well as a number of significant countries on global transshipment routes.”<sup>291</sup> “Tijuana’s geographical location along a drug transit route has created a local consumption market [of IDUs].”<sup>292</sup> It follows that Tijuana has the highest concentration of illicit drug users of any Mexican city.<sup>293</sup> Ciudad Juárez, which like Tijuana, is also home to a heavily transient population, is believed to have the second largest population of illicit drug users in Mexico—roughly twice the national average.<sup>294</sup> Mexico ranks third among Latin American countries with respect to IDU populations, with 2008 estimates indicating that Mexico is home to approximately 53,662 IDUs.<sup>295</sup>

“Poppy fields in Mexico . . . supply the raw material for heroin manufacture.”<sup>296</sup> While not used extensively elsewhere in Latin America, where cocaine is the most used injection drug, heroin is injected in Colombia and northern Mexico, with “[i]ncreased Mexican poppy cultivation and heightened security at the Mexican–US border . . . likely to be contributory factors to local

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<sup>290</sup> *See id.*

<sup>291</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 67.

<sup>292</sup> Morgan M. Philbin, et al., *Exploring stakeholder perceptions of the acceptability and feasibility of needle exchange programmes, syringe vending machines and safer injection facilities in Tijuana, Mexico*, available at <http://ncbi.nlm.nih.gov/pmc/articles/PMC2727467/> (2008) (explaining that “Tijuana also attracts large numbers of migrants and displaced individuals who lack family and financial support, creating vulnerabilities that can lead to drug use”).

<sup>293</sup> *Id.* (observing that “[i]n 2003, there were an estimated 6000 active IDUs and 200 shooting galleries in Tijuana, but the actual number of IDUs is likely to be much higher.”).

<sup>294</sup> Joan P. Baumbach, et al., *Seroprevalence of select bloodborne pathogens and associated risk behaviors among injection drug users in the Paso del Norte region of the United States – Mexico border*, available at <http://www.harmreductionjournal.com/content/5/1/33> (2008) (noting that as of 2000, Ciudad Juárez had an estimated population of 1.2 million, with a community-based survey estimating a population of 6,000 IDUs).

<sup>295</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 68.

<sup>296</sup> *Id.* at 67 (observing that “[t]here is strong evidence to suggest that the role played by many Latin American countries in cultivation, refinement and transshipment of drugs is related to the patterns of drug use in the region.”).

heroin use[.]”<sup>297</sup> The HIV prevalence rate among IDUs in Mexico is estimated to range from 0-6%.<sup>298</sup>

### *History of SEPs and Current Status*

“Harm reduction is a fairly new concept in Mexico and one that has often been met with controversy by government.”<sup>299</sup> The first SEP in Mexico, Chihuahua, opened in Ciudad Juarez in 1986 and was operated by an NGO, Programa Compañeros.<sup>300</sup> In 2004, a second SEP opened in Tijuana, operated by Prevencasa A.C., a nonprofit organization.<sup>301</sup> As of 2008, there were small-scale SEPs operating in five other Mexican states: Coahuila, Nuevo Leon, Oaxaca, Sinaloa and Zacatecas.<sup>302</sup> At the time of a study conducted in 2008, there were no syringe vending machines in operation in Mexico.<sup>303</sup> Syringes may be purchased at pharmacies in Mexico.<sup>304</sup> Prisons in Mexico do not provide syringe exchange to inmates.<sup>305</sup>

### *Obstacles to the Effectiveness of SEPs*

While clean injecting equipment is permitted to be sold at pharmacies in Mexico, similar to the experience in other countries, pharmacists are often hesitant to sell injecting equipment to persons they suspect will use such equipment for injecting illegal drugs.<sup>306</sup> In addition, because injection drug use is

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<sup>297</sup> *Id.*

<sup>298</sup> *Id.* at 68 (noting that “[i]njecting drug use is associated with new HIV infections in . . . northern Mexico.”).

<sup>299</sup> Baumbach et al., *supra* note 294.

<sup>300</sup> *Id.* (noting that “Programa Compañeros provides a number of prevention, treatment and social services, including street and prison-based harm reduction programs”); see Philbin et al., *supra* note 292 (noting that this SEP was “unofficially sanctioned by the state Secretary of Health.”).

<sup>301</sup> Philbin et al., *supra* note 292.

<sup>302</sup> Baumbach et al., *supra* note 294. These SEP locations employ a community-based outreach strategy, similar to those in other Latin American countries. IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69.

