MODULE 4

Harm reduction advocacy

Aim of Module 4

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

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 sought through questionnaires sent to participants prior to the training, or found through some of these resources below:

- 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/
- West Africa Commission on Drugs (2013), Not just in transit: Drugs, the State and Society in West Africa, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
- 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/

Introduction

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", and West Africa has been no exception to the rule (see Module 1). Experience from around the world demonstrates that this objective is unlikely to ever be realised – historical evidence shows that virtually all known human societies have experienced some levels of drug use. We have seen in Module 3 that in West Africa the absence of drug dependence treatment systems poses significant public health risks, potentially aggravating existing challenges such as the spread of HIV. This is particularly concerning when evidence shows that the transit of cocaine, heroin and amphetamine-type stimulants (ATS) has led to increased drug use in the region, especially among young people.

The harm reduction approach is increasingly being considered as a political necessity in West Africa, as a way 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.

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 in West Africa. This will form the basis of the development of effective harm reduction advocacy interventions.

SESSION 4.1:
Activity: Defining harm reduction interventions

SESSION 4.2:
Presentation: Why is harm reduction important?

SESSION 4.3:
Activity: Harm reduction interventions

SESSION 4.4:
Presentation: Harm reduction in West Africa

SESSION 4.5:
Activity: Road blocks to harm reduction

SESSION 4.6:
Activity: Peers, patients, prisoners, or partners?

SESSION 4.7:
Activity: Responding to concerns about harm reduction

MODULE 4

Session 4.1
Activity: Harm reduction advocacy

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 the participants to sort the cards into three categories:
    a. the UN "comprehensive package of HIV prevention interventions among people who inject drugs"[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. The facilitator should ask the participants if there is any other harm reduction intervention that is not included in the list of interventions provided during the exercise.
6. Present the accompanying slides and 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.

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-unaids-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision

Information to cover in this presentation:

"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. The harm reduction approach to drugs is based on a strong commitment to public health and human rights.

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.
- r**esponds to the specific needs of a diverse range of vulnerable groups**, rather than offering a one-size-fits-all solution.

MODULE 4

Session 4.2
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 the information below and corresponding slides.

Information to cover in this presentation:

HIV through use of non-sterile injection equipment, overdoses, 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 access to healthcare, 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.

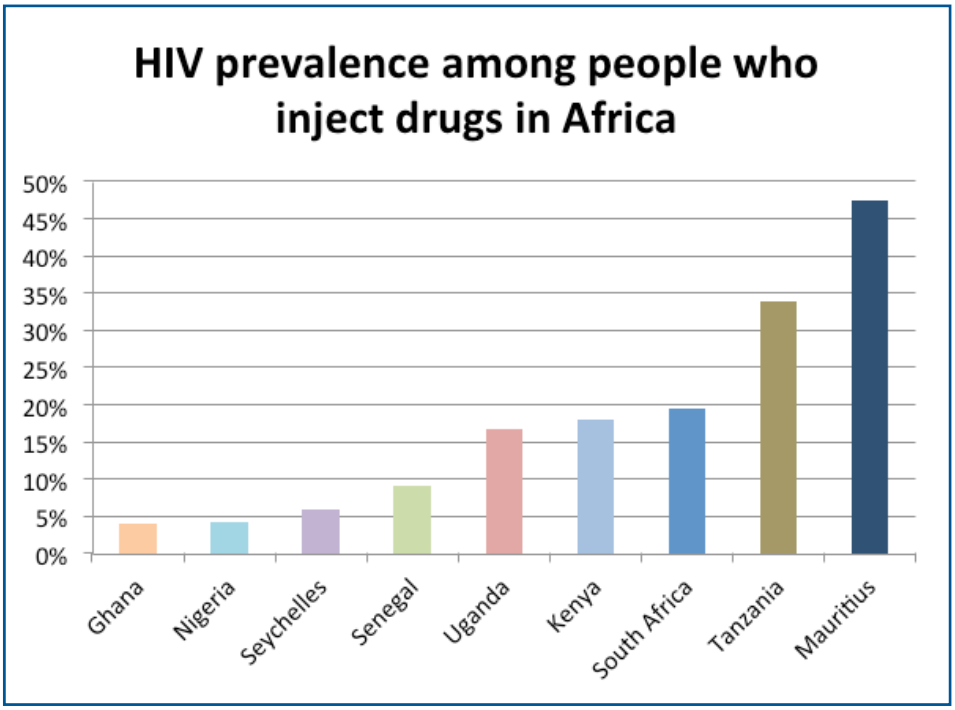
The following data demonstrate why harm reduction is a vital approach in West Africa:

- There are estimated to be 12.7 million people inject drugs worldwide, more than 13% of whom are living with HIV.[1]
- In Sub-Saharan Africa, an estimated 1 million people inject drugs. Of these 1 million people, between 5 and 10% are estimated to be living with HIV.[2] Although the Joint United Nations Programme on HIV and AIDS (UNAIDS) has reported a decline of 34% in the annual number of new HIV infections among adults in Sub-Saharan Africa since 2001,[3] there are risks that the gains in tackling HIV in the region may be lost if HIV among people who inject drugs is not addressed rapidly. In several Sub-Saharan African countries, HIV prevalence among people who inject drugs is on the increase:

Facilitators' note

Please replace with/add as much local data as possible when presenting this information.

- 4% in Ghana
- 4.2% in Nigeria (where 9.1% of all new HIV infections are now attributed to injecting drug use)
- 9.1% in Senegal (compared to under 1% among the general population)
- 16.7% in Uganda
- 18% in Kenya
- 19.4% in South Africa
- 33.9% in Tanzania
- 47.4% in Mauritius[4].



Source: Global State of Harm Reduction, 2014

- HIV prevalence in a number of countries (Senegal, Tanzania and others) tends to be significantly higher among women who inject drugs than among men – with HIV prevalence among women who inject drugs being between 5 and 15% higher than their male counterparts in Nigeria, and between 55 and 68% higher in Tanzania. In Senegal, the prevalence rate was at 21.1% among women, compared to 7.5% among men. This can be explained by the fact that some women who inject drugs participate in highly risky injecting practices because of gender inequality, dependence on male partners and their possible involvement in sex work.[5]
- Globally, there are an estimated 10 million people who inject drugs who are also living with **hepatitis C** – indicating a prevalence among this group of more than 60 per cent. Approximately 800,000 of these people are in Sub-Saharan Africa.4 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. In Senegal, hepatitis C prevalence among people who inject drugs reached over 23%.[6]
- **Drug overdose** is a major cause of mortality in many parts of the world.
- **Non-injecting drug** use can also be associated with negative health outcomes. Many parts of the world, including West Africa, have seen an increase in the use of cocaine and ATS, and in the non-medical use of pharmaceutical medications:

