

MODULE 3

Harm reduction advocacy

Aim of Module 3

To build strategies and arguments that promote the existence, or support the adoption, of drug policies that protect people who use drugs from infections, discrimination, overdose and other preventable harms.

Learning objectives

Participants will be able to:

- Understand and explain the meaning and principles of the harm reduction approach
- Recognise how harm reduction principles can contribute to an effective, balanced drug policy
- Identify potential opportunities for policy development and barriers to success
- Agree short, medium, and long term actions to encourage a harm reduction approach in their own countries

This module examines the set of practices and principles which make up what is known as *harm reduction*.

For the past 100 years, most drug control policies have been grounded in ideological perspectives which seek to create a 'drug free society'. Experience from around the world demonstrates that this objective is unlikely to be ever realised – historical evidence shows that virtually all known human societies have experienced and embraced drug use. Therefore, a harm reduction approach has developed across the world which seeks to work practically and compassionately with people who use drugs.

Fundamentally, harm reduction recognises that:

- there are positive aspects of drug use for many people
- many people are unwilling or unable to stop using drugs, even when there are negative consequences associated with drug use
- many harms associated with drug use are preventable.



Facilitators' note

Before the session, the facilitator should gather local data on drug-related harms and harm reduction service coverage (e.g. overdose rates, trends in spread of HIV and hepatitis B or C, prevalence in the general population and among people who inject drugs, rates of incarceration) to add local context to the session. Data can be found through some regional and global reviews,* or can be sought through questionnaires sent to participants prior to the training.

* HRI's 'Global state of harm reduction': <http://www.ihra.net/global-state-of-harm-reduction>; UNAIDS' 'AIDS Info' database: <http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>; Mathers et al (2008) The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*; **372**(9651):1733–45; Mathers et al (2010) HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*; **375**(9719): 1014–1028; The World Bank's database: <http://data.worldbank.org/>; Nelson et al (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*; **378**(9791): 571–583

Harm reduction strives to respond to each individual's unique experience of drug use by providing accessible information and support, and integrating services with primary care and specialist medicine, drug treatment, housing services, the criminal justice system, and other relevant areas. When adopted, harm reduction approaches tackle drug use as a health, rather than a criminal, issue. This, in turn, can reduce some of the harms of punitive criminal justice approaches to drug use, which exacerbate stigma and discrimination and drive vulnerable individuals away from life-saving harm reduction services. Harm reduction seeks to protect the human rights of people who use drugs, particularly for vulnerable populations such as women who use drugs, young people, etc.

This module looks in detail at some of the specific interventions that characterise harm reduction, as well as the overall concept and values of harm reduction and the common challenges for implementation. This will form the basis of the development of effective harm reduction advocacy interventions.

SESSION 3.1: Activity:	The harm reduction hand
SESSION 3.2: Presentation:	Why is harm reduction important?
SESSION 3.3: Activity:	Harm reduction interventions
SESSION 3.4: Activity:	Road blocks to harm reduction
SESSION 3.5: Activity:	Peers, patients, prisoners, or partners?
SESSION 3.6: Activity:	Responding to concerns about harm reduction

SESSION 3.1



Activity: Defining harm reduction interventions



30 min

Aim – To share experiences and perspectives on harm reduction, come to a shared understanding of what the approach encompasses, and agree on a working definition to use during this training and in subsequent advocacy work

1. Introduce the aim of the session.
2. Divide the group into groups of three or four people.
3. Cut out and distribute the series of cards included in the handout 'Harm Reduction Cards'.
4. Ask participants to sort the cards into three categories:
 - a. the United Nations "comprehensive package of interventions"¹
 - b. other harm reduction services
 - c. non-harm reduction services.
5. Participants should be encouraged to discuss any disagreements or questions they may have – with the facilitator playing a key role in validating, clarifying and filling in any gaps in knowledge.
6. Present the definition below and ask participants if it matches the outcome of the activity above and if it works for them as a definition.
7. For more information, facilitators can give the participants copies of the handout 'Principles of harm reduction'.



Facilitators' note

The concept of harm reduction is most commonly associated with the protection of public health and human rights as they relate to drug use. The harms of drug use and drug control are broad – from blood-borne viruses such as HIV and hepatitis, to the mass incarceration of people who use drugs, to the damage caused to farmers and their families by crop eradication projects. As such, the term harm reduction has been used broadly by some groups. For the purposes of this module, the facilitator should use his/her judgement about whether to apply a broader or narrower definition of harm reduction, provided it fits firmly within the principles listed below.



Information to cover in this presentation:

'Harm Reduction'² 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. The harm reduction approach to drugs is based on a strong commitment to public health and human rights.

