3.2 Harm reduction

Harm reduction refers to public health interventions that seek to reduce the negative consequences of drug use and drug policies. Harm reduction has been rigorously evaluated and shown to be effective at reducing the transmission of blood-borne infections as well as morbidity and mortality related to drug use.

Why is harm reduction important?

A broad definition of harm reduction was presented in Chapter 1. This chapter focuses primarily on harm reduction as a set of health interventions, while touching on related efforts to shape public policies in ways that promote the well-being of people who use drugs.

Drug use, particularly in the context of the current drug control regime, may lead to a number of preventable health consequences, including soft tissue infections and transmission of blood-borne infections such as hepatitis B and C and HIV, through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses. Harm reduction is equally concerned with the harms caused by public policies and attitudes directed at people who use drugs. In many countries, most harms result directly or indirectly from the criminalisation and mass incarceration of people who use drugs, but also include discrimination in medical settings and subsequent problems with access to health care, barriers to employment, housing or social benefits, or denial of child custody. As such, harm reduction is often conceived as both a public health and a human rights concept.

Harm reduction is both a public health and a human rights concept.

There are around 16 million people who inject drugs worldwide,¹ and it is estimated that 10% of all HIV infections occur through injection drug use, with 30% of new infections occurring outside sub-Saharan Africa.² In many countries in Eastern Europe, the Middle East, North Africa, Central, South and Southeast Asia, and Latin America, the largest share of HIV infections occurs among people who inject drugs.³ Injection-related transmission has more recently become an important part of HIV epidemics in sub-Saharan Africa as well, where the prevalence of injection drug use now approaches the global average.⁴

The EMCDDA identified drug overdose as a major cause of mortality in EU countries.⁵ An international study supported by the EMCDDA found that in seven European urban areas, between 10% and 23% of all deaths among those aged 15 to 49 years could be attributed to opioid use.⁶ In the USA, overdose is the leading cause of injury-related mortality among people aged 35–54 years.⁷ Studies have found
that 89% of heroin users had witnessed at least one overdose in their lifetime in San Francisco (USA),
personal experience of overdose has ranged from 51% of heroin users in Australia,9 to 66% in Yunnan
province, China,10 and 83.1% in North Vietnam.11 In Russia, overdose caused 21% of all deaths among
people living with HIV in 2007,12 and the country reported a total of 9,354 overdose deaths the previous
year, which is almost certainly an undercount.13

Non-opioid and non-injecting drug use can also be related to negative health outcomes. Many
parts of the world have seen an increase in use of cocaine and amphetamine-type stimulants such
as methamphetamine, and in the non-medical use of pharmaceutical medications.14,15 Non-injection
drug use has been found to be associated with an increased risk of sexual transmission of HIV in some
contexts.16 It has been speculated that sharing crack-smoking paraphernalia may increase the risks of
hepatitis C transmission.17 Stimulant drugs may cause hyperthermia, acute psychiatric disorders, and
other harms, and inhaled drugs may cause lung infections and possibly leukoencephalopathy.18 Box 1
provides examples of effective harm reduction services for people who use non-injectable drugs.

Box 1. Harm reduction services for people who use non-injectable drugs

Although sometimes less visible because of the emphasis on HIV within public financing
around drugs and health, services supporting people who use non-injectable drugs are a
crucial part of harm reduction. In response to the harms associated with non-injection drug
use, organisations such as DanceSafe in North America have promoted education, pill testing,
and other services to ensure that ‘party drug’ users are well informed about safer use and
know what they are consuming.

