

2.4

Harm Reduction

Key recommendations

- Harm reduction approaches and principles should be integrated across all areas of drug policy, and all services that work with people who use drugs – including across the health, social and security sectors
- The UN-endorsed package of harm reduction interventions should be expanded to address harms other than HIV, and delivered to scale and in a way that is acceptable and accessible for people who use drugs
- Governments and international donors should ensure sufficient funding to deliver the optimal harm reduction response. Funds should be diverted from punitive drug law enforcement practices and into harm reduction, where the returns on investments will be greater
- Legal impediments to harm reduction and other health services (including an over-reliance on incarceration and repressive drug policies) should be removed. Law enforcement practices undermining harm reduction services should be addressed and rectified
- Harm reduction should be delivered in a way that empowers communities and people who use drugs, and also meaningfully engages them in programme design, delivery and evaluation
- Harm reduction programmes should ensure that they are gender-sensitive and accessible and relevant for young people who use drugs. This may require the creation of specialist services or programmes for women, young people and other specific groups
- Harm reduction services must be made available in prisons and other closed settings, as well as in the community.

Introduction

Harm reduction has emerged as an evidence-based, highly effective and cost-effective response to drugs around the world in the last 30 years. This approach currently sits alongside other pillars of drug policy – such as demand reduction and supply reduction – and is distinct from these in that the primary focus is on reducing harms, even if this does not result in a reduction in the prevalence of drug use or the scale of the illicit drug market. Harm reduction is a pragmatic response to drug use that accepts that while abstinence may be a worthy goal, it may not be appropriate or desirable for some individuals.

Harm reduction has been best defined by Harm Reduction International as ‘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.’⁷⁹ In some contexts, this approach is referred to as ‘harm minimisation’ or ‘risk reduction’.

Harm reduction applies to all types of substances and drug use. Historically, it has been overwhelmingly associated with interventions aimed to reduce the health harms associated with the injection of opioids. This has resulted in a lack of attention for harm reduction interventions targeting other types of drugs and use – in particular stimulant use. As patterns of drug use and routes of administration are changing rapidly, there is an urgent need to address this situation.

Harm reduction can most usefully be conceived as a set of principles rather than a list of interventions (see Box 1). It is both a public health and human rights concept, but also one that focuses on public safety and security: the harms to be targeted may include overdose, infections, over-incarceration, police violence, stigmatisation, marginalisation or harassment, to name just a few – while harm reduction should also seek to empower and engage people who use drugs in the formation, delivery and evaluation of policies and programmes.

Box 1 The principles of harm reduction⁸⁰

- Harm reduction is targeted at risks and harms
- Harm reduction is evidence-based and cost effective
- Harm reduction is incremental, acknowledging the significance of any positive change that individuals make in their lives
- Harm reduction is rooted in dignity and compassion, and consequently rejects discrimination, stereotyping and stigmatisation
- Harm reduction acknowledges the universality and interdependence of human rights
- Harm reduction challenges policies and practices that maximise harm – including criminalisation
- Harm reduction values transparency, accountability and participation.

Around the world, an estimated 246 million people use internationally controlled substances.⁸¹ Of the 8.5 to 21.5 million people who inject drugs, around 13.5% are living with HIV – far exceeding the prevalence in the general population.⁸² While a minority of people who use drugs develop dependence, most experience heightened risks as a result of criminalisation and marginalisation. An estimated 52% of people who inject drugs are living with hepatitis C, and there are thought to be nearly 200,000 drug-related deaths each year – primarily by overdose.⁸³ A growing body of research also points to the harms associated with non-injecting drug use, in particular the snorting and smoking of cocaine and its derivatives. In Latin America, there is increasing evidence that such use is associated with increased vulnerability to HIV and hepatitis C, as well as lung infections.⁸⁴ However, more data is required on the issue.

Legislative/policy issues involved

Available data and statistics clearly demonstrate the need for services and interventions which aim to protect the health and well-being of people who use drugs, prevent infections and prolong life, as well as policies to remove barriers to accessing health or justice.

