

Fact Sheet

Supply, demand & harm reduction

Injecting drug use is on the rise throughout the world. Research suggests between 10 and 15 million people in 135 countries inject drugs. Globally, 5 to 10 per cent of HIV infections come from injecting drugs but in some countries the rate is more than 50 per cent. The traditional approach to controlling drug use is to focus on law enforcement to reduce the supply of drugs reaching the community. This is coupled with other strategies to reduce the demand for drugs. Research shows that when the demand for drugs is high, reducing the supply is largely ineffective.

“Harm reduction can co-exist with supply and demand reduction...”

The emergence of HIV/AIDS, and its rapid spread among injecting drug users (IDUs), meant that effective strategies had to be developed and adopted – these effective strategies form the harm reduction approach. Harm reduction can co-exist with supply and demand reduction but its focus is on public health rather than law and order.

What is supply reduction?

Supply reduction means using various strategies to disrupt the production and supply of illicit drugs. The strategies may include:

- destruction of the crops from which many illicit drugs are derived
- introducing crop substitution as a replacement
- removal of the precursor chemicals required for the processing of various drugs such as plant-based drugs (opium into heroin) or in the manufacture of synthetic drugs such as methamphetamine or ecstasy
- interrupting the trafficking of drugs along the various shipping, air and road transport routes.

Supply reduction has been used for decades but the evidence is that it is extremely expensive and not cost-effective.

“Basically when people want drugs they will find a way to get them”

Basically, when people want drugs (demand) they will find a way to get them (supply) whether it means finding a new supplier or changing to a new drug. Supply and demand reduction strategies do not stop this from happening.

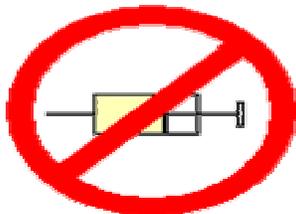
Supply reduction might work if all countries worked together to get rid of illicit drugs. But countries which are significant cultivators and/or manufacturers of illicit drugs, such as Russia, Afghanistan, Myanmar and Colombia, have chronic political instability, poverty and corruption which inhibits any chance of supply reduction. Introducing effective supply reduction is prohibitively expensive and requires massive human and technical resources. Some drug seizures are large and law enforcement agencies and governments publicise them greatly but over 90 per cent of all drugs still reach the market.

Research shows that the global illegal drug trade industry is flourishing. It is worth about US\$400 - \$500 billion a year and is a part of the ‘black economy’. It is one of the largest sectors of international trade and completely outside government control. In terms of global industries, as part of the black economy, it is second in magnitude only to the arms trade, and just ahead of prostitution. The three are often inextricably linked, with money from drugs and prostitution financing arms deals. No country is free of corruption and the huge unprecedented profits from the illicit drug trade allow corruption to flourish. For example, a kilogram of coca base (for cocaine) in Colombia costs about US\$950: it then sells for US\$25,000 in the United States. Lastly, from a public health perspective, supply reduction has had some unintended and disastrous consequences. Research shows that closing down one trafficking route often leads to the development of new trafficking routes and new populations are exposed to drug use and in turn HIV/AIDS.

What is demand reduction?

Demand reduction means trying to prevent people from wanting to and taking illicit drugs. The various approaches may include:

- providing education and information to the general community, young people (often within school-based programs) and drug users to enable them to make informed decisions about drugs
- treatment for drug users such as detoxification, drug substitution and social rehabilitation of drug users by promoting employment prospects and re-integrating drug users into the community
- community development which addresses poverty, promotes economic opportunities and the integration of people into meaningful social structures.



Just say No!

Research has shown that drug education programs often only work best for those who need it least. Scientific evaluations of various drug education programs show they are generally ineffective at reducing or stopping drug use. The largest drug education program in the United States, operating for 20 years, is called Drug Abuse Resistance Education (DARE). Various studies have shown it to have little effect on student drug use. In 2001 the U.S. Surgeon General announced DARE was an ineffective program.

Analysis of other drug education programs shows they can affect people's attitudes to drugs and increase their knowledge about drugs, but reduction of drug use is rarely achieved. The majority of drug education programs view abstinence as the sole measure of success. The failure of these programs largely comes from ignoring why people start and continue to take drugs. It is crucial to examine the links between drug use and society such as unemployment, poverty, political and cultural factors. Various forms of drug treatment exist including:

- detoxification

- residential rehabilitation
- therapeutic communities
- drug substitution therapies.

These approaches are widely used in drug demand reduction with varying degrees of success. The focus of detoxification is to manage drug withdrawal with the aim of long term abstinence. Detoxification succeeds in removing people from the drug scene in the short term but the relapse rates usually approach 100 per cent.

Longer term treatment in therapeutic communities and residential rehabilitation is used worldwide, but it is expensive, slow and often requires constant repetition. Many programs do not have a comprehensive understanding of drug users. Addiction is sometimes seen as behaviour requiring punishment rather than as a medical condition. Drug substitution, such as methadone and buprenorphine, has excellent results for many drug users, especially for chronic relapsers.

These benefits include:

- reduction in criminal behaviour
- decrease in illicit drug use
- improved job performance
- reduction in HIV-related risk behaviours
- improved retention rates in treatment
- assisting drug users to regain control of their lives by lessening relapse.

Lastly, demand reduction also focuses on community development and tries to address some of the root causes of drug use. But there are no quick solutions to deeply entrenched social and psychological risk factors for drug use.

What is harm reduction?

A principle element of harm reduction is to reduce the harmful consequences of drug use without *necessarily* reducing drug consumption.

Some major harmful consequences of drug use are:

- blood borne diseases such as HIV/AIDS and Hepatitis
- the social costs of widespread drug use
- economic costs of treating people infected with HIV/AIDS
- legal costs of imprisoning drug users
- the criminalization of drug use leading to the denial of basic health care and other social services.

"Harm reduction aims to keep drug users alive and healthy"

The philosophy of harm reduction is to encourage drug users to progress towards reduced harm and improved health at a speed which is more acceptable and realistic for them. Importantly, it does not stigmatise those who practise high-risk behaviour, recognising that such behaviours result from various complex social, environmental, economic, cultural and personal factors.

The aim of harm reduction is to keep drug users alive, well and productive until treatment works or they grow out of their drug use and can be reintegrated into society. The strategies of supply and demand reduction are primarily focused on mid to long term goals and consequently do not address the rapid transmission of HIV/AIDS. With harm reduction the emphasis is on short term practical goals, compatible with long term idealistic goals.

Harm reduction involves multiple strategies including:

- drug substitution programs (which is also part of demand reduction)
- outreach programs and peer education
- needle and syringe programs.

Scientific evidence shows that harm reduction remains the only successful effective approach to tackling illicit drug use and HIV/AIDS yet devised. Providing sterile needles and syringes plays a crucial role in decreasing the level of equipment sharing and lowers the spread of HIV/AIDS, Hepatitis B and Hepatitis C among IDUs. Outreach and peer education is a good way to reach at risk drug users, enabling them to reduce their risk behaviours and minimise their risk of blood borne viruses and other health problems. Harm reduction is pragmatic, humane, effective and holistic.

Supply reduction is extremely expensive, has substantial unintended consequences and will only ever have limited success as long as lots of people want to take drugs. Demand reduction is slow and often unrealistic but it does share some strategies with harm reduction such as drug substitution. Harm reduction is realistic, humane and has been successful in reducing the spread of HIV/AIDS. While there are substantial differences between the three approaches they actually can co-exist, complement each other and work together to contain the spread of HIV/AIDS.

Resources

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