Harm reduction groups in Canada and elsewhere have promoted kits for safer crack use that include
education and smoking paraphernalia made out of materials that do not emit toxic chemicals when
heated, and that have resulted in adoption of less risky drug-using behaviour among participants.19
Similarly, in Latin America and the Caribbean, where powder cocaine and crack use predominate,
harm reduction services for people who use non-injectable drugs, such as counselling, housing
services, linkages to drug dependence treatment, etc, have existed alongside NSPs since the early
1990s. ‘Safer-inhalation facilities’, where people may smoke or sniff drugs in a medically supervised
environment have also been established alongside safer injecting facilities in several countries.20

While sharing non-sterile injecting equipment has been a major source of HIV infections in North
America and Western Europe, implementation of harm reduction services has increasingly controlled
the epidemic. For example, in 2009 New York City, which had been supporting harm reduction services
for nearly 20 years, reported that only 5% of new HIV cases were transmitted through injecting drug
use.21 Similarly, Australia, the first country to have incorporated harm reduction into its national HIV
strategy, has maintained an extremely small HIV epidemic among people who inject drugs, and as a result had net healthcare cost savings of more than US$820 million22 in the years 2000–2009 alone.23 The UK,
the Netherlands, France, Spain and other European countries have seen similar success in reducing HIV incidence among people who inject drugs through widespread availability of NSPs, OST and related services. On the
contrary, countries like Russia and Thailand, which have refused to develop harm reduction interventions, have a high prevalence of HIV infections among people who inject drugs.24

Harm reduction programmes have always had a commitment to evidence-based practice. Core harm reduction services have been exhaustively
evaluated and found to be effective at reducing the transmission of HIV and other blood-borne diseases, broadly improving health, and have been found not to be associated with increased drug use.\textsuperscript{25,26} As a result, harm reduction has become the leading public health approach to drug use, and has been endorsed by numerous international health agencies, professional associations, including the UN system, the International Federation of Red Cross and Red Crescent Societies, the International AIDS Society, and the American Medical Association. At least 82 countries support harm reduction in policy and/or practice.\textsuperscript{27}

### Principles of harm reduction

This chapter uses the definition of harm reduction principles espoused by Harm Reduction International (HRI)\textsuperscript{28} and describes how these principles are applied in practice.

According to HRI, harm reduction refers to ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits drug users, their families and the community’.\textsuperscript{29}

At its roots, harm reduction recognises that despite the negative consequences associated with drug use, many people are unwilling or unable to stop using drugs; that most harms associated with drug use are preventable; and that drug use has positive aspects for many people, which must be considered in the frame of reducing drug-related harm. Harm reduction strives to respond to each individual’s unique experience of drug use, and at the community level to integrate with primary care and specialist medicine, drug treatment, housing services, the criminal justice system, and other relevant areas. At local, provincial and national levels, harm reduction is concerned with orienting government policy toward health promotion and away from criminal justice approaches to drug use.

### Harm reduction:

- **is targeted at risks and harms** – harm reduction begins from the standpoint of identifying what specific risks and harms are occurring with an individual’s or population’s drug use, defining the causes of those risks and harms, and determining what can be done to reduce them. In Thailand, this could involve encouraging methamphetamine users to smoke methamphetamine rather than injecting it, in order to avoid the harms associated with injection. In Ukraine, for example, this has led harm reduction practitioners to identify unequal access to reproductive health care for women who use drugs and to develop innovative services in response.\textsuperscript{30} In the USA, harm reduction programmes have used geographic mapping to determine ‘hot spots’ where people who inject drugs most frequently run out of new, sterile syringes, in order to better target NSP services.\textsuperscript{31}

- **is evidence based and cost effective** – harm reduction approaches are founded on public health science and practical knowledge, and employ methods that are most often low cost and high impact. New evidence on the efficacy of syringe-cleaning methods, for example, has led to renewed attention to how to support people who reuse syringes.\textsuperscript{32} There is a growing body of literature on the cost effectiveness of harm reduction intervention – particularly regarding needle exchange and OST.\textsuperscript{33}

- **is incremental** – as HRI explains, ‘Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative
rather than coercive, and ... are designed to meet people's needs where they currently are in their lives. This principle plays out in countless ways in the day-to-day work of harm reduction service providers, from working with individuals to reduce immediate harms associated with chaotic crack cocaine use in Rio de Janeiro, to helping people who use drugs to find housing in New York