<sup>303</sup> See IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69.

<sup>304</sup> *Id.*

<sup>305</sup> International Harm Reduction Association, Latin America—Region Overview, available at <http://www.ihra.net.LatinAmerica> (2009).

<sup>306</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69-70. As opposed to directly refusing to sell sterile injecting equipment to IDUs, pharmacists will sometimes simply charge an exorbitant price. Philbin et al., *supra* note 292.



illegal in Mexico, IDUs legitimately fear potential arrest if they attempt to access SEP services.<sup>307</sup> This is particularly so because relevant drug laws are ambiguous, allowing “room for arbitrary interpretations by law enforcement officers.”<sup>308</sup> Moreover, healthcare workers often embrace stigmatizing attitudes towards IDUs, assuming IDUs are all similarly situated individuals, “regardless of the substance used, or the frequency, quantity and mode of use[,]” dissuading IDUs from accessing SEP services.<sup>309</sup>

## **F. South America**

### ***Levels of Injection Drug Use and Current Trends***

Argentina and Brazil, the two most populous countries in South America with SEPs, both have significant HIV prevalence among IDUs, although estimates of infection rates vary widely. Brazil, a country of 191.2 million people, has between 196,000 and 800,000 IDUs, of whom it estimates 28-42% to be HIV positive.<sup>310</sup> Argentina, a country of 40.5 million people, has 65,000 IDUs, and estimates that 18.8-39.2% of those IDUs have HIV.<sup>311</sup>

The much smaller nations of Paraguay and Uruguay have correspondingly smaller populations of IDUs, each in the 3,500 to 4,500 range.<sup>312</sup> Paraguay has not recently estimated HIV infection rates among its population of IDUs, but Uruguay has found that 24.4% of its IDUs are HIV positive.<sup>313</sup>

### ***History of SEPs***

South America consists of twelve independent countries and two European-held territories.<sup>314</sup> Among these countries, only four—Argentina,

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<sup>307</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 70.

<sup>308</sup> *Id.*

<sup>309</sup> *Id.* (noting that healthcare workers often label IDUs “as self destructive addicts who are largely unconcerned about their own health,” putting IDUs at risk for sub-standard healthcare).

<sup>310</sup> *Id.* at 66; Mathers et al., *supra* note 9, at \*10 (see Table 4).

<sup>311</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 66, 69.

<sup>312</sup> *Id.* at 66.

<sup>313</sup> *Id.*

<sup>314</sup> South America consists of twelve countries (Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela), as well as two territories held by European powers (the Falkland Islands and French Guiana).

Brazil, Paraguay and Uruguay—currently operate SEPs, with most of the approximately 125 SEPs in South America operating in Brazil and Argentina.<sup>315</sup>

In Brazil, the first SEP opened in March 1995 in Salvador, a city in the northeastern state of Bahia, to some controversy, because at the time federal drug laws prohibited the operation of SEPs.<sup>316</sup> After the Salvador SEP opened, the coordinator of the Ministry of Health's National Program on STD/AIDS approved SEPs and began assisting other states with their implementation of SEPs.<sup>317</sup> Still, early SEPs struggled to reach their clients, in part because IDUs feared exposure from visiting SEPs in public places. Once SEPs began distributing needles more privately, the needle exchange became more successful.<sup>318</sup> Nevertheless, the success of SEPs in Brazil has been hindered by Brazil's penal code, which is ambiguous on the legality of possessing injecting equipment.<sup>319</sup> In fact, the police sometimes use an individual's possession of needles as proof that the individual has engaged in illegal drug use.<sup>320</sup>

In Argentina, NGOs began implementing harm reduction strategies for reducing HIV infection rates among IDUs in the early 1990s.<sup>321</sup> In furtherance of these initiatives, an NGO opened the first SEP in Argentina in June 1999 and by 2001, that organization received national government assistance in distributing syringe kits to IDUs.<sup>322</sup> In 2003, facing estimates that 40% of HIV infections among individuals over twelve years of age were caused by injection drug use, the

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<sup>315</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69. Little information exists on SEPs or their effectiveness in either Paraguay or Uruguay because they are newer and more isolated. Paraguay initiated needle exchange in 2004, when a municipal ordinance in Ypejhú, a border town, approved the first SEP in the country. *Id.* at 66; INTERCAMBIANDO NO. 6, *supra* note 15.