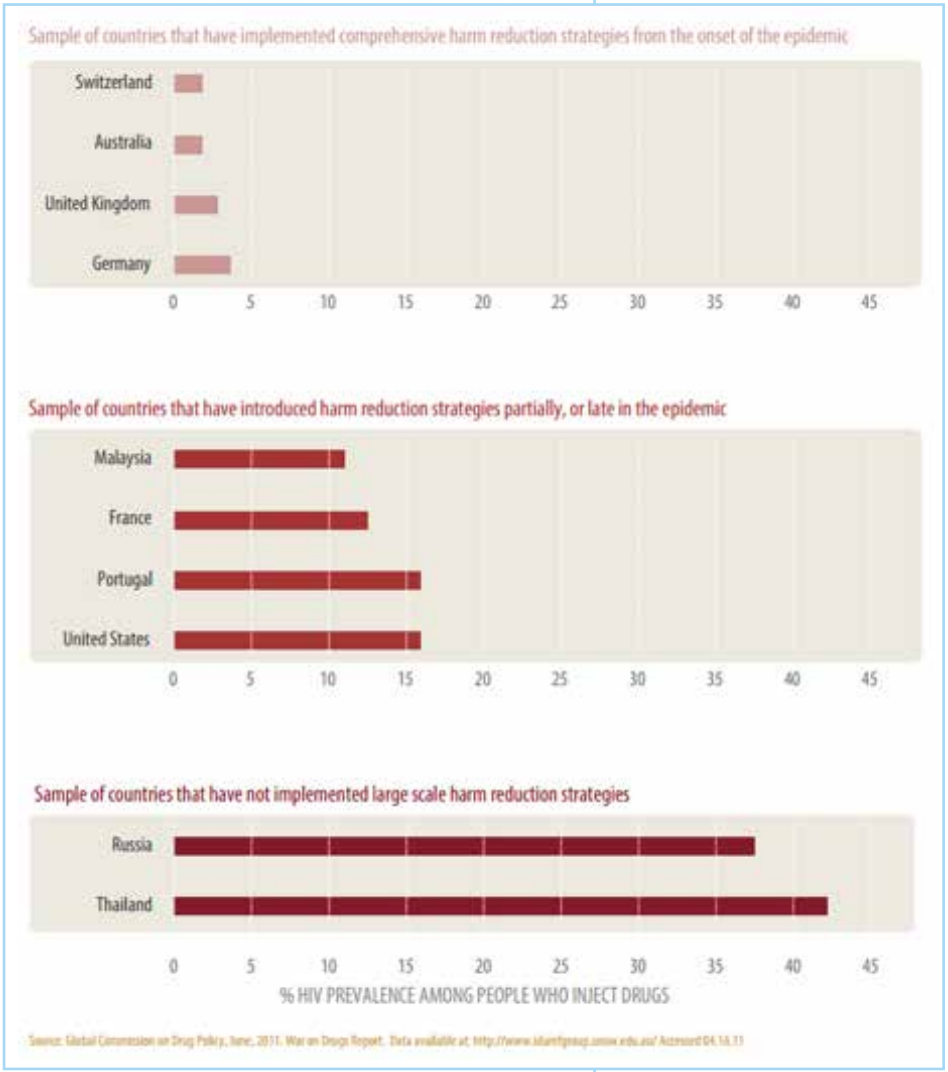
- Non-injecting drug use can be associated with an increased risk of sexual transmission of HIV in some contexts. This can be explained by the fact that people who use cocaine, ATS or other substances may be less likely to use a condom while under the influence of the substance,[7] but also that some dependent users may turn to trading sex for drugs or money to feed their drug dependence, making them more vulnerable to HIV infection and other STIs
- Sharing drug smoking paraphernalia may increase risks of hepatitis C transmission
- Stimulant drugs may cause hyperthermia, acute psychiatric disorders, dehydration and other harms
- Inhaled drugs may cause lung infections and other health complications (including cancers).

Evidence in support of harm reduction interventions

There is a wealth of evidence from around the world that supports the effectiveness of harm reduction interventions. In 2011, the Global Commission on Drug Policy produced the three graphs that show the prevalence rates of HIV among people who inject drugs in:

1. countries that have consistently implemented comprehensive harm reduction services from the onset of their HIV epidemic;
2. others that have adopted harm reduction strategies partially, or later on in the epidemic; and
3. those countries that are resisting the implementation of such strategies.

The graphs show that the HIV prevalence rates are significantly lower in the first group of country, compared to the second group, and more drastically compared to group three.[8]



1. United Nations Office on Drugs and Crime (2014), *World Drug Report 2014*, http://www.unodc.org/wdr2014/
2. Harm Reduction International (2014), *The Global State of Harm Reduction 2014*, www.ihra.net
3. Joint United Nations Programme on HIV and AIDS (2013), *2013 Global Report*, http://www.unaids.org/en/resources/campaigns/globalreport2013/globalreport
4. Harm Reduction International (2014), *The Global State of Harm Reduction 2014*, www.ihra.net
5. Nelson, P.K. et al (2011), 'Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: Results of systematic reviews', *The Lancet*, **378**(9791): 571-83, http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2811%2961097-0.pdf
6. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
7. See: African Union Plan of Action on Drug Control (2013-2017), p. 4, http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf
8. Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, http://www.globalcommissionondrugs.org/reports/

MODULE 4

Session 4.3

Presentation: Harm reduction in West Africa

40 min

Aim – To explore the range and accessibility of harm reduction services available in West Africa

1. Introduce the aim of the session.
2. Ask the participants to brainstorm on which harm reduction services are available in their country/region and note them on a flipchart.
3. Ask the participants to discuss the availability and quality of existing services.
4. Present slides and distribute the handout "The state of harm reduction in Sub-Saharan Africa".

Facilitators' note

As the situation regarding harm reduction is constantly evolving, if participants present information that contradicts what we have below – please let us know so that we can update our records.