- **is rooted in dignity and compassion** – a harm reduction approach views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects discrimination, stereotyping and stigmatisation. The COUNTERfit harm reduction project in Toronto used this principle to develop widely influential, drug-user-friendly workplace guidelines. Early harm reduction programmes in Iran propagated a caring, open environment and made a strong case for harm reduction in Islamic terms, in order to reach out to an extremely marginalised population of people who inject drugs

- **acknowledges the universality and interdependence of human rights** – the UN High Commissioner for Human Rights, Navanathem Pillay, declared that ‘People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment’ (see Section 1.2: Ensuring compliance with fundamental rights and freedoms)

- **challenges policies and practices that maximise harm** – the political environment in which drug use occurs plays an important part in creating the harms linked with drug use. Harm reduction thus seeks to reduce harm associated with drug policy, just as it seeks to reduce harms resulting from drug use. In much of Western and Central Europe, this insight has led governments to decriminalise drug use, which in some countries, such as Portugal, has resulted in substantial public health gains. In other countries, the objective has been to remove policies that prevent people who inject drugs from accessing HIV treatment, OST and other life-saving medical care

- **values transparency, accountability and participation** – harm reduction staff, donors, public officials, and other relevant people are ultimately accountable to people who use drugs. Harm reduction seeks to ensure such accountability by prioritising participation and leadership by people who use drugs in the design and implementation of policies and programmes that affect them. Examples of this principle include the central role of people who use drugs in conceiving and building the US harm reduction movement, requirements by harm reduction organisations that people who use drugs be represented on their boards of directors, the 2006 ‘Vancouver Declaration’ and founding of the International Network of People Who Use Drugs (INPUD).

**Box 2. The Community Action on Harm Reduction project**

The Community Action on Harm Reduction (CAHR) project is an example of how harm reduction principles can be incorporated into a comprehensive programme. The CAHR project seeks to expand access to harm reduction services for people who inject drugs in Kenya, China, India, Indonesia and Malaysia. The project is unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local authorities, public health facilities, and academics, and addressing the policy and structural barriers to programme sustainability.

The project places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China,
increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within the injecting drug using population in Indonesia.

There is a strong policy agenda that is defined by the pragmatic objective of developing effective HIV and drug use services based on available evidence. Experiences of the project on the ground are captured to influence policy debates both at the national and international level. Finally, CAHR objectives include the full and meaningful participation of people who use drugs in policy and programme design and a strong commitment to protecting and promoting human rights.

A wide range of interventions

Harm reduction entails a holistic approach to dealing with the health of people who use drugs. WHO recommends a comprehensive package of harm reduction interventions and recognises that such interventions mutually reinforce each other and maximise effectiveness in terms of health outcomes. Evidence also shows that harm reduction services lead to an increase in access to general healthcare interventions. The following, while not exhaustive, is an indication of evidence-based and cost-effective harm reduction interventions.

Needle and syringe programmes (NSPs)

The most recognisable harm reduction intervention is the supply of sterile injecting equipment to reduce the spread of HIV and other blood-borne infections. Such programmes also prevent skin and soft tissue infections (such as abscesses and cellulitis) that may result from using non-sterile injection equipment. NSPs also serve as a bridge by which people may access a wide array of other health and social services, including primary health care, drug treatment, etc.

The success of NSPs depends on a wide range of factors. These include the involvement of people who use drugs in the design and implementation of the service; accessibility and breadth of coverage; adaptability of the service to moving local drug use patterns; engagement with law-enforcement agencies not to interfere with the services; and consultation with the wider community.

While many early NSPs were developed primarily for heroin and cocaine injectors, today harm reduction addresses the complete spectrum of drug use. Similar in concept to NSPs, Canada and the USA, for example, pioneered the development of safer crack-smoking materials to reduce the potential for burns, lung infections and possible transmission of hepatitis or other infections through blood–blood contact from sharing pipes. Methamphetamine-oriented programmes like Crystal Clear in Vancouver, Canada have used peer-based programming to adapt the approach to both injecting and non-injecting use (see Box 4).