<sup>316</sup> Tarcisio Andrade et al., *The Opening of South America's First Needle Exchange Program and an Epidemic of Crack Use in Salvador, Bahia-Brazil*, 5 AIDS AND BEHAVIOR 51, 52 (2001).

<sup>317</sup> Andrade et al., *supra* note 316, at 57.

<sup>318</sup> *Id.*

<sup>319</sup> See Caiaffa et al., *supra* note 17, at 369.

<sup>320</sup> *Id.*

<sup>321</sup> Mercedes Weissenbacher et al., *High Seroprevalence of Bloodborne Viruses Among Street-Recruited Injection Drug Users from Buenos Aires, Argentina*, 37 CLINICAL INFECTIOUS DISEASES S348, S351 (2003); Diana Rossi et al., *Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Prevention in Injection Drug Users and their Partners and Children: Lessons Learned in Latin America—The Argentinean Case*, 37 CLINICAL INFECTIOUS DISEASES S362, S362 (2003).

<sup>322</sup> Rossi et al., *supra* note 321, at S362-63.

Minister of Health launched a national program of syringe and condom distribution to drug users, run by NGOs with support from the Ministry of Health and local municipalities.<sup>323</sup> Argentina has thus fostered the growth of needle exchanges and needle distributions through NGOs, operating with the collaboration and funding of government entities.

While possession of illicit drugs for personal use is a crime in Argentina,<sup>324</sup> it is legal in Argentina to purchase syringes.<sup>325</sup> Thus, unlike Brazilians, Argentineans who inject drugs do not face criminal prosecution from seeking out clean needles from pharmacies or SEPs.

### *Status of Current SEPs*

SEPs throughout South America operate through the efforts of community workers, rather than direct governmental control, to provide syringe exchange-related services. Most SEPs are located in Brazil, which has approximately 95 SEPs, and Argentina, which has approximately 25 SEPs. The number of SEPs has remained stable throughout the region, but has recently declined slightly in Brazil,<sup>326</sup> where SEP expansion has suffered from lack of managers, lack of training for staff and limited resources.<sup>327</sup>

Brazil's and Argentina's SEPs are similar in that both rely upon governmental and international funding for support, and yet both are primarily implemented by NGOs that are supported by governmental institutions.<sup>328</sup> SEPs in both countries primarily exist in urban areas, with fewer SEPs operating in

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<sup>323</sup> *Distributing Syringes to Drug Addicts*, LA NACIÓN, Mar. 13, 2003, available at <http://www.intercambios.org.ar/english/artperiodisticos/art5.htm>.

<sup>324</sup> *Drug Legislations*, INTERCAMBIANDO NO. 2 (Intercambios), May 2003, <http://www.intercambios.org.ar/english/boletin/intercambiando2.htm> (discussing Law 23.737, enacted in 1989); Graciela Touzé et al., *Harm Reduction in Argentina: A Challenge to Non-Governmental Organisations*, 10 INT'L J. DRUG POL'Y 47, 48 (1999).

<sup>325</sup> Rossi et al., *supra* note 321, at S363.

<sup>326</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69; see Caiaffa et al., *supra* note 17, at 366 (identifying Brazil as having over 100 SEPs). The recent decline of SEPs in Brazil may be related to reported debts at some SEPs, resulting in less funding for direct services such as needle exchange. See Elize Massard da Fonseca et al., *Syringe Exchange Programs in Brazil: Preliminary Assessment of 45 Programs*, 22 CAD. SAÚDE PÚBLICA, RIO DE JANEIRO 761, 766-67 (2006), available at <http://www.scielo.br/pdf/csp/v22n4/06.pdf>.

<sup>327</sup> Caiaffa et al., *supra* note 17, at 366.

<sup>328</sup> See, e.g., Andrade et al., *supra* note 316, at 57; *Distributing Syringes to Drug Addicts*, *supra* note 323.

more isolated regions.<sup>329</sup> While services vary from one SEP to another, many SEPs in both countries provide an exchange-based system whereby SEPs can supply injecting equipment as well as provide education on safe sex and safer injection practices, and provide medical and social service referrals.<sup>330</sup> In Brazil, some SEPs are less effective in providing needle disposal services, and thus function more as distribution services than as genuine needle exchanges.<sup>331</sup>

Independent of SEPs, IDUs throughout South America may also purchase sterile needles from pharmacies, although pharmacists sometimes refuse to sell needles to customers whom they suspect of injecting drugs.<sup>332</sup> One study found that pharmacies were an important source of clean needles for IDUs in Brazil, even in areas with few barriers to SEP access.<sup>333</sup>

