Conference report


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Received 14 August 2007; accepted 5 October 2007

Introduction

Coming of age can be assessed by dimensions such as height, weight, psychological maturation as well as social development. Measured by size, harm reduction conferences had reached the height and weight of a healthy adult a number of years ago. The 18th International Conference on the Reduction of Drug Related Harm brought together well over 1200 people from 580 different institutions, including UN agencies, governmental departments and many non-governmental organisations whose commitment, over the last two decades, have allowed harm reduction to develop into the global movement it has become. Eighty-nine countries were represented in Warsaw (a record number for the conference) compared to 60 in Vancouver (2006) and 40 in Melbourne (2004). This growth reflects not only the more convenient location of Warsaw for many participants but also the geographical expansion of harm reduction as a movement. Nevertheless, the majority of the world’s countries are not attending and some regions are heavily under-represented—over 430 participants attended from Western and Central Europe and over 170 from North America compared with about 20 participants each from Africa and Latin America (Graph 1).

Altogether there were more than 300 oral presentations and approximately the same number of poster displays. A team of rapporteurs identified nine major shifts that signify the “coming of age” of harm reduction: from top-down initiatives to bottom-up movements; from general drug environments towards more specific settings and populations; from HIV to a range of harms; from developed countries to developing regions; from public health approaches to human rights issues; from controversial issues to normalisation; from illicit drugs (and mainly opiates) to other substances; from the outskirts of drug policy towards integrated drug policy; from an individual issue to a structural question.

From top-down initiatives to bottom-up movements

“Unless harm reduction actively engages with how service users conceptualise their own use, harm reduction messages...
may fall on deaf ears” (Charlotte Wareing, “Slipping through the gateways; engaging service users in harm reduction”). Today, many harm reduction programmes are initiated and sustained by drug users, particularly in countries where the state is either against or ambivalent to harm reduction policies (Bijay Pandey, “Networking among drug users and drug user organisations in Nepal”; Serhiy Panasyuk, Olha Muradyan, “Consumers as activists: organising the first drug user advocacy group in Western Ukraine”). The active engagement of drug users has become an important feature of harm reduction initiatives as an expression of horizontal relationships in a democratic society where drug consumers are active partners and not passive recipients (Luis Mendao, “Hepatitis policies of prevention: The community perspective”). In Vancouver, for example, a hundred drug users participated in designing an overdose prevention programme in order “to network, enhance, and support informal community initiatives and ... to enable community agencies to respond in the most timely and effective manner to minimise harm to their client populations” (David Marsh, “The overdose grapevine: consulting with community in development of an early warning system”).

Currently, harm reduction can increasingly be described in terms of social movement(s) with clear tendency towards institutionalisation also at international level. The first ever Drug Users’ Congress took place in Vancouver in 2006 where a wide range of objectives were formulated including outreach, self-help, peer support, advocacy (Milena Naydenova, “Recent developments in user organising around the world and where we go from here?”). The second Drug Users’ Congress took place in Warsaw just before the conference, and offered a platform for the International Network of People who Use Drugs (INPUD) to become a legal entity. In Warsaw, INPUD formally adopted its manifesto “Nothing About Us Without Us”—where the major aspirations and claims of drug using community are expressed.

Parallel social movements have also emerged with a clear focus on harm reduction. Sex worker organisations have become active in different regions of the world (Rachel Wotton, “Harm reduction frameworks in sex worker peer education”). Parents, partners and other family members who are accepting of harm reduction principles have also become organised (Dirce Blochinger—session Empowering Communities). Last but not least, youth movements have become more visible. This was the first conference to have a satellite meeting for young people, and young people’s perspectives were also included in the opening and final plenary sessions and in a dedicated major session.

From general drug environments towards more specific settings and populations

Struggling for public recognition and respect, the harm reduction movement has tended to speak increasingly loudly on behalf of the most underprivileged groups—those who suffer multiple forms of stigma and discrimination such as prisoners, women (and pregnant mothers), sex workers, indigenous peoples, homeless people and young people.