Drug-consumption rooms

Some governments, such as Australia, Canada, Spain, Germany and Switzerland, have established drug-consumption rooms. These are supervised facilities where people may bring their own drugs and inject (or in some places smoke) them without fear of arrest, and where overdoses or other health problems can be addressed by medical staff. They have been especially successful at reducing overdose mortality: deaths in the neighbourhood around Vancouver’s Insite facility dropped by 35% in the year after it opened.
Treatment for drug dependence

Opioid substitution therapy (OST) using methadone or buprenorphine is currently the most widely used evidence-based method of treatment for opioid dependence. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) as a substitute for street heroin, which is usually adulterated. OST programmes have been shown to reduce or eliminate injection drug use, reduce criminality, and improve a wide range of measures of health and social well-being. OST plays a crucial role in supporting adherence to HIV, hepatitis C and tuberculosis treatment among opioid-dependent people, and is a potent tool for overdose prevention. Although substitution therapies are not yet available for non-opioid drugs, alternative forms of treatment, such as cognitive-behavioural therapy and other psychosocial approaches, are supported by public health evidence. For more information, see Section 3.3: Treatment for drug dependence.

Overdose prevention

Overdose is experienced by a substantial portion of opioid users over their lifetime, and is a leading cause of death among people who inject drugs, and young people generally, in many countries. In the 1990s, programmes in the UK, the USA (see Box 3) and elsewhere began educating heroin users and their friends and families about overdose prevention and response, and distributing naloxone, a medication that quickly and safely blocks the effects of opioids, thereby reversing the respiratory depression that may lead to death. Such programmes have recently become more widespread, from Vietnam to Tajikistan and Puerto Rico to Slovakia, and there is growing evidence that they have contributed to significant reductions in mortality. Drug-consumption sites and OST facilities are also important tools for overdose prevention (see above). Cocaine overdose, which is implicated in a large number of deaths in some countries, poses a challenge in that there is no medication equivalent to naloxone that could be administered by lay people. Other policies that support overdose prevention include improving emergency medical services for overdose, ‘good Samaritan’ laws protecting people who respond to overdoses from potential liability, and increasing overdose surveillance and research.

Box 3. The first overdose-prevention programmes in New York City

After years of increasing overdose mortality and the deaths of many harm reduction participants, and inspired by colleagues in Chicago, San Francisco and New Mexico, three community-based harm reduction programmes launched New York City’s first overdose-prevention programmes in 2004 that included naloxone distribution to people who use opioids. The three groups covered a geographically diverse section of the city, included one programme of harm reduction services for young people, and quickly moved from an initially small-scale, periodic service to one that expanded to street-based training and saturated communities with information and tools to prevent and reverse overdose. In mid-2006, following an evaluation of the first projects, the New York City government picked up the programme, contributing enough funding to support overdose programmes at all of the city’s harm reduction organisations and to hire a full-time medical director for the programme. In the two years that followed, overdose mortality dropped by 27% citywide, and unpublished data indicate that this trend has continued. Hundreds of similar projects have since proliferated around the world, based on the simple model pioneered in the USA and parts of Western Europe.

Prevention, testing and treatment of HIV and other sexually transmitted infections

As with anyone else at risk of sexual transmission of HIV or other STIs, condoms and sexual health education and services should be made available to people who use drugs, and their sexual partners. STI testing and treatment is often linked to harm reduction services, in part because STIs – particularly
those that cause genital lesions – may increase the risk of HIV transmission. Voluntary HIV counselling and testing is also a core harm reduction activity, and should be tied to efforts to connect newly diagnosed individuals to care and treatment services. Research has found that people with a history of injecting drug use have comparable success with HIV treatment to non-drug users.\textsuperscript{57}