### *Obstacles to the Implementation and Effectiveness of SEPs*

IDUs face both legal and practical barriers in accessing SEP services in South America. The primary legal barrier facing IDUs is that some penal codes in South America, such as Brazil's, are ambiguous on the criminality of possessing drug paraphernalia, potentially discouraging IDUs from accessing SEPs for fear of criminal prosecution.<sup>334</sup> As a secondary matter, states and municipalities typically pay for the costs of health services, permitting localities to set their own health care priorities while disregarding national policies.<sup>335</sup> Moreover, as researchers found in Brazil, police enforcement of drug laws can have the effect of deterring IDUs from frequenting SEPs.<sup>336</sup>

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<sup>329</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69; *see also* Rossi et al., *supra* note 321, at S362-63 (charting development in Argentine SEPs exclusively in large cities).

<sup>330</sup> *See, e.g.*, Andrade et al., *supra* note 316, at 57 (analyzing SEPs in Salvador, Brazil); Caiaffa et al., *supra* note 17, at 366, 369 (discussing Brazilian SEPs generally); Hernan Fluk, *Syringes to Go*, PAGINA 12, Apr. 8, 2001, *available at* <http://www.intercambios.org.ar/english/artperiodisticos/art2.htm> (discussing SEP services in Buenos Aires, Argentina).

<sup>331</sup> da Fonseca et al., *supra* note 326, at 766; Caiaffa et al., *supra* note 17, at 369.

<sup>332</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69-70.

<sup>333</sup> Caiaffa et al., *supra* note 17, at 369.

<sup>334</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 70; *see* Caiaffa et al., *supra* note 17, at 369 (discussing the ambiguity of Brazil's drug laws).

<sup>335</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69; *see* da Fonseca et al., *supra* note 326, at 762 (detailing the regional responses to HIV in Brazil). Decentralizing national health care has the effect of permitting some localities to deemphasize the importance of SEPs.

<sup>336</sup> Andrade et al., *supra* note 316, at 61-62.

IDUs also face practical impediments to accessing SEP services. Geographically, less densely populated areas have fewer SEPs.<sup>337</sup> Brazil in particular has faced difficulties in obtaining funding to expand its network of SEPs into more rural areas. Additionally, IDUs sometimes face stigma from health care workers in the region, further deterring them from seeking access to SEP services.<sup>338</sup>

### *Impact of SEPs on HIV Infection Rates*

Brazil has reported sharp reductions in HIV infection rates among IDUs as a result of its SEPs. While 21.4% of HIV infections were related to injection drug use in 1994, the year before Brazil introduced its first SEP, by 2004, HIV infections among IDUs had fallen by 62%.<sup>339</sup> In several major Brazilian cities, by 2001, HIV prevalence among IDUs had fallen from 25% to 8%, in part as a result of SEPs.<sup>340</sup>

Although Argentina has not reported the specific effect of SEPs on rates of seroconversion, one study found reduced rates of needle sharing between IDUs as well as reduced rates of individual reuse of needles, which the researchers of the report attributed in part to “the effectiveness of harm reduction activities in relation to shared use of injection equipment.”<sup>341</sup> Moreover, a recent United Nations study concluded that as more people used sterile injecting equipment in Argentina, HIV infections fell among IDUs.<sup>342</sup>

## **III. Policy Lessons from Global SEPs**

As the United States Congress considers whether to fund or implement a domestic program of syringe exchange, SEPs worldwide are instructive in demonstrating the numerous ways that the United States can create an efficient

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<sup>337</sup> IHRA, GLOBAL STATE OF HARM REDUCTION 2008, *supra* note 1, at 69.

<sup>338</sup> *Id.* at 69-70; Rossi et al., *supra* note 321, at S364 (citing such stigma in Argentina).

<sup>339</sup> Ministry of Health of Brazil, *supra* note 26.

<sup>340</sup> da Fonseca et al., *supra* note 326, at 762.

<sup>341</sup> Diana Rossi et al., *The HIV/AIDS Epidemic and Changes in Injecting Drug Use in Buenos Aires, Argentina*, 22 CAD. SAÚDE PÚBLICA, RIO DE JANEIRO 741, 747 (2006), available at <http://www.scielo.br/pdf/csp/v22n4/04.pdf>.