Legislation in all countries criminalises certain forms of drug use to varying extents. In many countries, prisons become arenas of high concentration of drug users where the risk of harm is amplified. Therefore, prisons ought to become significant target settings where harm reduction may reach substantial numbers of people at risk (Annette Verster, “Evidence for action: review of harm reduction interventions in prison settings”). A large proportion of drug-using prisoners come from marginalised or discriminated against groups. In the United States, for example, women of colour, including indigenous groups, are more harshly treated regarding drug related offences (Deborah Peterson Small, “Caught in the net: how US punitive drug policies lead women to prison and increase their risk for HIV”).

Harm reduction in prisons, though controversial, is emerging in developing countries as a legitimate policy measure—e.g. in Central Asian Republics and in Indonesia (Cantau Nicolas, “Drug use and infectious diseases in Central Asian Republics Penal Systems: Opportunities and threats”; David Djaelani Gordon, “Peer program for Inmates in Paledang Prison, Bogor, West Java, Indonesia”). The recognition of the need for prison-based interventions crosses religious boundaries also. Iran, for example, has one of the biggest prison Methadone Maintenance Treatment (MMT) programmes in the world, with more than 60 MMT clinics and 8200 patients—an 80% coverage rate (Parviz Afshar, “Efficiency of harm reduction measures in prisons of Islamic republic of Iran”).

Ethnic minorities, particularly aboriginal peoples, are at an elevated risk of harm associated with drug use. For example, representatives of the First Nations in British Columbia (Canada) are heavily over-represented among those who die from drug overdoses. Meaningful, culturally appropriate harm reduction initiatives are urgently needed (Margo Elaine Pearce, “Demographic and behavioural factors associated with drug overdose among Aboriginal youth that use injection and non-injection drugs”).

Sex workers bear the multiple stigma of prostitution, crime, drug use and often minority status. In Romania a third of sex workers were injecting drug users (Iulia-Veronica Broasca, “Harm reduction activities among sex workers/IDUs in Romania: Towards a better access to prevention, care and treatment”). To effectively reduce the risks that this group face, sex work must be seen as a legitimate practice to be made safer, rather than a harm of drug use that needs to be reduced (Rachel Wotton).

From HIV to a range of harms

The expansion of harm reduction and its legitimisation have been closely connected with preventing HIV among injecting drug users. However, it was soon realised that a...
narrow HIV-focused harm reduction strategy may have limited preventive potential with regard to other infections, in particular hepatitis C (HCV)—which is much more infectious and prevalent than HIV and can be transmitted by a wide range of paraphernalia and not just needles and syringes (Luis Mendao, “Hepatitis policies of prevention: The community perspective”). The number of HCV positive people is estimated to be as high as 200 million worldwide and mortality is likely to triple in two decades (Mauro Gauriniari, “Idle but deadly: The battle to fight HBV and HCV”).

With the growing participation of people who use drugs, HIV-oriented harm reduction networks tend to increase their field of operation becoming more sensitive to immediate needs of their target population. Depending on the local situation, harm reduction programmes may include hepatitis B vaccinations, overdose prevention and provisions of medicines to prevent and treat malaria, tuberculosis and other infections.

In addition, the legal harms caused by drug prohibition and punitive law enforcement affect people who use drugs but also those close to them. For example, punitive measures against women who use drugs often impact on the children for whom those women are primary carers. Under US Federal Law, if a child is placed in foster care for more than 15 months the parent can lose their parental rights.

HIV-focused harm reduction becomes part of a wider social package among socially excluded groups. The example of sex worker activist groups shows that general workplace issues (stress, burnout, safety, workplace characteristics) and problems with public attitudes (stigma and discrimination) are raised alongside drugs and HIV (Rachel Wotton, “Harm reduction frameworks in sex worker peer education”).

From developed countries to developing countries

For the last 10 years, harm reduction has rapidly been spreading in response to the HIV epidemics in developing or less developed jurisdictions. Harm reduction is considered absolutely essential in resource-poor countries “where conventional drug treatment is out of the reach for financial and other reasons” as declared by Thein Win from Myanmar. This voice was supported by a representative from Nepal—“Idle but deadly: The battle to fight HBV and HCV”.