**Prevention, testing and treatment of viral hepatitis**

Vaccines for hepatitis A and B are highly effective and should be made available to all people at risk of hepatitis infection, especially people who inject drugs. Globally, some 90\% of new hepatitis C cases are related to injecting drug use, and while there is no hepatitis C vaccine available, hepatitis A and B immunisation may improve clinical outcomes for people with hepatitis C. There have recently been major advances in treatment for hepatitis C and it should be made available to any eligible person, regardless of their drug-use status.\textsuperscript{58}

**Prevention and treatment of tuberculosis**

People who have compromised immune systems, such as people living with HIV, are at high risk of active tuberculosis infection, particularly in closed environments such as prisons and in countries with endemic tuberculosis.\textsuperscript{59} Tuberculosis is the leading killer of people living with HIV worldwide, including people living with HIV who use drugs, and notably in Eastern Europe and Central Asia, where multi-drug-resistant strains have proliferated. Harm reduction programmes like the Anti-AIDS Foundation in Tomsk, Russia, have responded by leading surveillance efforts, educating people who use drugs about tuberculosis prevention, and supporting people in tuberculosis treatment.

**Mental health, social welfare, and other services**

While sometimes not considered to be core harm reduction strategies, a number of other services are often offered to people who use drugs. Psychiatric illness, for example, is more prevalent among people dependent on drugs than among the general population.\textsuperscript{60,61} Major depression, post-traumatic stress disorder, and other illnesses may exacerbate drug-related risk behaviour, and drug use may complicate psychiatric care. Chronic stress related to social, economic and other circumstances may also impact drug use and psychiatric comorbidity (for more information, see Section 3.1: Prevention of drug use).\textsuperscript{62} New York’s Lower East Side Harm Reduction Centre has, for example, established a team of mental health professionals to support clients living with psychiatric illness, as well as housing services, legal support, and case management to co-ordinate health and social services.

**Supporting groups at higher risk of drug-related harm**

Some groups, including women, young people and minorities, are at higher risk of drug-related harm because of discrimination, power relationships, and other factors. Harm reduction programmes consequently have a responsibility to identify people in their communities who may face unique challenges in terms of drug use, and develop appropriate services.

**Young people**

Although many young people use drugs,\textsuperscript{63} most harm reduction services are designed for adults. Most obviously, young people often have shorter drug-use histories than adults, and may also have different risk behaviours and different social, economic and legal circumstances, and may be at risk of exploitation by adults. For all these reasons, youth-specific harm reduction programmes are needed (see Box 4), yet are absent in many countries. Many barriers also exist that prevent young people from accessing harm reduction services, including parental consent. These barriers should be removed. Successful youth-oriented harm reduction programmes,
such as The Way Home in Odessa, Ukraine, and the Homeless Youth Alliance in San Francisco, USA, have given young people a leading voice in the design and administration of programmes, and grow out of a rights-based approach to health. Other interventions have targeted young people in nightlife settings, with interventions ranging from drug-information leaflets to drug-checking services, information sharing through websites, etc.⁶⁴

**Box 4. Harm reduction services for young people**

Established in 2003, Vancouver, Canada’s Crystal Clear harm reduction project began as a three-month, peer-based training course for street-involved young people concerned about their methamphetamine use. With support from the national and city health agencies, Crystal Clear expanded to become an ongoing programme that includes peer outreach, support and leadership development, harm reduction education and health services, and engagement with other civic and governmental organisations, to represent young people who use methamphetamine. The project has also produced a manual published by the Vancouver Coastal Health Authority, *Crystal Clear: a practical guide for working with peers and youth.*⁶⁵

Similarly, Youth RISE, a membership-based international harm reduction network of young people, was established in 2006 to advocate for high-quality harm reduction services and policies for young people. Rooted in peer-based leadership and human rights, including application of the Convention on the Rights of the Child to harm reduction, among other work, Youth RISE piloted a series of workshops on harm reduction for young people in Romania, India, Mexico and Canada, subsequently producing a training manual with Espolea, a Mexico City-based youth AIDS, gender and drug policy organisation.⁶⁶