¹ See: World Health Organisation, United Nations Office on Drugs and Crime & United Nations Joint Programme on HIV/AIDS (2012), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*, <http://idpc.net/publications/2013/01/who-unodc-unajids-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>

² Adapted from: Harm Reduction International (2010), *Position Statement: What is harm reduction?* <http://www.ihra.net/what-is-harm-reduction>; International HIV/AIDS Alliance (2011), HIV and drug use: Community responses to injecting drug use and HIV, www.aidsalliance.org/publicationsdetails.aspx?id=454

The fundamental principles of harm reduction are that it:

- **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 – if not eliminate – them.
- **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.
- **is incremental** – harm reduction seeks to achieve any positive change in individuals' lives through interventions that are facilitative rather than coercive, and that take practical, achievable steps to reduce immediate harms associated with drug use.
- **is rooted in dignity and compassion** – harm reduction views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects and challenges discrimination, stereotyping and stigmatisation.
- **acknowledges the universality and interdependence of human rights** – harm reduction fully respects international human rights principles.
- **challenges policies and practices that maximise harm** – many factors contribute to drug-related risks and harms: the behaviour and choices of individuals, the environment in which they use drugs, and the laws and policies designed to control drug use. Harm reduction seeks to address all of these factors in order to protect the human rights and health of affected individuals.
- **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 accountability by prioritising participation and leadership by people who use drugs in the design and implementation of policies and programmes that affect them.
- **responds to the specific needs of a diverse range of vulnerable groups**, rather than offering a one-size-fits-all solution.

SESSION 3.2



Presentation: Why is harm reduction important?



20 min

Aim – To explore the rationale for a harm reduction approach

1. Introduce the aim of the session.
2. Remind participants that in Session 2.3 we saw that one of the high-level principles for effective drug policies is that '*drug policies should **focus on reducing the harmful consequences** rather than the scale of drug use and markets*' and in Session 1.5 we identified some of these harmful consequences.
3. Present slides.



Facilitators' note

Please replace with/add as much local data as possible when presenting the information to cover in this session..



Information to cover in this presentation:

Although many people are able to use drugs in a non-problematic way, for some individuals' drug use can lead to a number of **preventable health consequences**. These include soft tissue infections, the transmission of blood-borne infections such as hepatitis B and C and HIV through use of non-sterile injection equipment, overdose, and the exacerbation of existing mental or physical illnesses. In many settings, these harms are exacerbated by repressive and punitive drug policies that deter individuals from accessing health care and advice. Harm reduction interventions seek to minimise these health harms.

Harm reduction is equally concerned with the **harms caused by public policies and attitudes** directed at people who use drugs. In most countries, the policy environment leads to the criminalisation and incarceration of people who use drugs – affecting their chances of employment, housing, social support and even child custody. As a criminalised population, people who use drugs are also often subjected to discrimination in medical settings or denial of health care. Some groups of people who use drugs (such as women, young people and ethnic minority groups) experience additional social and cultural stigma. The harm reduction approach seeks to challenge these cultures of marginalisation. As such, harm reduction is often conceived as both a public health and a human rights concept.

The following data demonstrate why harm reduction is a vital approach around the world:

- Around 16 million people inject drugs worldwide.
- Around 3 million of these people are living with HIV. This means that 10% of all HIV infections occur through injecting drug use, with 30% of new infections occurring among people who use drugs outside sub-Saharan Africa. It also means that the HIV prevalence among this population globally is around 18 per cent.
- There are an estimated 10 million people who inject drugs who are living with hepatitis C – indicating a prevalence among this group of more than 60 per cent.

- In many countries in Eastern Europe, the Middle East and Asia, HIV and hepatitis C transmission are mainly driven by injecting drug use. Injection-related transmission has also recently become an important part of HIV epidemics in sub-Saharan Africa, where the prevalence of injecting drug use now approaches the global average.
- Drug overdose is a major cause of mortality in the EU, the USA, Russia and elsewhere.
- Non-opioid and non-injecting drug use can also lead to negative health outcomes. Many parts of the world have seen an increase in the use of cocaine and amphetamine-type stimulants such as methamphetamine, and in the non-medical use of pharmaceutical medications:
 - o Non-injecting drug use can be associated with an increased risk of sexual transmission of HIV in some contexts.
 - o Sharing drug smoking paraphernalia may increase the risk of hepatitis C transmission.
 - o Stimulant drugs may cause hyperthermia, acute psychiatric disorders, dehydration and other harms.
 - o Inhaled drugs may cause lung infections and other health complications (including cancers). It is worth noting, however, that strategies to address non-opioid and/or non-injecting drug use remain largely underdeveloped and overlooked compared to those for people who inject opioid drugs.