Nevertheless, there are huge territories and populations where harm reduction is out of reach for millions of people at risk of HIV and other infectious diseases. This is particularly the case in sub-Saharan Africa.

As noted by UNAIDS in the opening plenary session, harm reduction has also recently appeared in countries which have focused primarily on supply reduction and repression in their drug policies, such as China, Malaysia, Vietnam, the Central Asian Republics, Iran, Lebanon (Nadya Mikdashi, “Legalisation of buprenorphine substitution treatment in Lebanon”), and in North Africa including Morocco and Egypt (Fatema Asoub, Youssef Aziz Wahba, “The impact of harm reduction program on IDU’s knowledge and preventive practice: A pilot experience”).

From public health approaches to human rights issues

Over the last two decades, harm reduction has become much more than a public health approach. To an extent, harm reduction has become an essential response to harm generating drug prohibition policies (Kenneth W. Tupper, Gillian Maxwell “Changing paradigms: Raising awareness about the harms of prohibition”), including the marginalisation of people who use drugs, poor access to injecting equipment, unsafe drug use environments and limited access to health education and appropriate treatment. As argued by one presenter “the War on Drugs is an international war rooted in racism, xenophobia and other forms of discrimination” (Deborah Peterson Small). The extreme violation of human rights by drug prohibition approaches is perhaps best demonstrated by the imposition of the death penalty for drug offences. This is still in force in at least 34 countries even though the death penalty must be restricted only to the “most serious crimes” according to the UN and international law (Rick Lines, “A most serious crime? The death penalty for drug offences as a violation of international law”). In recent years, China has celebrated the UNODC’s “International Day Against Drug Use and Trafficking (June 26th) by publicly executing drug offenders. In 2002, over 60 people were executed for drug related offences.

Harm reduction is a symbol of social solidarity and of respecting human rights. However, it can also be a symbol of social exclusion and stigmatisation. “Campaigns, programmes and interventions should not contribute to a rise in discrimination, stigmatisation and marginalisation of the people they are aimed at. They must have the exact opposite effect. The message must be clear – not moralistic – with respect for human rights” (Luis Mendao, “Hepatitis policies of prevention: The community perspective”).

From controversial issues to normalisation

Implementing the 2003 Recommendation of the Council of Europe 24 European Union countries now have out-reach work, 23 distribute condoms, 24 have needle exchanges, and 24 have maintenance treatment. The coverage of harm reduction initiatives, however, varies greatly from country to country—from Cyprus where harm reduction is practically not existent to UK or the Netherlands where many forms of harm reduction are available. Even if some harm reduction services exist, coverage may be very low. For example, Poland introduced methadone maintenance in 1992 but only a few hundred people who use drugs have access and Warsaw has waiting times of over a year—prompting INPUD to circulate a petition to the Polish Government calling for an urgent up-scaling in the country. In the majority of EU countries,
interventions such as heroin maintenance and prison projects are still considered controversial (Dagmar Hedrich, “Harm reduction in European Union: Follow-up on the Council recommendations on drugs and harm reduction”).

The involvement and support of multilateral agencies such as UNAIDS, World Health Organisation and the Global Fund to fight AIDS, Tuberculosis and Malaria, has paved the way towards the normalisation of harm reduction in other parts of the world. However, some harm reduction approaches are accepted in a number of countries while others are still resisted by national governments and local professionals. For example, in Russia, syringe exchange is legal but methadone maintenance is banned. The reverse trend appears in the US where methadone maintenance has been a legitimate treatment approach for several decades while syringe exchange is still treated with suspicion and subjected to various legal and funding barriers.

Harm reduction remains hugely controversial for children and young people. In numerous countries, there are age thresholds for participating in harm reduction interventions and in most countries honest drug education for young people is severely lacking.