**Women**

Although women represent a minority of people who inject drugs in most countries, they often face specific social stigma and marginalisation due to their drug use, because of cultural perceptions. A range of factors increase women’s risk of drug-related harm, including misogyny; unequal social and economic power relationships with men; discrimination, extortion, or sexual violence perpetrated by law-enforcement officers or others; discrimination by healthcare providers, especially towards pregnant drug-using women; and a preponderance of harm reduction and treatment programmes that are primarily directed at men. Women who use drugs are often less likely than men to buy drugs themselves, know how to inject properly, or access harm reduction services. Pregnant and parenting women who inject drugs are particularly vulnerable.⁶⁷ Some harm reduction programmes have addressed these issues in numerous ways (see Box 5 and 6), including by creating women-only spaces and support groups, adapting outreach models to better suit women, and developing a range of sexual and reproductive health services specific to the needs of women who use drugs. Global networks have also been formed to advocate for the rights of women who use drugs, including the International Network of Women Who Use Drugs and the Women’s Harm Reduction International Network.
Box 5. Building services for women who use drugs in Ukraine and Russia

In response to the particular issues facing women who use drugs, harm reduction organisations in Ukraine and Russia have made important progress in establishing model services in recent years. After discovering that some two-thirds of drug-using women in their city had no access to health services, the Tomsk Anti-AIDS Foundation in Western Siberia established a women-only space that has resulted in better linkages to medicine and uptake of harm reduction services by women, and a more than 100% increase in the number of women tested for HIV. Similarly, St Petersburg’s Humanitarian Action Foundation operates an outreach bus exclusively targeting female sex workers, as well as one of Russia’s few crisis centres for women with young children.68

Simple efforts to focus more attention on outreach to women can have a dramatic effect on access to services: by doing so, the organisation Virtus, in Dnipropetrovsk, Ukraine, saw a 50% increase in the number of women clients and an 80% increase in the number of women clients with children. The MAMA+ program in Kyiv, meanwhile, offers a more intensive service model for women living with HIV. MAMA+ has increased the proportion of clients who use drugs, and provides HIV and STI testing and treatment, counselling, family planning, gynaecological care, child care, and nutritional services, multidisciplinary support for pregnant women, home visits, and legal assistance.69

Box 6. Reaching out to women who inject drugs in Manipur, India

Although women only constitute a small proportion of people who inject drugs in Manipur, India, they are highly vulnerable to blood-borne infections, especially HIV. In partnership with the Social Awareness Service Organization (SASO), the International HIV/AIDS Alliance India developed a programme to meet their immediate needs, enhance access to harm reduction services for women who inject drugs and their partners.70

A drop-in centre was established as part of the project where women receive support such as NSP, free condoms, health check-ups (including basic healthcare, clinic-based detoxification, OST, counselling and referrals to other institutions for reproductive health and HIV care and support. The drop-in centre also offers recreational opportunities including watching TV, reading newspapers and magazines, and a space for chatting with friends and staff. Women can also bathe and use make-up kits provided by the centre. Finally, the centre acts as a venue for meetings for self-help and support groups as well as for educational classes. As women who use drugs constitute a particularly marginalised group of society, the main objective of the centre is to reach out them and encourage them to access harm reduction and general healthcare services.71

Minority groups

Some minority groups, including lesbian, gay, bisexual, transsexual, transgender and intersex and queer (LGBTTIIQ) people, racial or ethnic minorities, immigrants, or refugees, may be at increased risk of drug-related harm due to discrimination, legal or economic pressures, and barriers to accessing services. Local harm reduction services should be explicitly designed so as to be accessible by minority groups, and should be undertaken as collaborative projects between policy makers and affected communities. They should also be accessible to minorities in their own language and be culturally sensitive.72 Numerous positive examples exist (see Box 7), such as NSP services targeting Uzbek minority communities in Osh, Kyrgyzstan or Roma in Bucharest, Romania, and peer-based amphetamine-type stimulant harm reduction counselling at the San Francisco AIDS Foundation.
Box 7. Protecting the health of minority groups in Australia and Romania

From London to Chiang Mai to Zanzibar, racial and ethnic minorities often have relatively poor access to harm reduction services, and services that are less culturally appropriate when they do gain access.