The concept of harm reduction has been highly politicised in drug policy debates, with a large number of countries strongly in favour, some countries strongly against, and others preferring to refer to individual interventions rather than a harm reduction approach per se. Yet harm reduction is now widely endorsed and recommended by the UN General Assembly, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC), the Human Rights Council, the Global Fund, and many others.⁸⁵ It is also endorsed in national policy documents in 91 countries, and such high-level endorsement (often through national HIV/AIDS policies) can be important for ensuring the funding and scale-up of these services.⁸⁶

Globally, the coverage of harm reduction services for people who inject drugs remains woefully inadequate: for example, just two needles are distributed per person who injects drugs per month, and only 8% of people who inject opioids had access to opioid substitution therapy (OST).⁸⁷ In many settings, this is a consequence of a lack of political will to scale-up and endorse harm reduction programmes, and a global funding crisis for this approach.⁸⁸ As highlighted above, people who use stimulants have even more limited access to harm reduction services that respond to their specific needs.

In some settings, the coverage of harm reduction is actively undermined by laws or law enforcement practice. For example, the delivery of needle and syringe programmes (which provide sterile injecting equipment to people who use drugs to prevent blood-borne virus transmission through the re-use of unsterile items) face severe barriers in countries where the possession of needles and syringes is deemed as evidence of drug use, or outlawed in its own right. Similarly, OST using methadone, buprenorphine or other medicines is prohibited in some countries.⁸⁹ The WHO has therefore clearly stated that ‘Countries should work toward developing policies and laws that decriminalize the use of clean needles and syringes (and that permit NSPs) and that legalize OST for people who are opioid-dependent.’⁹⁰ Similar legislative reforms may also be required for other harm reduction interventions – including drug consumption rooms/safer injecting facilities, and pill or drug checking services. A wide range of UN agencies have now called for the decriminalisation of drug use in order to support harm reduction responses (see Chapter 3.1).

In many countries, harm reduction workers (especially peer and outreach workers) are also targeted by law enforcement for ‘promoting’ or ‘facilitating’ drug

Box 2 The Community Action on Harm Reduction (CAHR) Project

The CAHR project is an example of how harm reduction principles can be incorporated into a comprehensive programme. Funded by the Dutch Ministry of Internal Affairs (BUZA), via the International HIV/AIDS Alliance, the five-year project sought to expand access to harm reduction services for people who inject drugs in China, India, Indonesia, Kenya and Malaysia. The project was unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local stakeholders, and supporting international and national advocacy efforts to address the policy and structural barriers to programme sustainability.

By mid-2014, the project had reached 65,000 people who inject drugs and 240,000 further beneficiaries (such as sexual partners and family members). More than 13,000 people across the five countries have received voluntary HIV testing and counselling, 40,000 have benefited from psycho-social support, legal support, housing and/or income generation services, and 47,000 have been reached by sexual rights and health services. Furthermore, 90% of people who inject

drugs reported the use of sterile injecting equipment the last time they injected.⁹¹

The CAHR project also places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce or improve essential harm reduction interventions. In Kenya, for example, the project was instrumental in starting needle and syringe programmes (NSPs) and OST – despite major challenges from police crackdowns and some religious and community leaders.

CAHR also has 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 – for example, the project enabled the establishment of the Kenyan Network of People who Use Drugs.⁹²

use. Wherever possible, it is important that harm reduction services are delivered with the agreement, understanding and collaboration of law enforcement agencies to prevent such issues – whether this is negotiated at the local level, or formalised in national policy guidelines and protocols.⁹³ Similarly, if law enforcement officers target harm reduction services to find and arrest people who use drugs, these services will not be used by their clients and the potential health benefits will be lost.

Implementation issues involved

In 2009, the WHO, the UNODC and UNAIDS articulated a ‘comprehensive package’ of nine interventions to address HIV among people who inject drugs (see the first nine interventions listed below). These interventions collectively ‘have the greatest impact on HIV prevention and treatment’ and a ‘wealth of scientific evidence supporting [their] efficacy’.⁹⁴

It has been widely acknowledged that this list of interventions is not exhaustive. We therefore propose a number of additional evidence-based interventions (interventions 10 to 21 below) – although even this list is not comprehensive as harm reduction is forced to evolve to respond to new patterns of use and harms.