Information to cover in this presentation:

Globally around 90 countries and territories support the harm reduction approach in policy or in practice (2014 data). In some regions, harm reduction services have expanded in scale and in range, with innovative services now available to prevent a number of drug-related harms.[1]

We saw in Session 4.2 that the use of heroin, cocaine and ATS – which is increasing in West Africa – has been associated with a number of health harms. Yet access to harm reduction interventions in the region remains limited. Indeed, only a few African countries have some form of harm reduction programmes:

Reference to harm reduction in national policy documents	Kenya, Mauritius, Tanzania
Opioid Substitution Therapy (OST)	Burkina Faso, Kenya, Mauritius, Senegal, Seychelles, South Africa, Tanzania
Needle and syringe programmes (NSP)	Kenya, Malawi, Mauritius, Senegal, South Africa, Tanzania
Heroin Assisted Treatment	N/A
Safer injecting facilities	N/A
Take-home naloxone programmes to manage overdose emergencies	N/A

No West African country currently has national policy documents that explicitly refer to harm reduction, and only two West African countries offer OST – Burkina Faso (through private services only) and Senegal (since 2014). Only Senegal provides sterile needles and syringes to people who inject drugs (also since 2014), although a pilot is being proposed in Nigeria as well. Other services, such as heroin assisted treatment, safer injecting facilities, and medicines to reverse opioid overdoses are not available in any Sub-Saharan African country.

Across the world, even when harm reduction interventions are in place, global coverage remains woefully low. It has been estimated that worldwide just two needles and syringes are distributed per person who injects drugs per month. Only 8% of people who inject drugs have access to OST, and just 4% of those in need receive antiretroviral therapy.[1] Access to these services is often limited by the fact that people who use drugs are often stigmatised, criminalised and denied access for ideological reasons.

Regional documents supporting harm reduction in Africa

- **The African Union Plan of Action on Drug Control (2013-2017)[2]**

  For the first time, the African Union (AU) adopted a plan of action in October 2012 that highlighted the need to "pay greater attention to health and other social consequences of drug use", in addition to law enforcement approaches. As such, one of the four key priority areas of the Plan of Action is the development of "Evidence-based services scaled up to address health and social impact of drug use in Member States". Although the Plan of Action does not refer explicitly to "harm reduction", it mentions, as a key output, "comprehensive, accessible, evidence-informed, ethical and human rights based drug use prevention, dependence, treatment and aftercare services implemented". In addition, the accompanying 'Implementation Matrix' calls on member states to provide the United Nations (UN) "comprehensive package on HIV prevention, treatment and care among injecting and non injecting drug users (IDUs), most at risk populations and in prison settings" (see Output 2.4.3).[3] Although the documents are non-binding, they are an important acknowledgement of the need for harm reduction interventions in the region.

- **The ECOWAS Regional Action Plan to Address the Growing Problem of Illicit Drug Trafficking, Organised Crimes and Drug Abuse in West Africa (2008-2011) – extended until the end of 20144**

  The ECOWAS Regional Action Plan calls for drug policies and HIV policies to be harmonised at regional levels, as well as for programmes to be implemented to integrate drug and HIV prevention services. The plan also requests the establishment of integrated health services to address mental health and HIV/AIDS and drug use. Similarly, Output 15 in the ECOWAS regional action plan is framed as follows: "A network of treatment centres is established and best practices on drug abuse treatment, including HIV prevention for vulnerable groups, are implemented in selected West Africa countries".

- **The Abuja Declaration – Political Declaration on the Prevention of Drug Abuse, Illicit Drug Trafficking and Organized Crimes in West Africa, 20085**

  The Abuja Declaration also raises concerns over the increasing health harms related to drug use, and calls for governments in the region to "Take appropriate steps to make health care and social support available, affordable and accessible to those who abuse drugs and those dependent on drugs".

Case study: Harm reduction in Senegal

Senegal is emerging as a pioneer in the provision of government-supported harm reduction services in West Africa. A survey conducted in 2011 showed that although HIV prevalence remained low (0.7%) in the general population, prevalence among people who injected drugs was as high as 9% and hepatitis C prevalence reached over 23%.[8] HIV prevalence among women who injected drugs was significantly higher than among men (21.1% compared to 7.5%). Needle sharing was also frequent in this population.[9] Generally, people who use drugs in Senegal faced a very high mortality risk. Seeing the danger of a possible injection-linked HIV epidemic, the government included injecting drug use as a priority in its 2011-2015 National AIDS Programme. The government project Usagers de Drogues au Senegal (UDSEN) mobilised teams of outreach workers to begin sensitising people who use drugs to the need for safer use practices. In 2013, NSPs began on a small scale, and in 2014, a major national centre for treatment of drug dependence opened and includes the provision of methadone maintenance therapy. The Senegal experience is an interesting example for other West African countries as the extent of injection drug use in the sub-region becomes clearer.[10]