**From illicit drugs (and mainly opiates) to other substances**

Harm reduction developed in response to the use of injectable opiate drugs. It has now expanded to include all psychoactive substances. During the Warsaw conference there were sessions on stimulant drugs (including cocaine and crack cocaine), party drugs, tobacco and alcohol.

For legal drugs in particular, the major claim was that harm reduction can complement and enhance existing approaches. Targeted interventions are realistic and innovative approaches, especially where resources are limited and population-level measures are politically unimportant or unfeasible—“Alcohol policy is the art of the possible” (Marijana Martinic, “Drinking in context: The need for targeted intervention”). For tobacco, much discussion focussed on the international restrictions imposed on potentially less harmful products such as smokeless tobacco.

However, in most countries, alcohol and tobacco are legal commodities whose supply and accessibility can be controlled in an efficient manner through socially accepted measures within a regulated market. Paradoxically, the global prohibition of other drugs deprives modern societies of those efficient measures that proved to work with legal psychoactive substances.

**From the outskirts of drug policy towards integrated drug policy**

Harm reduction originated from outside of mainstream drug policy (which was then, and is still now, dominated by the ideals of a drug-free world). After two decades harm reduction is still generally sidelined (and, at best, accepted but not talked loudly about). For years, harm reduction was not discussed by UNDCP in Vienna. Even at the conference, the Polish Minister of Health, Zbigniew Religa, gave a warm welcoming address expressing his compassion for young people who use drugs and his support for the conference—but managed to avoid using the term ‘harm reduction’.

Despite this low level of integration at the international level, there are numerous examples of successful co-operation between harm reduction services and law enforcement at the local level. In fact, without this cooperation (or at least tolerance) from the police, many harm reduction efforts would be in vain. For harm reduction programmes across the world, the police can either be a best friend or a worst enemy. However, transforming the worst enemy into a friend is not that difficult—as evidenced by a project launched in Vietnam, China and Myanmar (Greg Denham, “Engaging law enforcement in harm reduction: Advocacy resources”) and IHRA’s “50 Best Collection on Policing and Harm Reduction”.

The integration of harm reduction services with drug education and treatment agencies, particularly those with an abstinence-based approach, is more difficult—especially as competition for public attention and funding prevails. It is, however, high time for both sides to come together to elaborate on an integrated concept of harm minimisation—consisting of supply reduction, demand reduction and harm reduction (Robert Power, opening plenary discussion).

**From an individual issue to a structural question**

For most problematic drug use, the sources of problems are often located on individual, institutional or structural levels. If an individual is blamed for his or her situation, then social exclusion, prosecution and isolation are most likely to occur. If the ‘disease model’ or ‘medical model’ dominates in public perceptions, then medical treatment is very likely to follow. If institutional deficiencies are considered to have created the problem, then institutional or legal measures are expected to solve it. If a problem is perceived as having its roots in social structure, then revolutionary or semi-revolutionary changes may be demanded.

In its early adolescent years, harm reduction sought legitimisation in the concept of a ‘lesser evil’—preventing HIV epidemics took priority over the ideals of a drug-free society. Harm reduction did not challenge prevailing concepts of drug use as a disease and/or a criminal act. As it developed into a teenager, harm reduction began to disclose and attack institutional sources of problems associated with drug use. Drug prohibition was identified as a key harm generator and a major barrier to harm reduction. As harm reduction has ‘come of age’ at this year’s conference, it is showing
signs of more revolutionary approaches (Plenary session, “Policies and ideologies against people who use drugs: what about harm reduction”). In his presentation, “User activism and harm reduction in an age of socio-ecological change”, Samuel R Friedman warned that current global changes including the “race to the bottom economic policies, cutbacks on social and health services, international aggressiveness of the USA and its allies . . . may create massive socio-economic disruption and population dislocation which in turn would threaten the economic, social, religious and political environment in which drug users live and in which user activists and harm reduction programs function”. At the same session Alexander Rumyanzev eloquently stated that “the global system needs obedient slaves and effective mechanisms to manipulate and secure a process of ‘natural selection’ among groups alien to the existing structure . . . Harm reduction should protect the groups, classes and populations against whom drugs are being used as a weapon” (“The ideological evolution of harm reduction in response to the use of drugs as an instrument for social/class control and oppression”).

Barriers to harm reduction

Many presenters and delegates approached the question of barriers to harm reduction. Numerous obstacles were identified, including international conventions, national legislation, public attitudes, the place of drug users in the social structure and tensions within the drug policy field at global, national and local levels.

Resistance of powerful actors on international arenas

There is an intrinsic contradiction between drug prohibition and harm reduction. Many of the key global and regional superpowers (including USA, Russia, Japan, China and Pakistan to mention a few) are very much in favour of prohibitive policies and rather reluctant as far as harm reduction is concerned. This is reflected at the international level—especially in the consensus-driven world of the UN.

Prohibitive international and national legislations

International drug conventions affecting national legislation provide a framework in which harm reduction cannot develop its full potential. Instead of arguments between advocates of prohibition and advocates of legalisation, a public dialogue is needed to discuss compromises and changes to legislation to increase the control and regulation of drug supply (Kenneth W. Tupper, Gillian Maxwell, “Changing paradigms: Raising awareness about the harms of prohibition”). Drugs are far too important an issue to be left in the hands of criminals (Danny Kushlick, Chair of the final plenary session).

Negative public attitudes

The criminalisation of drug related behaviours (and resulting overlaps between drug-using and criminal sub-cultures) evokes negative public attitudes towards people who use drugs. This stigmatisation is often reinforced by the media. As a result, harm reduction initiatives may be opposed by national legislators and local communities keen to respond to public opinion demands (Barbara Tempalski, “Placing the dynamics of syringe exchange programs in the United States”).

High level of marginalisation and social exclusion

The punitive responses to drug use that prevail in the majority of contemporary societies push people who use drugs to the outskirts of social life. Harm reduction has to use much of its potential for out-reach work to make its services more available, increase their coverage rates, reach hidden populations and overcome social exclusion.

Competition from other drug policy fields

Harm reduction is often perceived by other drug policy fields (such as abstinence-based treatment or prevention and education) as a competing force when it comes to clientele, political support, public attention, and funding. Therefore, the implementation of harm reduction initiatives such as methadone maintenance is sometimes resisted or even blocked by traditional drug agencies.

Accumulation of problems

Rarely do drug users live with just one problem or use just one drug. Often, they use a range of substances and suffer from a combination of harms—including numerous health, social, economic and legal complications. In this context, harm reduction needs to be efficient in offering a wide range of support which in turn calls for increased human and financial resources.

Discussion

There are certainly many limitations to this report. First of all, our team of rapporteurs was not able to attend every session at an extremely busy conference and those which were attended were not randomly selected. Therefore, it is very likely that some important issues were overlooked and are not presented in the report. For all of the team, this was their first IHRA conference and, as newcomers, we may also have misinterpreted some of the presentations and debates—paying too much attention to some issues or neglecting others. Finally, the conference itself may offer a one-sided picture of harm reduction and its achievements. In all of the sessions that we were able to attend, the experiences
The nine major shifts in the harm reduction movement that have been identified and described in this report cannot entirely be generalised. In a few countries, harm reduction is a matured and well recognised approach. In many countries, it is just ‘coming of age’—with all of the positive and negative implications of this age period. Crucially, however, harm reduction is still in its infancy in the majority of countries.

No matter the level of development, however, harm reduction is a growing movement with a strong bottom-up component. It is becoming increasingly professional and institutionalised through the convergence of different movements, loose networks and structures. Institutionalisation, however, has its positive implications but also intrinsic risk of alienation from its original constituency. The harm reduction movement is expanding in new and innovative directions; tackling new settings, new populations, new territories, new drugs and a wider range of harms. It has placed itself in the more comprehensive context of human rights and global socio-economic changes—searching for stronger legitimisation and recognition. It is expressing a need to join the mainstream of drug policy dialogue, which would integrate supply and demand reduction with harm reduction under a new banner of harm minimisation.