This list is predominantly focused on people who inject drugs and on HIV. However, in an effort to respond to the urgent need to elaborate better harm reduction responses for non-opioid and non-injecting drug use (for instance cocaine and ATS use,⁹⁵ as well as the non-medical use of some pharmaceutical medications), we propose a set of harm reduction interventions specifically targeted at stimulant use (interventions 19 to 21).

1. Needle and syringe programmes: The supply of sterile injecting equipment (including needles and syringes, but also filters, spoons, cleaning swabs and sterile water) to reduce the spread of infections.⁹⁶ Clients are also encouraged to return

their used equipment to allow for their safe disposal, and should be provided with information and education on safer injecting techniques. NSPs have a very strong evidence base in terms of reducing HIV transmission, risk behaviours such as syringe sharing, and helping to signpost individuals into drug treatment where required.⁹⁷

2. **OST and other drug dependence treatment:** WHO Essential Medicines such as methadone or buprenorphine can be used to substitute street opioids such as heroin – either in the long term (referred to as ‘maintenance’ therapy) or the shorter term. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) for this purpose, particularly to patients who have not responded to the other medicines available. This heavily-researched intervention has been proven to reduce injecting, reduce criminality, support adherence to HIV,⁹⁸ hepatitis C and tuberculosis⁹⁹ treatment, and improve overall health and well-being.¹⁰⁰ For more information, see Chapter 2.5.
3. **HIV testing and counselling:** This is targeted specifically at people who use drugs – but always on a voluntary and confidential basis, and ideally tied to efforts to connect newly diagnosed individuals to accessible care and treatment services.
4. **Antiretroviral therapy:** People who use drugs should have the same access to HIV treatment, following the same recommendations as for all adults.¹⁰¹ In practice, they are often discriminated against or perceived as likely to fail on treatment – yet when treatment is provided in a supportive environment, people who use drugs have similar outcomes to everyone else.¹⁰²⁻¹⁰³

5. **Prevention and treatment of sexually transmitted infections:** For people who use drugs and their sexual partners, particularly because such infections – especially those that cause genital lesions – may increase the risk of HIV transmission.
6. **Condom distribution:** Targeted at people who use drugs and their sexual partners.
7. **Targeted information, education and communication:** Including safer injecting advice (also known as ‘behaviour change communication’). It is important to provide credible information on the effects and harms associated with different substances, as well as objective information about different routes of drug administration. Information, education and communication should be up-to-date and adapt to changing patterns of drug use and purchase – for example, the trend in some countries towards online drug sales provides opportunities for the provision of harm reduction advice through online forums and customer reviews.
8. **Vaccination, diagnosis and treatment of viral hepatitis:** The vaccine for hepatitis B is highly effective and should be made available to all people at risk, including people who use drugs, prisoners and harm reduction workers. There have been major advances in treatment for hepatitis C, which is a curable disease regardless of a person’s drug use.¹⁰⁴
9. **Prevention, diagnosis and treatment of tuberculosis:** People who use drugs are at heightened risk of tuberculosis (and multi-drug-resistant tuberculosis) for a range of reasons – from frequent incarceration to the

Credit: Pham Hoai Thanh



A peer educator collecting used needles in Vietnam

Box 3 Overdose programmes in New York City

After years of increasing overdose mortality and the deaths of many friends and clients, three community-based harm reduction programmes launched New York City's first overdose prevention programmes in 2004, including naloxone distribution to people who use opioids. The three groups covered a geographically diverse section of the city, included one harm reduction programme 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 overdoses. In mid-2006, following an evaluation of the first projects, the New York City government picked up the costs of 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 a further 27% across the city.¹⁰⁵

compromised immune systems associated with HIV infections.