In Australia, rates of drug use, HIV, viral hepatitis, and related health issues are significantly higher among Aboriginal (indigenous) communities than Australians of European descent. While some drug services for Aboriginal Australians are longstanding, efforts to expand them are more recent, and have included engagement by the governmental National Council on Drugs and partnerships between key organisations such as the National Aboriginal Community Controlled Health Organisation and the Australian Injecting and Illicit Drug Users League.

In Romania, Roma are a significant minority group that is overrepresented in terms of poverty, poor health and drug use. From the time the first harm reduction programmes were founded in Bucharest in the late 1990s, such services have targeted Roma communities, employed Roma staff, and developed materials in the local Romani dialect. Roma communities deeply stigmatise drug use, which has created barriers to services. In response, in 2009 the first Roma-led harm reduction initiative was launched in Bucharest's Ferentari district by Sastipen, a Roma health services organisation. Among other tactics, Sastipen's basic preventive health services were made available to the entire community, as a means of increasing acceptance of the harm reduction programme.

Recommendations

1) Based on public health, economic, and other evidence, a package of harm reduction services and policies should be adopted in all locations where injecting drug use is prevalent, in order to promote access to healthcare services and commodities and reduce unintended negative consequences of criminal, health and social policies.

2) Harm reduction should not be conceptualised as a standalone service but as an integrated approach that complements, and is complemented by, all levels of health, social and other services that people who use drugs come into contact with. Harm reduction should therefore be integrated whenever possible with drug treatment, primary and relevant specialist health care, social services and justice systems.

3) Harm reduction aims to empower people who use drugs to improve their health and manage, reduce, or eliminate the negative consequences of drug use. Programmes should therefore be evaluated in terms of harm reduction's core objective – to lead to any positive change. While abstinence is a potential outcome of harm reduction approaches, reducing ‘success’ to abstinence-only goals runs counter to scientific evidence about drug dependency and ignores the great value to individuals and society of countless incremental positive steps.

4) Harm reduction services should be as comprehensive as is feasible in a given setting, at minimum seeking to address the following either directly or through referral networks: prevention of HIV, hepatitis, STI and tuberculosis, and links to care and treatment; promotion of safer drug-use practices; overdose prevention and response; and basic mental health and social welfare needs.
5) Harm reduction programmes that target women, young people, and minorities who use drugs should be established, improved or scaled-up to ensure that such groups have equal access to appropriate services.

6) Harm reduction programmes and drug policies gain legitimacy when people who use drugs are meaningfully involved in their development, implementation and evaluation. Harm reduction and allied organisations, and government bodies should encourage the development of community-based organisations of people who use drugs, and should ensure that people who use drugs are represented at all levels of decision making and policy implementation and in ways that actively support participation.

7) It is critical that all these harm reduction interventions be extended to prison settings (for more information, see Section 2.4: Effective drug interventions in prisons).

**Key resources**


Endnotes


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The CAHR project is funded by the Dutch Ministry of Internal Affairs (BUZA) and led by the International HIV/AIDS Alliance and Alliance Ukraine in collaboration with project partners: Alliance China, International HIV/AIDS Alliance in India, Rumah Cemara in Indonesia, the Kenyan AIDS NGOs Consortium, the Malaysian AIDS Council, IDPC, HRI, INPUD, the AIDS Foundation East/West and Prevention, Information et Lutte Contre le Sida. For more information: http://idpc.net/policy-advocacy/special-projects/cahr-project

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