1. 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
2. African Union Plan of Action on Drug Control (2013-2017), http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf
3. AU Plan of action on drug control and crime prevention (AUPA) (2013-2017) – Implementation matrix, http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf
4. Regional action plan to address the growing problem of illicit drug trafficking, organised crimes and drug abuse in West Africa (2008-2011), https://www.unodc.org/westandcentralafrica/en/ecowasresponseactionplan.html
5. Economic Community of West African States, Political declaration on the prevention of drug abuse, illicit drug trafficking and organised crimes in West Africa, https://www.unodc.org/westandcentralafrica/en/ecowaspoliticaldeclaration.html
6. Raguin, G., Leprêtre, A., Ba, I. et al (2011), 'Drug use and HIV in West Africa: a neglected epidemic'. *Tropical Medicine and International Health,* **16**: 1131-33
7. Retrieved from: West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
8. Maynart, M., Ba, I. & Leprêtre, A. (2012), *Accès aux soins du VIH et des hépatites B et C des usagers de drogues injectables dépistés dans le cadre d'une enquête menée à Dakar* (ANRS 12243 UDESN). AFRAVIH 2012, 6e Conférence Francophone VIH/SIDA, Geneva
9. Raguin, G., Leprêtre, A., Ba, I. et al (2011), 'Drug use and HIV in West Africa: a neglected epidemic'. *Tropical Medicine and International Health,* **16**: 1131-33
10. Retrieved from: West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

MODULE 4

Session 4.4

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.

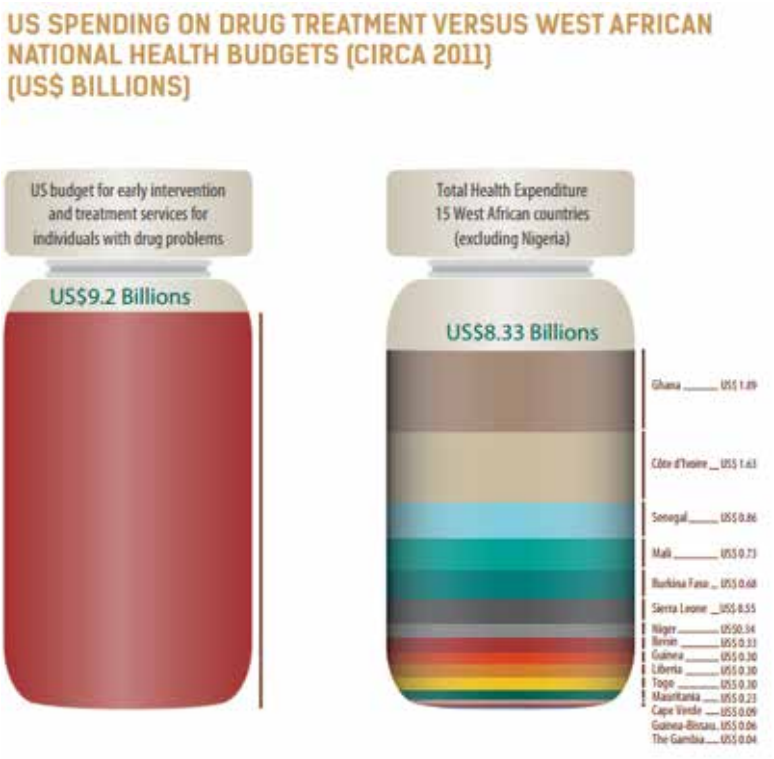
1. Introduce the aim of the session.
2. Ask participants to work in small groups of three or four and give each group some flipchart paper and different coloured marker pens.
3. Ask each pair / group to note as many harm reduction interventions as they can think of and once they have done so to rate them from 1 to 5 *(acknowledge that some may already be implementing some of these)*
   - first *(in one colour)* – in terms of how effective they would be (or are) in the local context
   - 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 reductoin interventions".