10. Basic health services, including overdose prevention and management:¹⁰⁶

Overdose is a common experience for many people who use drugs, and a leading cause of death among people who inject drugs. Harm reduction programmes include the provision of naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Box 3). Services may also focus on resuscitation techniques, and advice on how to prevent overdose in the first place. Additionally, medical amnesties and 'good Samaritan' laws in many countries help to protect people who respond to overdoses from potential liability, increasing the likelihood of life-saving interventions.

11. Services for people who are drug dependent or using drugs in prison or detention:

The whole suite of harm reduction services should be made available in prisons and other closed settings, just as in the community. Yet only eight countries have NSPs in prison (compared to 90



Credit: Studio KO & Association Premiere Ligne



Credit: PHS Community Services Society & Open Society Foundations

countries with community programmes), and only 43 countries provide OST in prison settings (compared to 80 countries with community programmes). For more information, please refer to Chapter 3.6.

12. Advocacy: This is identified by UNAIDS as one of the 'critical enablers' for an effective HIV response, and covers a wide range of interventions promoting and protecting the health and human rights of people who use drugs, and other affected populations. A key part of this is advocacy for drug policy reform and for harm reduction services.¹⁰⁷ Efforts to reduce the stigma associated with drug use are also crucial to remove key barriers faced by people who use drugs (see Box 4).

13. Psychosocial support: In order to meet the needs of people who use drugs, services should also be able to provide – or help clients to access – mental health, social and financial services where they are required. Psychiatric disorders such as depression, stress and post-traumatic stress disorder are more prevalent among drug using populations.¹⁰⁸ New York's Lower East Side Harm Re-

Box 4 Support Don't Punish: A global show of force for harm reduction and policy reform

The 'Support. Don't Punish' campaign¹⁰⁹ is a global advocacy initiative calling for greater investments in the harm reduction response, and for the reform of ineffective drug policies. First conceived as part of the CAHR project (see Box 2), the campaign comprises independent branding, an interactive website featuring open-access resources, social media presence,¹¹⁰ an Interactive Photo Project where more than 7,000 supporters around the world have taken part,¹¹¹ and a 'Global Day of Action'. For the latter, advocacy efforts are focused on 26 June – the United

Nations Day Against Drug Abuse and Illicit Trafficking – with the aim of reclaiming the media, the public narrative and the political discourse on this high-profile day. On 26 June 2015, activists in 160 cities around the world organised a wide variety of local actions – all using the 'Support. Don't Punish' branding and messaging to raise awareness of the campaign issues, in particular allocating more funding for harm reduction, scaling up services, and removing political and legislative barriers to ensure better access.¹¹²



Credit: Collectif Urgence Toxida

Global Day of Action in Mauritius, 26th June 2015

duction Centre, for example, established a team of mental health professionals to support clients living with mental health issues, as well as housing services, legal support, and case management to coordinate health and social services.¹¹³

14. Access to justice/legal services: As an almost universally criminalised population, people who use drugs often find themselves in confrontation with the criminal justice system. They may also be subject to human rights abuses, police abuse, mistrial and harassment. It is important, therefore, that they have access to legal support. For example, Release is a UK charity focused on drug laws and human rights, which provides a free helpline for people who use drugs to access confidential expert legal advice and support.¹¹⁴

15. Children and youth programmes: Although many young people use drugs, most services are designed for adults and may not even be legally allowed to provide people under the age of 18 with services such as NSPs. Many other

barriers exist that prevent young people from accessing harm reduction services, including parental consent in some countries. Yet many successful youth-oriented harm reduction programmes exist. For example, Vancouver's Crystal Clear harm reduction project provides peer outreach, support and leadership development, harm reduction education and health services, to support young people who use methamphetamine.¹¹⁵

16. Livelihood development/economic strengthening: This includes education, training and financial support for people to access employment, and micro-financing programmes to support people in generating legitimate incomes.

17. Drug consumption rooms/safer injecting facilities:¹¹⁶ These supervised facilities allow people to bring their pre-purchased drugs to be injected, smoked and/or snorted in a sterile, safe environment. The presence of medically trained staff ensures that overdoses and oth-

er health problems can be addressed quickly and effectively. As of 2015, there were 86 drug consumption rooms across seven European countries,¹¹⁷ plus additional services in Sydney, Australia and Vancouver, Canada. Despite many years of operation, and millions of injections overseen, there has never been a fatal overdose in these supervised facilities. The effects extend beyond the facilities themselves: deaths in the neighbourhood around Insite, Vancouver's injection facility, dropped by 35% in the year after it opened.¹¹⁸ In Switzerland, drug consumption rooms have also drastically reduced levels of disturbance in the surrounding public areas.