<sup>342</sup> JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, AIDS EPIDEMIC UPDATE REGIONAL SUMMARY: LATIN AMERICA 2 (2007), [http://data.unaids.org/pub/Report/2008/jc1530\\_epibriefs\\_latinamerica\\_en.pdf](http://data.unaids.org/pub/Report/2008/jc1530_epibriefs_latinamerica_en.pdf). Neither Paraguay nor Uruguay have reported whether their isolated SEPs have affected HIV infection rates among IDUs.

program of syringe exchange that reduces incidence of HIV infection without curbing laws against drug use. Indeed, one of the clearest lessons from these global SEPs is that SEPs have proven effective at reducing HIV infections in a variety of contexts and forms. In a broad sense, there are five key features of successful SEPs that GMHC wishes to draw to the United States Congress' attention as it considers how to craft a domestic program of syringe exchange:

- **SEPs Are Typically Community-Based Programs Supported by Governmental Funds and Regulatory Oversight.** The United States should establish a community-led system of SEPs that nevertheless encompasses government support and regulatory oversight. The most fundamental lesson learned from countries' efforts to establish SEPs worldwide is that successful SEPs tend to be collaborative efforts between national or state governments and community-based organizations or NGOs. Typically, community-based organizations will operate SEPs directly, but will do so with the financial and political support—and oversight—of the government. Some regions, such as Eastern Europe, have also drawn support and sponsorship in formulating SEPs from international governing bodies, such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC).
- **Governments Craft SEPs Flexibly to Meet National Goals and the Particular Needs of Domestic IDUs.** A brief survey of some of the most successful SEPs globally (such as those in Australia, New Zealand, France, China, Ukraine and Iran) demonstrates that SEPs may offer their services to IDUs in many different ways. These countries variously employ comprehensive SEPs with medical referrals, mobile exchange services, pharmacy-based SEPs and syringe vending machines. While each of these particular forms of SEPs have their own benefits and limitations, each form can be successful so long as it is well-tailored to meet the government's goals for the program and the needs of local IDUs. GMHC does not recommend one form of SEP over another; the most efficient form for the United States will be the form that maximizes safe injection practices by meeting the specific needs of local IDUs.
- **Laws and Regulations Legalize SEPs, but Not Necessarily Drug Use or Drug Possession.** One key legal barrier to establishing an effective system of SEPs is a legal regime that criminalizes the possession or distribution of injecting equipment for drug use. To the extent that particular states, countries or municipalities have enacted laws that forbid the distribution or possession of injecting equipment for the use of illegal drugs, such regulations should be modified in order to permit SEPs to function without violating the law. This is not, however, to say that drug possession should be decriminalized; indeed, many countries with

effective SEPs continue to enforce drug laws that prohibit the possession and use of banned substances.

- **Social and Religious Mores Disapproving of Drug Use Do Not Inhibit SEPs from Operating Effectively.** The success of SEPs in countries such as Iran and China demonstrates that countries may implement effective SEPs even where observers might expect that social or religious mores would inhibit their success. It is true that social stigma and discrimination can prevent IDUs from seeking sterile needles; nevertheless, countries that as a whole disapprove of drug use have managed to reduce the incidence of HIV among their IDUs by establishing SEPs. Indeed, our global review of SEPs suggests that governments need not fear that social and religious mores will inhibit SEPs from working effectively to reduce HIV infection rates.
- **SEPs Can Promote Rehabilitation and Reduce the Incidence of Drug Use.**<sup>343</sup> SEPs need not promote drug use or challenge enforcement of drug laws. To the contrary, SEPs can serve to provide treatment and rehabilitation services to IDUs and thereby reduce the overall incidence of drug use. Such rehabilitation is particularly important for SEPs that provide educational services and programs for aiding IDUs who have stopped using drugs. In this way, SEPs “are a useful way of getting in touch with [IDUs] in order to provide education and counseling and to connect them to health-care services and drug treatment programs.”<sup>344</sup> As previously noted, drug use remains illegal in many countries that have operating SEPs, and by promoting rehabilitation services, countries can make targeted efforts to reduce the incidence of injection drug use in addition to reducing the incidence of HIV among IDUs.

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<sup>343</sup> See generally Gay Men’s Health Crisis, *Syringe Exchange: An Effective Tool in the Fight Against HIV and Drug Abuse* (2009).

<sup>344</sup> Info Sheet No. 9, *supra* note 35.