Yet the global coverage of evidence-based harm reduction interventions remains woefully low. It has been estimated that worldwide just two needles and syringes are distributed per person who injects drugs per month. Just 8 per cent of people who inject drugs have access to OST, and just 4 per cent of those in need receive antiretroviral therapy. Even where these services exist, these individuals are often stigmatised, criminalised and denied access.³

³ For more information, see: Mathers, M.B. et al (2010), 'HIV prevention, treatment, and care services for people who inject drugs : A systematic review of global, regional, and national coverage', *The Lancet* **375**(9719): 1014-1028, <http://www.lancet.com/journals/lancet/article/PIIS0140-6736%2810%2960232-2/abstract>

SESSION 3.3



Activity: Prioritising harm reduction interventions



40 min

Aim – To explore participants' knowledge about, experience of, and attitudes towards different harm reduction measures. To describe the main harm reduction interventions based on global evidence

1. Introduce the aim of the session.
2. Ask participants to work in pairs or in small groups and give each pair or group some flipchart paper and different coloured marker pens.
3. Ask each pair / group to note as many harm reduction interventions as they can think of and once they have done so to rate these from 1 – 5 (*acknowledge that they may already be implementing some of these*)
 - a. first (*in one colour*) – in terms of how effective they would be (or are) in the local context.
 - b. second (*in a different colour*) - in terms of how achievable it would be to set them up in the local context.
4. Ask participants to present their work and explore the reasons for their ratings.
5. Present the information below.
6. Give participants copies of the Handout on 'Harm Reduction Interventions'.
7. Check if they have any comments or questions.



Information to cover in this presentation:

In some countries, policy makers pick and choose from these lists at the expense of high-coverage implementation of essential interventions. Although harm reduction services should be considered as comprehensive and mutually reinforcing, many governments may be unable to develop all interventions because of resource constraints. It is paramount to prioritise the interventions that will be most effective in reducing harms according to the specific local contexts. The revised UNODC, WHO, UNAIDS Technical guide on HIV prevention lists the nine interventions in the order of effectiveness with NSPs and opioid substitution therapy (OST) at the top.⁴

Harm reduction interventions should also be scaled up so that all of those who need them have access to these services.⁵ If these services are not widely available for people who use drugs, they will be ineffective in reducing harms. For example, the UN guidance states that more than 200 needles and syringes should be distributed annually for each person who injects drugs, and that more than 40 per cent should have access to OST.

The quality of these services is essential to their effectiveness, and refers to the scope, completeness, effectiveness, efficiency, safety and accessibility of interventions. One way to promote service quality is to meaningfully involve people who use drugs in service design, development and delivery. Even simple mechanisms such as anonymous feedback forms and client surveys can help to obtain valuable feedback about a service. The UN guidance provides several options for measuring quality, including how many clients are provided with additional services (such as psychosocial support, IEC or adherence support).

Because a large number of people who use drugs end up in prison (either because drug use remains criminalised or because of other crimes related to some people's drug use), harm reduction interventions should be provided both in the community and in prison settings. The 'principle of equivalence' clearly articulates that prisoners should not be denied health care that would have been available in community settings – including NSPs and OST where applicable.

⁴ World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2013), *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* (Geneva: WHO), <http://idpc.net/publications/2013/01/who-unodc-unaid-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>

⁵ Joint United Nations Programme on HIV/AIDS (2005), *Intensifying HIV prevention: UNAIDS policy position paper*, http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf

SESSION 3.4



Activity: Road blocks to harm reduction



45 min

Aim – To explore local barriers to harm reduction and identify possible solutions

1. Introduce the aim of the session.
2. Divide the group into smaller groups of 3 or 4 people and distribute four A4 cards to each group.
3. Ask each group to identify:
 - a. Two barriers to the adoption of harm reduction interventions in their country/ region (e.g. ideological resistance, laws criminalising drug use and/or possession of drug paraphernalia).
 - b. Two possible barriers that people who use drugs might face even when these services are available (e.g. distance of services, opening hours, fear of arrest).
4. Ask the participants to fold their A4 cards in half and draw or write one barrier on each card.
5. Place the cards in a row on the floor, so that they look like a series of road blocks. While doing so, try and group identical / similar barriers together (i.e. 'ideological barriers' and 'religious barriers' could be discussed together).
6. Walk along the road blocks, and discuss why each barrier has been identified, and how it might be overcome.
7. Encourage the participants to identify the most important barriers of those discussed.
8. Present slides.
9. Allow time to explore each of these sets of issues and how they relate to the local context with participants, ask the participants whether and how they have been confronted to these barriers.



Information to cover in this presentation:

Policy and legislative barriers

It has been argued by some, including the INCB, that harm reduction practices fall outside the terms of the three UN drug control conventions to which most countries are signed up. The debate prompted the INCB to request the Legal Affairs Section (LAS) of the UN Drug Control Programme, now part of the UNODC, to examine the legality of harm reduction interventions.

In 2002, the LAS provided a nuanced response to the INCB. It drew attention to the fact that the treaties do not define either the 'scientific and medical' purposes to which drugs are to be restricted, or the nature of the 'treatment' and 'social reintegration' that states parties are allowed (and encouraged) to provide. This means that there is an inherent flexibility within the drug control treaties, of which member states can make use. Of the four specific harm reduction interventions discussed by the LAS statement, it found that OST, drug consumption rooms, and NSPs fall comfortably within the measures allowed by the treaties and subsequent UN resolutions. LAS also found that drug quality control interventions (such as the testing of dance drugs and tablets at clubs or festivals) run 'contrary to the spirit of the Convention' – though even here it noted a lack of any *intention* to induce or facilitate the use or possession of drugs (the intent that would be necessary for informal drug-testing to constitute a legal offence).

In general, the LAS found harm reduction practices to be well within the 'wobble-room' built into the drug control conventions. It should be added that, across much of the world, harm reduction concepts and

practices are now an established element of policies aiming to manage drug use, and are widely supported by many countries, and UN agencies, including WHO, UNODC and UNAIDS.⁶

However, in some countries, it has proved difficult to roll out interventions even though they fall within the provisions of the international drug control treaties. For instance, the overregulation of substances, such as methadone and buprenorphine, does not allow the development and scale up of OST programmes in certain countries. A notable example is that of Russia, where OST is explicitly outlawed by the State. The Russian government usually defends its position on the grounds that substitution treatment 'merely replaces one addictive drug with another', and therefore does not qualify as a medical treatment. This is, however, a very reductive argument that fails to acknowledge the enormous impact that the provision of a safe, quality-controlled and legal alternative to heroin has on the stabilisation and quality of life of people dependent on opioids. It also wilfully ignores the considerable evidence-base supporting the use of medications such as methadone and buprenorphine, which can produce clear and demonstrable improvements in health and social function.

In other countries, coverage of harm reduction services remains low, hindering their ability to respond efficiently to drug-related harms. This is often due to lack of national political and financial commitment to support the programmes, and/or lack of international funding. Indeed, in countries where harm reduction is not officially recognised and endorsed at the political level, it is not included in national programmes and is therefore not allocated any funds within national state budgets.

Finally, in many countries, the criminalisation of people who use drugs presents a direct barrier to the effective provision of harm reduction services. If the police arrest, or are widely perceived as targeting, people who access harm reduction and treatment facilities, this will deter many individuals from seeking support and life-saving services. Similar barriers exist where drug services are perceived as being too closely linked to law enforcement agencies – for example, where people who use drugs must be added to police registries before accessing support.

Institutional and socio-cultural issues

Often, cultural and ideological assumptions can represent the greatest obstacles to the design and implementation of harm reduction programmes. The notion that providing NSPs, for example, 'is likely to encourage drug use' is entirely unsupported by scientific evidence, but is a familiar argument.

At their most basic, social and cultural barriers include prejudicial, stereotypical images of people who use drugs, and harm reduction programmes must address these attitudes and misconceptions among the general population and policy makers. An education-oriented advocacy intervention that addresses these beliefs and prejudices is, in consequence, an essential element of harm reduction.

Economic and technical resource issues

Globally, there is a huge funding gap for harm reduction – with the available resources from governments and international donors falling far short of the estimated need. This is often a result of a lack of political will in both developed and developing countries, rather than an actual shortage of resources. In 2007, it was estimated that approximately US\$ 160 million was invested in HIV-related harm reduction in low and middle income countries: just three US cents a day for each person who injects drugs. To put this into perspective, the estimated need in 2009 was more than US\$ 2 billion!⁷ The lack of funding for harm reduction interventions is in many cases a harm caused by the hostile political environments and reluctance from governments to provide support to people who use drugs.

However, these interventions are generally highly cost-effective. In fact, a powerful economic case can be made in favour of harm reduction, since a relatively modest outlay can often prevent very significant costs accumulating in the longer term. For example, costs incurred in the on-going treatment of conditions such as HIV and hepatitis C, or the very large sums spent on criminal justice measures such as imprisonment, can be avoided by the timely scale up of harm reduction interventions that prevent infection and help people to avoid the criminal lifestyles often associated with the funding of drug dependence.⁸

⁶ See, for example: https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

⁷ Harm Reduction International (2010), *Three cents a day is not enough: resourcing HIV-related harm reduction on a global basis* http://www.ihra.net/files/2010/06/01/IHRA_3CentsReport_Web.pdf

⁸ Harm Reduction International (2011), *Harm reduction: A low-cost, high-impact set of interventions*, <http://dl.dropbox.com/u/64663568/library/Harm-reduction-low-cost-high-impact.pdf>

SESSION 3.5



Activity: Peers, patients, prisoners, or partners?



30 min

Aim – To explore common perceptions of people who use drugs and discuss their importance to the harm reduction approach, and drug policy reform more generally

1. Introduce the aim of the session.
2. Divide the participants into four groups. Provide each group with flipchart pads and pens.
3. Ask the participants to consider three terms: 'criminals', 'patients' and 'partners'. Using the flipcharts, ask the participants to do a brief word association exercise of the three terms – writing what words and images each term creates in their minds.
4. Back in plenary, discuss some of the words that have been used. Encourage the participants to think about how each of these labels might impact on a person's own self-image and their likelihood to access services or talk to practitioners. Ask participants to also think about what terms are more commonly used in the country/region to characterise people who use drugs, and what impact this has on public perceptions.
5. Present the information below and distribute the handout 'The Vancouver Declaration'.



Facilitators' note

If time is allowed, the facilitator can also show the entirety or abstracts of this 6-minute video on drug user involvement in drug services: <http://vimeo.com/aldp/review/61355076/5f8ee8995f>



Information to cover in this presentation:

In the 1970s, two of the first drug user organisations were created:

- The 'JunkieBond' was developed by people who use drugs in the Netherlands in order to lobby politicians and the media about their treatment and misrepresentation.
- The Committee of Concerned Methadone Patients and Friends (CCMP) was formed by Methadone patients in New York.

These groups were both engaged in drug user-led, grassroots activism and played a key role in advocating for effective and quality treatment. They also focused on conflict resolution within drug using communities in order to portray positive identities and engender a sense of community. JunkieBond are also widely accredited with opening the world's first needle and syringe programmes – in response to sudden Hepatitis B epidemics among their friends and colleagues.

The emergence of HIV and hepatitis led to a growth in drug user organising, particularly among people who inject drugs. The Australian IV and Illicit Drug Users League (AVIL) began to run needle and syringe programmes, undertake social marketing campaigns and produce magazines. Similar groups were also developed in Europe and North America – sometimes officially and sometimes 'underground'. More recently, similar models have been adopted across Asia, Eastern Europe and Africa.

Over time, many drug user organisations have developed a human rights discourse in addition to continuing public health work. Adopting a rights-based approach has even allowed people who use drugs to take legal actions against governments in order to gain access to services.

The [International Network of People who Use Drugs](#) (INPUD) was established in 2006 at the International Harm Reduction Conference in Vancouver, Canada. It aims to represent the interests of people who use drugs on the world stage – advocating for their rights, engaging with decision makers, support regional and national networks, promoting harm reduction, and building alliances with other organisations (including those representing sex workers, people living with HIV, and men who have sex with men). INPUD's founding statement is known as the 'Vancouver Declaration', and the organisation is now accepted as a legitimate partner by the relevant UN agencies.

Drug user networks are now flourishing both at regional level (with, for example the [Asian Network of People Who Use Drugs](#), the [Eurasian Network of People Who Use Drugs](#), the [Latin American Network of People Who Use Drugs](#), etc.) and national level (with, for example, the French drug user network [ASUD](#), the Kenyan Network of People Who Use Drugs, etc.).

SESSION 3.6



Activity: Responding to concerns about harm reduction



30 min

Aim – To practice responding to concerns about harm reduction from groups that may often not understand or approve of this approach

1. Introduce the aim of the session.
2. Split participants into three groups and give them the scenario below:

You/your organisation are invited to meet with [NAME THE TARGET]. They want to know more about your organisation and about some harm reduction interventions that are being implemented. They have some concerns about the concept of harm reduction and ask some questions. You have a short amount of time to answer the questions below:

 - o *Doesn't harm reduction send out the wrong message – promoting drug use or making it look safe?*
 - o *Surely we must enforce the law, and that means that drug users have to be punished?*
 - o *I hear that the outreach workers help people use drugs. Are outreach workers assisting and encouraging illegal acts?*
 - o *Why do we need NSPs when we have methadone programmes?*
3. Give each of the group a different audience to whom they must respond (e.g. the police, the head of the national drug control agency, the Minister of Health, a religious leader, a community leader, the media, etc.).
4. In each group, one of the participants will be the targeted audience, and another participant will be the advocate defending harm reduction, as a role play exercise.
5. After 10 minutes, encourage each group to swap roles so that each participant has a chance to respond to concerns on harm reduction. The facilitator should encourage the participants to tailor their responses to the specific audience. For example, senior police officers will want to hear about reduced crime, while religious leaders will prefer to hear about humane responses in line with their own beliefs, community strengthening, etc.
6. At the end of the exercise, encourage the participants to share any challenges or thoughts they may have – and reflect back on some of the arguments you have heard while walking around the room.



Facilitators' note

The audience in this exercise will be chosen depending on the participants and the local/national/regional context at hand.

This exercise can be adapted to the international context, using audiences such as the INCB chair, the UNODC Executive Director, CND delegations, etc.

Harm reduction cards (to cut out and distribute)

The United Nations “comprehensive package”



Needle and syringe programmes	Opioid substitution therapy	Voluntary HIV testing and counselling
Antiretroviral therapy for people living with HIV	Treatment of sexually transmitted infections	Condom distribution
Information, education and communication	Hepatitis vaccination, testing and treatment	Tuberculosis prevention, testing and treatment

Other harm reduction interventions*



Crack pipe and smoking foil distribution	Drug consumption rooms	Outreach services
Advocacy for drug policy reform	Provision of alternative livelihoods	Overdose prevention and management
Drug user organising and peer-led advocacy	Legal services and legal aid	Psychosocial support

Non-harm reduction interventions*



Crop eradication	Police efforts to arrest drug dealers	Compulsory / forced detention
Mass-media campaigns against drug use	Imprisonment of people who use drugs	Abstinence-based programmes

* Although the nine interventions in the UN “comprehensive package” are clearly defined, there may be more disagreement in the group in terms of what else is a harm reduction intervention or not. There are no right or wrong answers here, and discussion should be encouraged in order to reach agreement. The comprehensive package is available at: World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2013), *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* (Geneva: WHO), <http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Guide-HTML/Chapter-3.2.pdf>

Harm reduction interventions for people who inject drugs*

The **World Health Organisation (WHO)**, the **Joint United Nations Programme on HIV and AIDS (UNAIDS)** and the **United Nations Office on Drugs and Crime (UNODC)** have developed a comprehensive package of nine interventions to prevent HIV among people who inject drugs:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

In addition to these nine interventions, the International HIV/AIDS Alliance have also described some further interventions that comprise a harm reduction approach:

10. Sexual and reproductive health services, including the prevention of mother-to-child transmission of HIV
11. Behaviour change communication
12. Basic health services, including overdose prevention and management, including the distribution of naloxone
13. Services for people who are drug dependent or using drugs in prison or detention
14. Advocacy
15. Psychosocial support
16. Access to justice / legal services
17. Children and youth programmes
18. Livelihood development / economic strengthening.

Finally, the **IDPC Drug Policy Guide** adds a final harm reduction intervention to this list:

19. Drug consumption rooms / safer injecting facilities

* World Health Organisation, United Nations Office on Drugs and Crime & United Nations Joint Programme on HIV/AIDS (2012), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*, <http://idpc.net/publications/2013/01/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>; International HIV/AIDS Alliance (2011), *Good practice guide: HIV and drug use: community responses to injecting drug use and HIV*, <http://www.aidsalliance.org/includes/Publication/GPG-HR-English.pdf>; International Drug Policy Consortium (2012), 'Chapter 3.2: Harm reduction', *Drug policy guide, 2nd edition*, <http://dl.dropbox.com/u/64663568/library/IDPC-Guide-HTML/Chapter-3.2.pdf>

Principles of harm reduction*

Harm reduction is targeted at risks and harms.

It 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 Ukraine, for example, this has led services to identify reproductive health and risks as important issues for women who use drugs. In response, they have developed innovative services for this population....

Harm reduction is evidence based and cost effective.

This approach is 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. There is a growing body of literature on the cost effectiveness of harm reduction interventions – particularly regarding NSPs and OST.

Harm reduction is incremental.

As Harm Reduction International (HRI) explain, '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.

Harm reduction is rooted in dignity and compassion.

This 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.

Harm reduction 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'.

Harm reduction challenges policies and practices that maximise harm.

Many factors contribute to drug-related risks and harms: the behaviour and choices of individuals, the environment in which they use drugs, and the laws and policies designed to control drug use. Harm reduction seeks to address all of these factors in order to protect the human rights and health of affected individuals.

In much of Western and Central Europe, for example, this insight has led governments to decriminalise drug use to various extents. In Portugal, a decriminalisation approach has resulted in substantial gains in reductions in HIV and hepatitis B and C infections and overdose deaths, a decrease in prison overcrowding, a reduction in drug-related crime, etc.

Harm reduction values transparency, accountability and participation.

Harm reduction principles encourage open dialogue, consultation and debate. A wide range of stakeholders must be meaningfully involved in policy development and programme implementation, delivery and evaluation. In particular, people who use drugs and other affected communities should be involved in decisions that affect them.

For example, in North America, people who use drugs played a central role in conceiving and building harm reduction movements as a practical response to the harms being experienced by their peers. The 2006 'Vancouver Declaration' outlines this approach and laid the foundation for the International Network of People Who Use Drugs (INPUD).

* For more information, please see: International Drug Policy Consortium (2012), 'Chapter 3.2: Harm reduction', *Drug policy guide, 2nd edition*, <http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Guide-HTML/Chapter-3.2.pdf>

Countering common misbeliefs and negative attitudes*

'There is no problem' – This is a common argument in countries with few recorded cases of (or inadequate data on) HIV or hepatitis C infections among people who inject drugs.

REPLY:

We know from experience that every country with injecting drug use is at risk of HIV, hepatitis B and/or hepatitis C epidemics among people who inject drugs and their partners, and that these epidemics can expand rapidly in the absence of prevention measures. Prevention that starts early is much less expensive and much more effective in saving lives than prevention efforts developed after an epidemic is established. Rapid assessment should be done immediately to determine the extent of injecting drug use, related risk behaviour, HIV and hepatitis. Based on these data and/or the experiences of community-based organisations, action should be taken immediately at a scale large enough to prevent epidemics among people who inject drugs, or to bring an existing epidemic under control.

'Drug users do not matter' – Some people believe that people who use drugs are 'bad', 'immoral' or 'evil' people, and therefore should not be provided with health services.

REPLY:

People who use drugs are members of society, and the health of all people in a society is important and must be protected: no one deserves to die simply because they use drugs, especially as we know how to prevent HIV and hepatitis C infections and how to prevent and manage overdoses.

The vast majority of people who use drugs do so in a non-problematic way with no health or social consequences – for example, people who use drugs are young people experimenting with substances in the context of their personal development. Drug use and drug-related problems can affect anyone, and the reasons for drug use are many and complex.

'There are more important health problems' – This is a very common argument, especially in developing and transitional countries. It is also often true, at least in the short term.

REPLY:

The truth about HIV and hepatitis C epidemics is that they overwhelm health systems several years after the initial epidemic has occurred. Unless they are brought under control, massive waves of related illnesses can occur. The only way to prevent this from happening is to prevent blood-borne transmission now, as part of a balanced health response that also tackles other acute health issues such as malaria, tuberculosis or other diseases.

'Needle and syringe programmes and opioid substitution therapy encourage drug use and drug injecting' – This is a particularly reactionary attitude that is easily debunked with the available evidence and international experience.

REPLY:

This is simply not true. Harm reduction activities have been studied extensively to determine specifically whether they lead to any negative consequences such as increased drug use or increased injecting. In no research has this been shown to occur. In fact, the effect is often the opposite, with people who use drugs being engaged in services that help them to address their drug use. Eventually, as a result of the trust and relationship established by programmes, many individuals will then voluntarily seek to stop or reduce their drug use.

'Police must enforce the law and drug users have to be punished' – This is a very common argument.

REPLY:

Across the world, it is common practice to enforce the law with some discretion. Although police cannot directly amend the law, they can determine whether to enforce certain laws more or less vigorously, in which areas to focus their resources, and on what crimes they will concentrate. Evidence shows that fear of arrest by the police is often stronger than fear of acquiring HIV or hepatitis C, so that people who use drugs are likely to take greater risks in injecting drugs when they fear arrest. They will also not seek out support or information if there is a perceived risk of arrest or police harassment. Health workers need to be able to communicate and build up this trust with people accessing services so that information on harm reduction can be conveyed and taken on board.

'Needle syringe programmes and opioid substitution therapy send the wrong message' – This is extremely common, especially from politicians, in almost every country. It means that the government is committed to 'fighting drugs' and being 'tough on drugs', and that they regard harm reduction as contradicting this.

REPLY:

Implementing harm reduction interventions does not imply 'weakness' or being 'soft on drugs' – quite the opposite. This argument can be easily turned around: the weakest approach to take is to persist with punitive policies that have been proven not to work. Countries that implement harm reduction also continue to have strong policies on reducing drug supply and demand. A balanced approach is needed that allows a government to maintain control over drug use by its citizens, while also preventing harms such as HIV and hepatitis epidemics among people who use drugs.

'The laws are fixed, and I cannot change them' – This is especially common among bureaucratic policy makers.

REPLY:

In this circumstance the law may not need to be changed. There may be regulations that can be amended while legal review or change is pending. There may be policy statements that can be changed, which can put pressure on legislators to change laws. It may also be possible to negotiate local agreements with police or prosecuting authorities to circumvent restrictive laws (such as laws prohibiting the possession of needles and syringes).

'Drug users should not receive special assistance'

REPLY:

Harm reduction activities do not mean that people who use drugs receive special assistance. Rather, they are just providing basic standards of care and protection to a population that otherwise has unequal access to health care. It means that a society gives priority to disease prevention among this group, in order to protect the health of all members of society and prevent the over-burdening of health systems.

'Ideas from Western countries are unsuitable in this country' – This is a common argument even from health professionals, lawyers and especially police and politicians in some countries.

REPLY:

Harm reduction has been proven to work across a broad range of settings – including low, middle and high income countries in every region of the world. It may be that local policy makers prefer to start with pilot programmes to demonstrate effectiveness in the local context, political commitments must be made to scale-up and support these services once their effectiveness has been demonstrated.

* Adapted from: World Health Organisation, Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime (2004), *Advocacy Guide: HIV/AIDS prevention among injecting drug users* (Geneva: WHO), <http://www.who.int/hiv/pub/advocacy/en/advocacyguideen.pdf>

The 2006 'Vancouver Declaration'

Why the world needs an international network of activists who use drugs

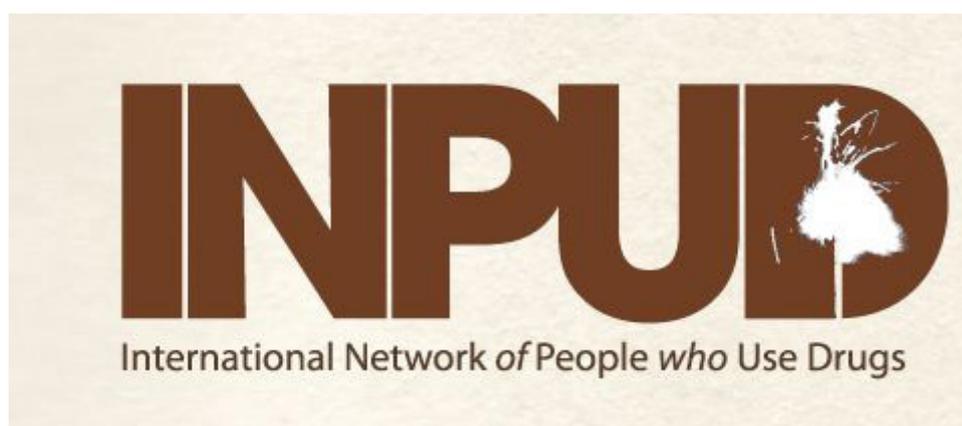
We are people from around the world who use drugs. We are people who have been marginalized and discriminated against; we have been killed, harmed unnecessarily, put in jail, depicted as evil, and stereotyped as dangerous and disposable. Now it is time to raise our voices as citizens, establish our rights and reclaim the right to be our own spokespersons striving for self-representation and self-empowerment:

- To enable and empower people who use drugs legal or deemed illegal worldwide to survive, thrive and exert our voices as human beings to have meaningful input into all decisions that affect our own lives.
- To promote a better understanding of the experiences of people who use illegal drugs, and particularly of the destructive impact of current drug policies affecting drug users, as well as our non-using fellow-citizens: this is as an important element in the local, national, regional and international development of these social policies.
- To use our own skills and knowledge to train and educate others, particularly our peers and any other fellow-citizens concerned with drugs in our communities.
- To advocate for universal access to all the tools available to reduce the harm that people who use drugs face in their day-to-day lives, including, i) drug treatment, appropriate medical care for substance use , ii) regulated access to the pharmaceutical quality drugs we need ii) availability of safer consumption equipment, including syringes and pipes as well as iii) facilities for their safe disposal, iv) peer outreach and honest up-to-date information about drugs and all of their uses, including v) safe consumption facilities that are necessary for many of us.
- To establish our right to evidence-based and objective information about drugs, and how to protect ourselves against the potential negative impacts of drug use through universal access to equitable and comprehensive health and social services, safe, affordable, supportive housing and employment opportunities.
- To provide support to established local, national, regional, and international networks of people living with HIV/AIDS, Hepatitis and other harm reduction groups, making sure that active drug users are included at every level of decision-making, and specifically that we are able to serve on the boards (of directors) of such organizations and be fairly reimbursed for our expenses, time and skills.
- To challenge the national legislation and international conventions that currently disable most of us from living safe, secure and healthy lives.

Well aware of the potential challenges of building such a network, we strive for:

- Value and respect diversity and recognize each other's different backgrounds, knowledge, skills and capabilities, and cultivate a safe and supportive environment within the network regardless of which drugs we use or how we use them.
- Spread information about our work in order to support and encourage development of user organizations in communities/countries where there are no such organizations.

- Promote tolerance, cooperation and collaboration, fostering a culture of inclusion and active participation.
- Democratic principles and creating a structure that promotes maximum participation in decision making.
- Maximum inclusion with special focus to those who are disproportionately vulnerable to oppression on the basis of their gender identity, sexual orientation, socioeconomic status, religion, etc.
- To ensure that people who use drugs are not incarcerated and that those who are incarcerated have an equal right to healthy and respectful conditions and treatment, including drug treatment and access to health-promoting supplies such as syringes and condoms and medical treatment or at least equal to that they would receive outside.
- To challenge execution and other inhuman treatment of people who use drugs worldwide.
- Ultimately, the most profound need to establish such a network arises from the fact that no group of oppressed people ever attained liberation without the involvement of those directly affected by this oppression. Through collective action, we will fight to change existing local, national, regional and international drug laws and formulate an evidence-based drug policy that respects people's human rights and dignity instead of one fuelled on moralism, stereotypes and lies.



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<http://www.inpud.net/index.php/statements-and-position-papers/12-vancouver-declaration.html>

The IDPC Training Toolkit on Drug Policy is available at:
<http://idpc.net/policy-advocacy/training-toolkit>