18. Gender-sensitive services: Women who use drugs often face greater stigma, discrimination and risks than men, and their needs may differ significantly. For example, gender-sensitive harm reduction services are those which provide, or make alternative arrangements for childcare, the prevention of mother-to-child HIV transmission, family counselling and support, programmes to reduce gender-based violence, sex work services, female condoms, and women-only spaces and/or times.¹¹⁹

19. Drug checking: In response to the harms associated with stimulant use and the emergence of a diverse array of NPS, drug checking has

Box 5 The Braços Abertos Programme in Sao Paulo

The 'Braços Abertos' (Open Arms) programme aims to address the significant health, social and security problems in Cracôlandia, a large open crack scene in Sao Paulo, Brazil. Launched in 2013, it is targeted at homeless people who use crack in the area. It provides housing in hotels contracted by the government, and offers access to healthcare, employment, clothing and one meal a day – without requiring abstinence from crack use. It is an example of a 'Housing First' approach – the objective being to support people with their drug problems by providing stable housing, hence enabling people to reduce a variety of harms associated with life on the street.¹²⁰

The 'Braços Abertos' programme required coordination across several municipal departments (health, culture, education, social welfare, environment, labour and human rights), as well as close partnerships with civil society groups. It seeks to strengthen social networks and encourage the participation and support of society. Since its creation, the programme has empowered participants to return to their families, gain formal employment or adhere to health treatments – and the Brazilian government has announced plans to scale up the approach in 21 cities.¹²¹



Participants of the Braços Abertos programme

Credit: João Luiz/SECOM

emerged to help people know what they are consuming, and avoid using unknown and potentially dangerous adulterants. This service also assists emergency medical staff and public health agencies in identifying trends in illicit drug markets to better tailor their harm reduction and treatment response. Organisations such as DanceSafe in North America provide drug checking services directly at electronic music events, with the cooperation of local public health departments.¹²²

20. Distribution of smoking paraphernalia: Crack use continues to be associated with various health problems, including blisters, sores, cuts on the lips and gums, as well as HIV and hepatitis C infections. Harm reduction groups in Canada have recently promoted the distribution of sterile crack smoking paraphernalia which include glass pipes (which are heat-resistant and shatterproof), mouthpieces, filters, alcohol swabs, screens and push sticks.¹²³

21. Social support services: Other relevant harm reduction services include housing, shelter and employment services (see Box 5).

Key resources

- European Monitoring Centres for Drugs and Drug Addiction (2010), *Harm reduction: Evidence, impacts and challenges*, <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>
- Harm Reduction International (2013), *When sex work and drug use overlap: Considerations for policy and practice*, http://www.ihra.net/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf
- Harm Reduction International (2014), *The global state of harm reduction 2014*, <http://www.ihra.net/contents/1524>
- Harm Reduction International (2015), *A global review of the harm reduction response to amphetamines: A 2015 update*, http://www.ihra.net/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf
- Harm Reduction International, the International HIV/AIDS Alliance, Save the Children & Youth RISE (2015), *Step by step: Preparing for work with children and young people who inject drugs*, <http://www.ihra.net/contents/1660>
- International HIV/AIDS Alliance (2010), *Good practice guide: HIV and drug use*, http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf
- United Nations Office on Drugs and Crime & World Health Organisation (2013), *Opioid overdose: Preventing and reducing opioid overdose mortality*, <https://www.unodc.org/docs/treatment/overdose.pdf>
- United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People Who Use Drugs (2014), *Women who inject drugs and HIV: Addressing specific needs*, http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
- World Health Organisation (July 2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
- World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2012), *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 Revision*, <http://www.who.int/hiv/topics/idu/en/index.html>