Information to cover in this presentation:

Although harm reduction services should be considered as comprehensive and mutually reinforcing, many governments may be unable to develop all nine interventions of the UN "comprehensive package" – let alone all 19 interventions listed on the handout – 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. As such, the UN Technical Guide emphasises that "To successfully address HIV where injecting drug use occurs, countries should prioritise implementing NSPs and evidence-based drug dependence treatment (specifically OST)".[1]

Harm reduction interventions should also adapt to different patterns and trends of drug use. In countries where drugs are mostly snorted or smoked, other harm reduction interventions will need to be prioritised. If people who were traditionally smoking cocaine or heroin are suddenly turning to injection, new harm reduction interventions should be developed and prioritised to ensure that the risks associated with these new patterns of use are minimised.[2]

Policy makers often tend to place a low priority on harm reduction interventions, in particular in settings where even the most basic drug-related health services are scarce. However, research has consistently shown that investments in harm reduction services can lead to significant economic and social benefits which far exceed the resources invested.3 For example, a study of the available evidence by the United Nations Office on Drugs and Crime (UNODC), UNAIDS and World Health Organisation (WHO) concluded that: "According to several conservative estimates, every dollar invested in opioid dependence treatment programmes may yield a return of between US$4 and US$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1".[4] Part of the massive expenditure on drug law enforcement, policing and interdiction therefore needs to be urgently redirected towards harm reduction interventions.[5]



To ensure their effectiveness, harm reduction interventions should be scaled up as much as possible – while also taking into account local resource constraints – to ensure that those in need have access to these services.6 If these services are not available widely enough for people who use drugs, they will not be able to reduce 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% should have access to OST. As we explained earlier, services implemented in West Africa are far from reaching these numbers.

The quality of services is also 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 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, information and education, 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 related crimes), harm reduction interventions should be provided both in the community and in prison settings. The "principle of equivalence" articulates that prisoners should not be denied health care that would have been available in community settings – and this includes harm reduction interventions.

Case study: Harm reduction in Tanzania[6]

Until the 2000s, Tanzania's drug policy focused on reducing supply, with little emphasis on treatment or harm reduction services for people who use drugs. During the late 1990s and early 2000s, researchers documented a rapid escalation in heroin use and a simultaneous rise in HIV among people injecting heroin. On World AIDS Day 2006, medical researchers met in Dar-es-Salaam to discuss the links between injection drug use and the rising HIV rates in the country. The government subsequently commissioned a study that estimated HIV prevalence in the general population at 5.6%, but an alarming 42% among people who inject drugs in Dar-es-Salaam. One study of residual blood from syringes used for drug injection found that 57.4% of the syringes tested positive for HIV. Subsequent studies showed that 45% of men and 72% of women who injected heroin were HIV positive. Supported by the US Centers for Disease Control and Prevention, the Tanzanian authorities began implementing a methadone maintenance programme in Dar-es-Salaam despite the fact that the existing drug law was not supportive of the intervention. One NSP was started with support by non-governmental organisations around the same time. The national Drug Control Commission, operating from the Prime Minister's Office, helped coordinate the police, health and social sectors in these activities. Today, the OST programme, launched in February 2011, is the largest government-run methadone programme in Sub-Saharan Africa. By early 2013 more than 1,200 patients were receiving methadone; outreach workers made contact with over 20,000 people who use drugs; some 25,000 needles and syringes were distributed monthly; and the police in some communities are constructively involved in the outreach programmes and in directing people dependent on drugs to treatment programmes rather than detaining them.[7]

1. 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-unaids-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision
2. Bridge, J. (2010), 'Route transition interventions: Potential public health gains from reducing or preventing injecting', *International Journal of Drug Policy*, **21**(2): 125-128, http://www.ijdp.org/article/S0955-3959%2810%2900012-5/abstract
3. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
4. World Health Organization, Joint United Nations Programme on HIV/AIDS & United Nations Office on Drugs and Crime (2004), *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV prevention* (Geneva: United Nations), http://www.unodc.org/documents/hiv-aids/Position%20Paper%20sub.%20maint.%20therapy.pdf
5. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction
6. 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
7. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
8. Based on a presentation to the WACD by Yovin Ivo, Drug Control Commission of Tanzania

MODULE 4

Session 4.5
Presentation: Road blocks to harm reduction

45 min

Aim – To explore the range and accessibility of harm reduction services available in West Africa

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:
   - Two barriers to the adoption of harm reduction interventions in their country/ region (e.g. resource constraints, not seen as a priority on the political agenda, ideological resistance, scepticism from influential religious leaders, and laws criminalising drug use and/or possession of drug paraphernalia).
   - 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:

Economic and technical resource issues

As explained earlier in this training, in most West African countries, the coverage of harm reduction services remains extremely low or non-existent, hindering their ability to respond efficiently to drug-related harms. This is often due to the fact that the issue remains low on the political agenda, as well as national resource constraints and/or lack of international funding. 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.

UNAIDS estimates that US$2.3 billion is required annually to fund HIV prevention among people who inject drugs, but only US$160 million are currently invested by international donors – that is, only 7% of what is required. In comparison, globally, at least US$100 billion is invested in drug law enforcement.[1]

This is despite evidence that 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.[2]

In Africa, although both ECOWAS and the AU policies address some of the prevention, treatment and harm reduction needs in the region, investment in these areas have remained marginal in comparison to investments related to security and drug law enforcement efforts – highlighting an urgent need to re-balance expenditure from interdiction towards public health measures. Recently, some external partners have started expressing a growing interest in the area. For example, the United States and France are supporting a joint UNODC and WHO programme on drug dependence treatment and care aimed at increasing the reach and quality of treatment services for poeple dependent on drugs. The programme includes the establishment of National Drug Observatories and a Specialised Reference Treatment Centre in Senegal, which will host the first methadone programme for people dependent on opioids in West Africa. The EU, the Nigerian government and UNODC are also supporting the establishment of a National Drug Observatory in Nigeria. Meanwhile, discussions are continuing with the EU, ECOWAS and UNODC to support a specific component of the ECOWAS Operational Plan on drug use epidemiology (surveys and data collection), drug prevention and treatment. These are important, yet still small steps towards a better balancing of resources invested in drug-related health services in the region.[3]

Policy and legislative barriers

- **International drug control and harm reduction**
  It has previously been argued 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 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. The LAS found that OST, drug consumption rooms, and NSPs fall comfortably within the measures allowed by the treaties and subsequent UN resolutions. However, the LAS found that drug quality control interventions (such as the testing of drugs and tablets at clubs or festivals) run "contrary to the spirit of the Convention" – although 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). 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.[4]

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. In Africa, methadone and buprenorphine are only available in a handful of countries. In others, such as Mauritius, although methadone maintenance treatment is well established, buprenorphine remains illegal and therefore inaccessible for OST programmes. The argument that is sometimes brought forward against OST is 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.

- **The criminalisation of people who use drugs**
  Across the world, 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 going to harm reduction and treatment facilities, this will deter many individuals from seeking support and accessing these life-saving services. The experience of countries that have decriminalised drug consumption and the possession of small amounts of drugs for personal use have reported positive health outcomes with a reduction in overdose deaths, of new HIV and hepatitis C infections, as well as an increase in people accessing treatment and employment.

  People who use drugs run a high risk of spreading HIV and/or hepatitis through the sharing of contaminated equipment. The criminalisation of injecting or smoking paraphernalia is also a significant barrier to the effectiveness of harm reduction services such as NSPs and the distribution of crack pipes. In Mauritius, the government passed the HIV and AIDS Act in 2006 to remove criminal sanctions for people enrolled in NSPs and caught with a syringe by the police. However, conflicts between the 2006 Act and the 2000 Dangerous Drugs Act (which criminalises people who use drugs and the possession of drug use paraphernalia) persist and people caught with a used syringe routinely continue to be processed in the criminal justice system. Nonetheless, this example constitutes an interesting attempt at protecting harm reduction services.

  Additional 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 among public opinion is, therefore, an essential element of harm reduction.

1. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction
2. 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
3. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf
4. See, for example: https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

MODULE 4

Session 4.6

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 four terms: "peers", "patients", "prisoners" and "partners". Using the flipcharts, ask the participants to do a brief word association exercise of the four 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 allows, the facilitator can also show the complete version or extracts of this 6-minute video on drug user involvement in drug services:

https://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 NSPs – 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 NSPs, 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 and national level. As of 2014, the Kenyan Network of People Who Use Drugs (KenPUD), REACT (Tanzania), and the Tanzanian Network of People Who use Drugs (TanPUD) have all recently been established in Africa – although no such networks exist yet in West Africa (as far as we are aware).

MODULE 4

Session 4.7

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.

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.

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:

   - *Doesn't harm reduction send out the wrong message – promoting drug use or making it look safe?*
   - *Surely we must enforce the law, and that means that drug users have to be punished?*
   - *I hear that outreach workers help people use drugs. Are outreach workers assisting and encouraging illegal acts?*
   - *Why would you offer methadone? Are you saying that we should replace an addictive drug with another?*
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. If you have time, you can ask each group to do a 3 minute role play in front of the whole group.
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.

Handout: Harm reduction cards (to cut out and destribute)

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	Safer injecting facilities	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
	Drug checking and pill testing	

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://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

** Although abstinence-based programmes are not typically included as a harm reduction intervention, whether they should be considered as such can be discussed and agreed upon by the participants.

MODULE 4

Handout: 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/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf?1405520726; International Drug Policy Consortium (2012), 'Chapter 3.2: Harm reduction', Drug policy guide, 2nd edition, http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition

MODULE 4

Handout: 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 former 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 contribute to 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, an increase in people accessing drug dependence treatment and employment, 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.dropbox.com/u/64663568/library/IDPC%20Guide%20HTML/Chapter-3.2.pdf

Handout: The state of harm reduction in Sub-Saharan Africa

Country/ territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response	
					NSP[i]	OST[ii]
Burkina Faso	nk	nk	nk	nk	x	✓[1]
Côte D'Ivoire	nk	nk	nk	nk	x	x
Djibouti	nk	nk	nk	nk	x	x
Gabon	nk	nk	nk	nk	x	x
Ghana	nk	nk	nk	nk	x	x
Kenya	18,327[2]	18[2]	51.4 (42.2-60.6)[3]	6.4[3]	✓[10][22]	x
Malawi	nk	nk	nk	nk	x	x
Mauritius	10,000[4]	44.3[4]	97.3[5]	9[3]	✓[52][4]	✓[16] (M, O)
Nigeria	11,692	4.2[6]	nk	nk	x	x
Senegal	1,324[7][iii]	9.1[8]	nk	nk	✓[1]	x
Seychelles	345[9]	5.8[9]	53.5[9]	0.1[9]	x	✓[9]
Sierra Leone	nk	nk	nk	nk	x	x
South Africa	67,000[10]	19.4[10]	nk	nk	✓[1][iv]	✓[M, B][v]
Tanzania	30,000[11]	33.9[11]	28[11]	nk	✓[7]	✓[3] (M, O)
Uganda	nk	16.7[12][vi]	nk	nk	x	x
Zambia	nk	nk	nk	nk	x	x

Source: Harm Reduction International (2014), *The Global State of Harm Reduction*, http://www.ihra.net/

MODULE 4

Handout: 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

"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, for example in Tanzania and Mauritius. It may be that local policy makers prefer to start

* 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

MODULE 4

Handout: The 2006 "Vancouver Declaration"

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

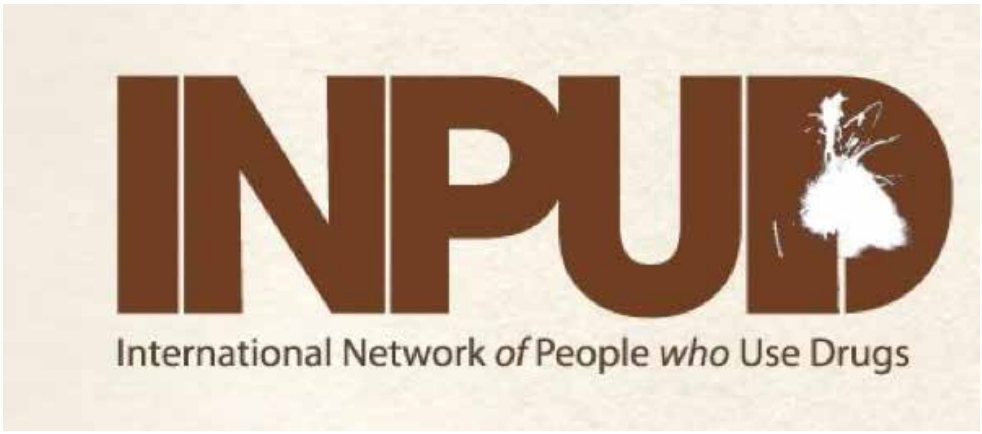
We are people from around the world who use drugs. We are people who have been marginalized and discriminated against; we have been killed, harmed unnecessarily, put in jail, depicted as evil, and stereotyped as dangerous and disposable. Now it is time to raise our voices as citizens, establish our rights 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.



http://inpud.net/en/vancouver-declaration

Notes: