

# HARM REDUCTION AT THE CROSSROADS: Case examples on scale and sustainability

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## Introduction

In the 25 years since the development of the first harm reduction programmes, a harm reduction approach has been adopted in policy or practice to varying degrees in 94 countries worldwide.<sup>a</sup> The majority of these countries, however, do not have comprehensive harm reduction programmes<sup>1</sup> operating at the scale necessary to impact on HIV,<sup>2</sup> or even more challenging, hepatitis C epidemics. Those countries that are containing or reducing HIV epidemics among drug-injecting populations are largely high-income and overwhelmingly European. There are notable successes in implementation in a variety of political, religious and economic contexts, but the vast majority of low and middle-income countries around the world lack adequate harm reduction responses.<sup>2</sup>

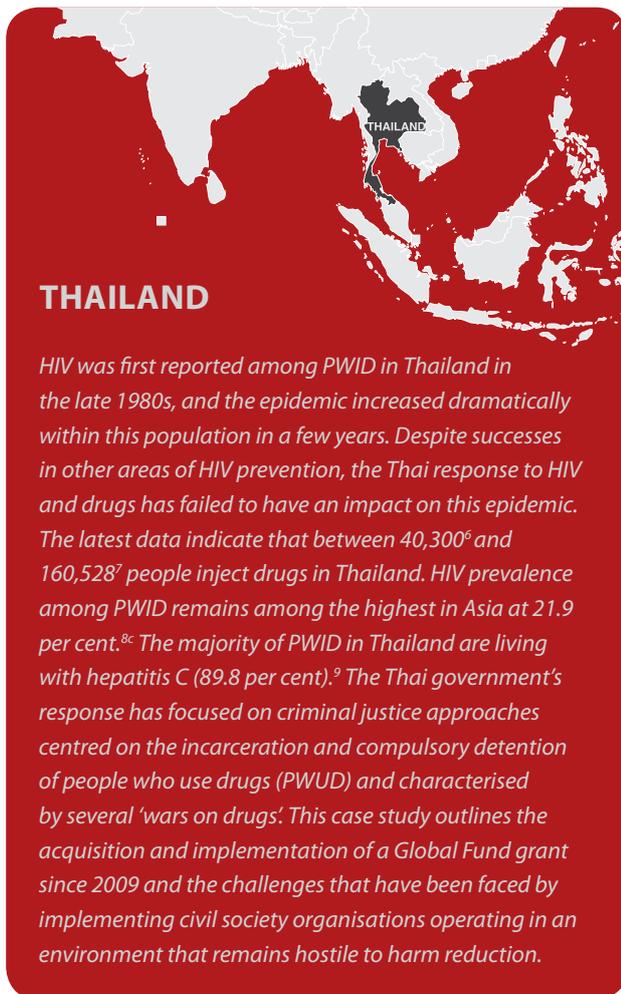
Threats to sustained harm reduction responses are multiple and vary within and across countries, but the financial and political contexts are often the underlying factors that determine the life or death of a programme. Although harm reduction interventions are evidence-based,<sup>3</sup> cost-effective<sup>b</sup> and a fundamental element of the international HIV response,<sup>4</sup> government investment in low and middle-income countries remains limited.<sup>5</sup> Of the \$160 million estimated to be invested in HIV-related harm reduction in low and middle-income countries in 2007, approximately 90 per cent came from a small number of international donors<sup>5</sup> (see the Global Overview section of this report for a more in-depth analysis of global financing for harm reduction). Bilateral and multilateral funding for harm reduction has been crucial to introducing and sustaining the response to some of the most severe HIV epidemics among people who inject drugs (PWID) around the world. However, reliance on international funds is becoming increasingly insecure as the global economic crisis impacts upon development and HIV funding. Middle-income countries with large numbers of PWID and governments hostile to harm reduction have been left particularly vulnerable. With recent developments at the Global Fund, and depleting funds available from several other major donors, the sustainability of harm reduction is under threat like never before.

Political support for harm reduction remains key to ensuring that investments are strategic and proportionate to need, particularly in the current financial environment. Many countries continue to emphasise drug control over public health, resulting in policy and legal contexts which hinder public health responses, increase potential for infections and lead to overburdened prison systems. While this approach is being questioned and openly debated by governments more than ever before, poor political backing for harm reduction remains one of the most crucial barriers to an effective response to epidemics among PWID. In addition to the countries where political support has long been lacking, the phenomenon of regression or backsliding in support for harm reduction in policy and practice is beginning to emerge in several countries where programmes have been long established and enjoyed long-standing government support. Given this backdrop, it is important to investigate the ways in which harm reduction programmes can be scaled up, or continue to operate to scale while adapting to changing policy and funding environments.

This chapter presents a series of case studies to examine the different strategies and responses that have emerged to secure the survival of harm reduction policies and practices. It will explore, through these case studies, strategies for ensuring sustainability in harm reduction programmes. Two of the case studies focus on protecting harm reduction during periods of wider political change, while a further two examine ways of overcoming stalled implementation or 'death by pilot'. Overall they look to encapsulate the interplay between harm reduction, local and national policies and politics. The final section of the chapter summarises these developments and attempts to identify successful and innovative strategies for overcoming the barriers to the survival and scale-up of harm reduction programmes.

a As reported in Section 1 of this report, 94 countries and territories worldwide now employ a harm reduction approach (compared to 93 and 82 countries in 2010 and 2008, respectively). This support is explicit either in national policy documents and/or through the implementation or tolerance of harm reduction interventions such as needle and syringe exchange programmes (NSPs) or opioid substitution therapy (OST).

b For example: National Centre in HIV Epidemiology and Clinical Research (2010) *Return on Investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia 2009*. Sydney: University of New South Wales.



Official policy language labels PWUD as patients;<sup>10</sup> however, practice at the community level in Thailand suggests that they continue to be treated as criminals. The government's response to drugs, guided by principles of prohibition and repression, has been consistently implemented with little regard to the health and human rights of PWUD.<sup>11–14</sup> Law enforcement initiatives have led to incarceration and compulsory detention with accompanying abuse of PWUD, both in community and closed settings.<sup>15</sup> The recently elected Pheu Thai party announced a new 'war on drugs'<sup>16, 17d</sup> with objectives of rehabilitating 400,000 'users' in compulsory 'treatment' centres, primarily run by military and law enforcement agencies.<sup>18</sup> The Thai government's reluctance to address drug-related issues through public health measures is embodied in the absence of national harm reduction policy instruments, mechanisms and measures beyond the national HIV/AIDS strategy. The Thai Office of Narcotics Control Board (ONCB) drafted a national harm reduction policy in 2010, but this has not yet been deployed. In spite of this unsupportive environment, some level of harm reduction services have been delivered in Thailand at least since 2003.

c This figure refers to men who inject drugs only.

d The 2003 campaign in particular illustrates the scale of the Thai government's approach to the war on drugs, including human rights violations and arbitrary killings that took place as a result, for more information: Human Rights Watch (2004) *Thailand: Not Enough Graves. The War on Drugs, HIV/AIDS, and violations of Human Rights*, Vol. 16, No. 8, <http://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf>.

At present, the national response to HIV transmission among PWID is essentially limited to the CHAMPION-IDU project, supported by the Global Fund Round 8 grant and implemented by PSI Thailand alongside civil society partners including Raks Thai Foundation, the Thai AIDS Treatment Action Group, the Thai Drug Users' Network, Alden House and the Thai Red Cross. This grant is for an approved total of US\$17 million for the period 2009–2014 – US\$6 million for the first phase of funding, and US\$11 million for 'Phase 2' – and covers 19 of the 76 Thai provinces. Earlier, in 2003, the Global Fund also provided a US\$1 million grant to Thai civil society groups to address HIV transmission among PWID.<sup>e</sup> Without support from the Global Fund, the national response to HIV transmission among PWID would be limited to small-scale community-led programmes whose operations have been under continued threat from police and government crackdowns.

During the first two years of operations, the CHAMPION-IDU project reached over 6,000 PWID across Thailand, providing them with education, information and behaviour change communication, safer injecting kits, condoms, referrals to voluntary HIV counselling and testing (VCT), diagnosis and treatment for sexually transmitted infections (STIs), and opioid substitution therapy (OST). In parallel, over 130 health service providers and approximately 50 prison guards received training to be sensitised to the needs of PWID, while over 1500 people have participated in advocacy activities to improve the operating environment. Meanwhile, CHAMPION-IDU supports 12D – a civil society coalition working to improve the drug and HIV policy environment – in coordinating and implementing additional advocacy activities, as well as the Foundation for AIDS Rights to develop effective legal aid services for PWID. The successes of the CHAMPION-IDU project largely belong to active and recovering PWID who comprise a large proportion of the implementing field teams.

However, the sustainability of these successes is constantly under threat. There continues to be a lack of support from all government sectors for effective and evidence-based interventions to address HIV transmission among PWID, which undermines the project. Government agencies have not signed identity cards that would protect field teams from arrest, which leads to peer outreach workers being routinely harassed and arrested by law enforcement officers. There are also anecdotal reports from implementing agencies in Thailand suggesting that law enforcement officers can benefit from financial incentives for drug seizures and the arrest of PWUD, as well as penalties if quotas are not met.

A further challenge has been posed by target-setting following the CHAMPION-IDU grant's mid-term review in 2011. As the Global Fund is a funding (rather than technical)

e For a more nuanced discussion of the challenges around this grant, please refer to Kerr T et al. (2005) *Getting Global Funds to Those Most in Need: The Thai Drug Users' Network, Health and Human Rights*, 8(2) 170–186.

body, it follows the agreed normative guidance to assess the quality of programmes – in this case the UN target-setting guide for PWID.<sup>1</sup> However, this guidance is ‘primarily intended for national target-setting’<sup>1</sup> whereas the CHAMPION-IDU programme is a nongovernmental initiative that operates in just 19 provinces. The guidance also states that interventions should be implemented ‘in an enabling environment created by supportive legislation, policies and strategies’<sup>1</sup>: this is clearly not the case in Thailand. In negotiations between PSI and the Global Fund to agree targets for Phase 2, the Global Fund requested high coverage levels in the 19 provinces in line with the UN target setting guide (i.e. 60% for NSP and 40% for VCT). The performance based funding (PBF) model is based on the principle that ‘to receive subsequent financing, [projects] must demonstrate results against defined performance targets’. This has raised concern that, despite its successes in health service provision, the CHAMPION-IDU programme may struggle to meet its performance targets and would therefore be rated by the Global Fund as ‘inadequate’ or ‘unacceptable’ (see Table 1).<sup>f</sup>

**Table 1:** CHAMPION-IDU key indicator targets (October 2011 – June 2014)<sup>19</sup>

Indicator	Phase 1 Targets	Phase 1 Performance	Phase 2 Targets	Increase between Phase 1 and 2 targets (%)
Number of PWID reached	6,574**	6,191	9,762***	148
Number of people trained (and retrained)# to implement HIV prevention activities for PWID	223**	137	258***	115
Number of condoms distributed to PWID	319,879*	170,411	986,364*	308
Number of needles/syringes distributed to PWID	1,151,495*	319,879	5,698,315*	495
Number of PWID referred for HIV testing and counselling (and have received their results)	602*	351	6,391***	1062
Number of STI cases referred and received their diagnosis result	577*	411	8,171***	1988

# In Phase 2, CHAMPION-IDU partners were allowed to count people re-trained, whereas in Phase 1, once a person received training, they could not be re-counted against indicator performance.

\* Not cumulative

\*\* Cumulative over project life

\*\*\* Cumulative annually

A further concern is that the Government, already unresponsive to harm reduction efforts, could potentially use this assessment as further justification to avoid deploying future interventions to reduce HIV among PWID. The Global Fund is a leading source of international support for harm reduction programmes<sup>20</sup> and remains the sole and best possible option for supporting the response to HIV transmission among PWID in Thailand. In order to maximize the Global Fund’s significant investment in HIV prevention among PWID in Thailand, it will be critical to balance the quantitative results of the CHAMPION-IDU project against the hostile operating environment. At the same time, it is important to provide flexibility to implementing agencies to re-program funds to support advocacy efforts towards the deployment of an evidence-based policy, while efforts are also needed to harmonize law enforcement and public health objectives so that these challenges can be transformed into genuine successes for the benefit of Thai society as a whole.



Australia has benefitted greatly from the early adoption of harm reduction as an effective way to reduce the impact of HIV and other blood-borne viruses such as hepatitis B and C that can result from sharing contaminated injecting equipment. Harm reduction initiatives including the implementation and rapid scale-up of NSPs and OST began in the mid- to late 1980s. These effective programmes have helped maintain low HIV prevalence of approximately 1 per cent among PWID in Australia for almost 30 years.<sup>21</sup>

In the early days of harm reduction, drug use was seen as a criminal issue to be stamped out by police arrests and customs seizures of imported drugs. The adoption of harm reduction shifted much of the rhetoric to one of drug use as a health issue. Language became an important way to convey ideas about ‘managing drug use’ and ‘reducing harm’. However, the

<sup>f</sup> See Global Fund (2012) Performance-based Disbursements, [www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/3](http://www.theglobalfund.org/en/performancebasedfunding/grantlifecycle/3).

rhetoric did not entirely reflect the reality. Examining funding for drug-related interventions in Australia reveals a very different picture of the priorities of the country's leaders. The majority of funding goes to supply and demand reduction measures, and just 3 per cent of funding has consistently been allocated to harm reduction.<sup>22</sup>

Despite this disparity, just one of the harm reduction measures, NSP, is recognised as one of the most cost-effective health interventions ever funded. For every \$1 spent on NSP, \$27 is saved just on health care costs,<sup>23</sup> and increased spending would result in a corresponding further reduction in blood-borne virus transmissions, other adverse health outcomes for PWID and overall health care costs, with the maximum benefit being achieved at increasing funding by 150 to 200 per cent of its current levels.<sup>23</sup>

To assess their impact, the Federal Department of Health commissioned two major cost-benefit analyses of NSPs in Australia. The first of these showed overwhelming evidence for the financial and health benefits of investing in NSPs in the first decade and a half of their existence. According to the second *Return on Investment Report*, published in 2010, these savings have continued to grow. Between 2000 and 2009, NSPs alone directly prevented approximately 32,000 HIV transmissions and almost 100,000 hepatitis C transmissions, and saved the Australian government over \$1 billion in health care costs.<sup>23</sup>

Integral to the success of the Australian harm reduction response has been the involvement of PWUD in providing services, conducting formal and informal peer education, and representing the needs of PWUD in Australian policy dialogue. From the earliest days of implementing the first pre-legal NSP to today, PWUD have done everything they can to be part of Australia's harm reduction response. PWUD have challenged stereotypes by developing their own organisations, advising on policies and procedures, developing resources and working in every area relevant to PWUD, from NSPs to outreach to government health departments. They have proved that not all illicit drug use is problematic and chaotic, and that PWUD have valuable skills and care about their peers and communities. Without the voluntary and paid work of these people, and the willingness of PWUD to take the necessary steps to look after themselves and their peers, Australia's response to HIV would have had a far less successful outcome. Drug users were organising themselves even before the identification of HIV and hepatitis C as potential concerns for PWUDs. The recognition that PWUD might pose a 'threat' to the 'general community' through sexual transmission of HIV meant that the drug user organisations that had been operating voluntarily began to receive some funding.

As drug user organisations at the state and national level gained experience and proved their worth by developing successful programmes and resources, more funding was

made available to allow these organisations to educate the PWUD community about blood-borne viruses. Australia, unlike many other countries, can rely on neither international donors nor philanthropic organisations to support community work. Almost all community organisations, including all harm reduction and drug treatment services, are primarily funded by the government, and the government is not very interested in funding organisations to look critically at its policies. Most of the advocacy work and lobbying for policy change remains unfunded, limiting the opportunities drug user organisations can take outside programmes to prevent transmission of blood-borne viruses.

Australia has rightly been proud of its record on implementing brave programmes in the mid-1980s that prevented an HIV epidemic. It has also been proud of what is called the 'partnership approach',<sup>24</sup> referring to the inclusion of affected communities such as PWUD organisations in the response to HIV. The Australian response has been promoted and modelled in Australia's aid development programmes around the world, particularly in Asia where HIV has devastating impacts on the lives of millions of PWUD and their communities.

Australian aid has funded many harm reduction programmes in Asia where the health and human rights of PWUD had previously not been considered. Meanwhile, in Australia, drug user organisations have despaired at government and community attitudes to PWUD and the lack of forward movement in our own programmes. More frightening is the fact that Australia appears to be going backwards towards denial and abstinence-oriented programming.

An 11-year conservative rule of the country from 1996, led by Prime Minister John Howard, produced the 'Tough on Drugs' strategy. Howard portrayed himself as a strong conservative, frequently talking about the evils of drugs and what he wanted to do about it. The 'Tough on Drugs' strategy emphasised supply reduction measures and language that pandered to stigma about PWUD. Increasing stigma is obviously damaging, particularly for already marginalised and criminalised communities such as PWUD. However, the 'Tough on Drugs' rhetoric was accompanied by continued harm reduction funding, and in some cases increased funding, although few new harm reduction programmes.

It was hoped that the election of a Labour government in 2007 might make the language and policies more progressive and compassionate. Instead, rhetoric around harm reduction and drug use has regressed further. A recent report developed by prominent Australians including politicians, medical professionals and parents of children who had died of overdose called on Australia to rethink the 'war on drugs' and reform drug policy.<sup>25</sup> The report, entitled *The Prohibition on Drugs is Killing and Criminalising Our Children and We Are All Letting It Happen*, received a lot of media and public attention. The only people unwilling to even acknowledge the idea,

let alone engage in a conversation about drug law reform, seemed to be the politicians responsible for the well-being of its citizens. Media questions about the report were met by blanket refusals from the ruling parties to discuss either the report or the ideas contained in it. Labour's silence has created confusion about where PWUD stand, and changes to budgeting have been even worse for many PWUD and harm reduction organisations.

The 'Tough on Drugs' strategy has gone, but it is being replaced by something drug user organisations are finding equally disturbing. 'New Recovery', following an agenda implemented in the United Kingdom (UK) in recent years, seems to be the new Australian strategy. 'New Recovery' promotes many ideas that seem positive such as increasing treatment programmes for PWUD. It sounds like people will have more choices in their treatment options. However, a closer reading of the current Australian *National Drug Strategy, 2010–2015: A framework for action on alcohol, tobacco and other drugs* reveals an increasing emphasis on abstinence-based outcomes for people who use drugs. It lists demand reduction as its 'First Pillar' and supply reduction as its 'Second Pillar' for responding to issues related to drug use. It also includes ideas such as 'outcomes-based funding', and 'episodes of care', which, experience from the UK shows us, can lead to rewarding numbers rather than quality outcomes. The number of times a person is told to see a particular professional does not mean they will enjoy quality or relevant treatment for their needs.

Harm reduction is slipping further into the background. Although evidence-based programmes are frequently mentioned, the actual objectives of the drug strategy concentrate far more on programmes that have proved to be costly and ineffective such as education campaigns to prevent young people trying drugs. The language used for people who are dependent on drugs emphasises 'reducing and/ or ceasing the use of drugs (to) ... help them lead more stable, healthy and productive lives'.<sup>26</sup>

Characterising any drug use as 'problematic' and linking drug use and mental health issues is appearing as a dominant discourse in both health and political forums. In this environment, we are seeing services and programmes for PWID moved into the mental health sector and harm reduction quickly losing its place in Australia's health sector.

We are also already seeing the first major signs of the effect such pathologising of drug use may have on the ability of drug user organisations and PWUD to be involved in the decisions being made around their lives and choices. Although drug user organisations have been a part of Australia's harm reduction response, the future is not assured. The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) has been integral to the newest initiatives in Australia including advocating for, designing and receiving funding to run Australia's first naloxone peer distribution programme. The first training sessions for PWUD and their friends and family

were held a few weeks before CAHMA was told that its 2012–2013 funding application for the organisation had been rejected by the Federal Department of Health, along with many other significant but small community organisations. It was only through intense lobbying by the national drug user organisation, the Australian Injecting and Illicit Drug Users League (AIVL), CAHMA and supportive local and national agencies that CAHMA's funding was reinstated and its ability to implement these new programmes realised.

Australia has not yet regressed to the time when drug users could not advocate for their communities for fear of imprisonment, but complacency could have devastating effects. The pathologising of drug use seems to be dominating policy and legislation, whereas harm reduction, involvement of the people affected by the issues, and evidence-based policy used to have a much stronger place. This is a time when drug user organisations are more important than ever.



**VANCOUVER**

*There are reported to be 286,987 PWID in Canada. HIV prevalence among them is estimated to be 13.4 per cent. Coverage of key harm reduction interventions such as NSP and OST remains lower than in Australasia and most Western European countries.<sup>2</sup> The current government has prioritised a law enforcement approach to drugs, which has overshadowed public health responses. Vancouver is home to two projects not only crucial for the local community of PWUD but also for their contributions to the international evidence base for two important harm reduction interventions – safer injecting facilities and heroin-assisted treatment. This case study outlines these two very different projects, the structural barriers they have encountered and the reasons why, despite substantial evidence of effectiveness, these pilots have not been scaled up in the Canadian context.*

Beginning in the mid-1990s, Vancouver's Downtown Eastside neighbourhood became the focus of unprecedented levels of harms related to illicit drugs, including an explosive outbreak of HIV transmission and an extremely high fatal overdose rate.<sup>27</sup> In response, a broad coalition of PWID, community-based advocates, public health professionals and elected officials coalesced around support for the implementation of a broad range of harm reduction interventions,<sup>28</sup> most notably establishing Insite, North America's first medically

supervised safer injecting facility (SIF)<sup>29</sup> and conducting the North American Opiate Medication Initiative (NAOMI) study, a randomised clinical trial of heroin-assisted treatment for severe heroin addiction.<sup>30</sup> However, despite the impressive body of scientific evidence generated attesting to the positive impacts of these programmes on the health and well-being of local vulnerable and marginalised illicit drug users, they have yet to be scaled up or implemented in a fashion consistent with their benefits and cost-effectiveness.<sup>31,32</sup>

Insite opened in 2003 in a low-threshold facility located within the epicentre of the neighbourhood's open illicit drug market. A joint initiative of a social services agency and the local health authority, Insite obtained the necessary federal government-issued exemption from criminal prosecution by being set up as a pilot project to study the effects of a SIF in the Downtown Eastside.<sup>33</sup> The scientific evaluation produced a wealth of peer-reviewed research describing the facility's benefits, including lower levels of syringe sharing,<sup>34</sup> increased uptake of addiction treatment<sup>35</sup> and significant reductions in fatal overdoses in the area around the facility.<sup>36</sup> In addition, Insite enjoys broad support from its clientele, members of the surrounding community including merchants and civic leaders, as well as the Vancouver Police Department and current and former city mayors and provincial premiers. Despite these successes, the agency operating Insite and two Insite clients were forced to take Canada's federal government to court to prevent it from shutting the facility shortly before the exemption expired in 2006. Subsequently, the Supreme Court of Canada ruled in 2011 that the facility could remain open indefinitely, and plans are underway to try to expand the service by creating supervised injecting environments elsewhere in Vancouver and in other regions in Canada.

In light of the successful implementation of heroin-assisted treatment in several European countries,<sup>37</sup> the NAOMI study recruited over 200 out-of-treatment long-term opioid injectors and randomly assigned them to receive standard medical care (oral methadone) or a diacetylmorphine (heroin) (DAM) plus flexible doses of methadone.<sup>38</sup> After 12 months, individuals in the DAM group were more likely to remain in treatment, less likely to be engaged in illicit heroin use or other criminal activity, and enjoyed greater improvements in social functioning than patients receiving methadone.<sup>39</sup> Additional analyses concluded that treatment with DAM was cost-effective.<sup>31</sup> Despite these findings, DAM has not been added as a treatment modality for opioid dependence, and all participants in the DAM group were transitioned to methadone or detoxification, making the NAOMI project the only heroin prescription study to discontinue heroin-assisted treatment upon conclusion.<sup>40</sup>

Although it is important to note the fundamental differences between Insite and the NAOMI trial, both interventions share similar structural barriers to implementation and scale-up. First, both interventions were the subject of numerous rules

and regulations rooted in political or legal considerations. For example, the City of Vancouver restricted NAOMI participation to individuals residing within one kilometre of the study site, limiting recruitment.<sup>38</sup> Clients at Insite are not permitted to share drugs within the facility nor assist in injections, limiting its effectiveness for a small but vulnerable group of clients.<sup>41</sup> Second, both interventions exist within a federal policy environment that is explicitly hostile to harm reduction interventions.<sup>42</sup> First elected in 2006, Prime Minister Stephen Harper has removed harm reduction from the federal government's official anti-drugs strategy and has pursued a strict prohibitionist strategy, including the implementation of mandatory minimum sentences for minor drug offences and expansion of the correctional system. Finally, the recent history of the NAOMI trial and Insite reveal the importance of community and academic advocacy in planning and implementing interventions for illicit drug users. In many respects, the establishment and continued existence of Insite is a result of the efforts of the broad coalition of clients, researchers, advocates and officials operating within legal, political, social and cultural contexts.<sup>43</sup> The NAOMI investigators were not similarly engaged with the community and other supporters, and patients in this study have not benefitted from similar advocacy efforts, resulting in the NAOMI intervention being halted without public education or legal efforts to prevent this outcome.

In a recent report on their experiences prepared by the NAOMI Patients Association,<sup>44</sup> one participant identified the marginalised status of illicit drug users as a reason for the failure to create a permanent heroin-assisted treatment programme: *'If they give you a drug for — they're experimenting with a drug for cancer and it starts working. I mean, what are they going to do? Oh, no. You can't have it any more; we're going to back off here.'*

These examples, with the success of the Insite programme resulting from collaboration between scientists, community groups and the legal and public health communities, and the closure of the NAOMI programme in the setting of researchers working largely in isolation from external stakeholders, demonstrate the importance of coalition-building between the research community, the non-profit sector, service providers and those with legal expertise to ensure that effective harm reduction programmes and other evidence-based approaches to prevent and treat harmful substance use can expand in a sustainable way.



The decade between 1996 and 2005 was a time full of hope for harm reduction in Russia. The country's first pilot harm reduction projects funded by the Open Society Institute (OSI) and Médecins du Monde (MdM) opened in 1996 and delivered high-quality results.<sup>45</sup> In 1997, Médecins Sans Frontières (MSF) Holland and OSI launched an ambitious programme to introduce harm reduction in Russia, in cooperation with the HIV/AIDS Department of the Russian Ministry of Health. As part of the new programme, MSF trained 300 doctors and NGO representatives from all over Russia in providing needle and syringe and outreach services, and OSI funded over 30 pilots.<sup>46</sup> To ensure sustainability, the Russian government agreed to gradually increase co-funding of the pilots, with a view to eventually fully fund and continue to scale up the project.<sup>46</sup> However, this did not transpire – the government continued to postpone the takeover of harm reduction services, encouraging international donors to step in and bridge the gap.<sup>47</sup>

In 2001 a new donor emerged – the UK Department for International Development (DFID). Its funds intended to 'bridge' the ending OSI grant programme and to fill the gap until a looming World Bank loan to meet the country's urgent health needs was agreed and signed off.<sup>48</sup> The DFID support included a large research project examining the effectiveness of harm reduction in Russia; it matched the funding for the 30 existing pilot projects and provided for significant scale-up of harm reduction services in two selected Russian regions

looking to prove the impact of harm reduction on the HIV epidemic. However, by the end of 2003, DFID decided to move its funding to post-war development in Iraq, changing its priorities abruptly; funds were withdrawn, and scaling up did not take place.<sup>48</sup>

However, there was hope that the government would support harm reduction efforts within the upcoming World Bank loan. Negotiations on the loan took place for almost five years; the World Bank conducted numerous assessments, research and consultations – all with a promise that the loan would support 30 harm reduction projects.<sup>49</sup> However, by the time the loan was accepted, both the government and the World Bank dismissed their written plans and agreements to take over harm reduction, reallocating the money towards purchases that were more convenient for the Russian officials, such as laboratory equipment and furniture for the state AIDS centres.<sup>49</sup>

In 2003 a consortium of five major NGOs took the decision to stop waiting for government support and submitted Russia's first application to the Global Fund (Round 3). The grant was successful and went on to support 22 harm reduction projects. A year later, support for 30 more projects was received through the Global Fund Round 4, and again in 2006 another 33 projects were funded through the Round 5 grant. As a result, the period between 2005 and 2008 saw the beginning of scale-up for harm reduction, with over 80 projects implemented.<sup>50</sup> Many of the projects, however, operated only as small-scale pilots. Scepticism was also increasing around governmental support to harm reduction, as government officials became increasingly vocal in their opposition to harm reduction. For example, government representatives unanimously refused to approve harm reduction as part of national applications to the Global Fund, meaning that the Round 5 proposal did not receive the approval of the Country Coordinating Mechanism due to its focus on harm reduction.

Unexpectedly, in May 2008, at the Eastern European and Central Asian AIDS Conference the newly appointed Russian Minister for Health, Ms Golikova, announced that the government had all the resources to fully take over harm reduction projects currently supported by the Global Fund.<sup>51</sup> After her announcement, the audience held their breath for a moment and then burst into applause. This was the moment harm reduction advocates had been waiting over a decade for. However, just one year later in September 2009, the same Minister, at a meeting with the President and Prime Minister in attendance declared that 'distribution of sterile needles and syringes stimulates social tolerance of drug addicts, and violates the Criminal Code.'<sup>47</sup> This speech marked the end of political support, if even only rhetorical, to harm reduction. The national 'Anti-Drug Policy Strategy', approved another year later, ignored significant evidence around major health challenges including HIV rates of around 37 per cent<sup>52</sup> and hepatitis C prevalence of between 49 per cent and 96 per cent<sup>9</sup> among PWID and even named harm reduction as a threat to the strategy.<sup>53</sup>

At the end of 2011, the last Global Fund-supported programmes ceased to function. As a result, by early 2012, only six organisations across the country were able to provide harm reduction services to PWID, all struggling for small-scale funding from independent sources.<sup>54</sup> This is grossly inadequate for the needs of PWID; current estimates in Russia are that nearly 2 million people inject drugs, with HIV rates around 37.15 per cent among this population and much higher in some provinces [for more information see Chapter 2.1: Harm Reduction in Eurasia].

One of these organisations, the Andrey Rylkov Foundation for Health and Social Justice (ARF), maintained its outreach services supported by the International Crystal of Hope Award. However, the organisation has been severely repressed by the government. In 2012, after multiple checks by police and prosecutors, its website was shut down by the Federal Drug Control Service citing 'drug propaganda' as its reasoning – specifically concerning materials discussing substitution treatment.<sup>55</sup> Through this action, the Russian government suggested that it believed that not only providing services but even discussing harm reduction was illegal.

What went wrong with harm reduction advocacy in Russia? Why were small but aspirational harm reduction pilots not scaled up by the government but, rather, fiercely opposed? Traditional advocacy has been undertaken in Russia: research and evidence-building, trainings and international study tours, publications and debate. However, so far none of these activities have had an impact on mainstreaming harm reduction into national public health strategies or services. The root of this strong ideological government resistance is hard to explain, and this opposition has never been scrutinised scientifically,<sup>47</sup> so more research into policy resistance is recommended to determine the causes of this ongoing phenomenon.

Advocates affiliated with the ARF have taken the decision to use legal tactics to force the government to change its policies. The organisation has taken several cases to national and international courts, claiming violations of the right to health,<sup>56</sup> the right to be protected from torture and inhumane treatment,<sup>57</sup> the right to receive information<sup>9</sup> and the right to benefit from scientific progress.<sup>58</sup> However, it remains uncertain whether this approach will be successful in bringing evidence-based programmes to PWID in Russia.

## Conclusion and recommendations

This chapter has brought together a diverse set of case studies from around the world to examine the problems of sustainability in harm reduction and to highlight successful or promising strategies for securing it. All four case studies clearly demonstrate the importance of continued advocacy, alongside sustained political support for the implementation and scale-up of harm reduction services. Although the circumstances of the four case studies differ in significant respects, there are a number of common issues that can be identified.

Each of the case studies and Vancouver, in particular highlights the importance of creating a broad and diverse coalition of advocates and supporters to ensure the survival of harm reduction services. The example of Insite demonstrates that a key element in ensuring the continuation of the facility was the broad support it received from community advocates, law enforcement officials, academics and clients, as opposed to the failed NAOMI trial which worked mostly in isolation. This case study also serves as a cautionary example, highlighting the marginal social status of PWID and the potential role this has in the 'acceptability' of rolling back on harm reduction.

The Canadian and Russian case studies highlight the importance of legal mechanisms and the value of forging connections with legal professionals to protect harm reduction. In the case of Insite the ongoing use of legal mechanisms bypassed political opposition to harm reduction and helped to ensure the survival of the project. Moreover, this ruling provided legal cover for the opening of further safer injecting facilities in other parts of Canada. Similarly in Russia the use of legal mechanisms is now being applied with the hope that it will enable NGOs to side-step political resistance to harm reduction. While these initiatives are in their early stages, it is clear from the Canadian example, in particular, that this is a strategy worth exploring further.

Several case studies highlight the fundamental role of funding (or the lack thereof) in sustaining harm reduction programmes, and the significant role of donor advocacy. The case study from Thailand emphasised the need for donors to balance performance-based quantitative indicators with less quantifiable activities such as advocacy, and for international donors to take into account hostile political environments and adjust indicators and activities accordingly. The Australian study highlighted the precariousness of government funding and the need for funding mechanisms that are independent from the state for civil society strengthening, in particular for organisations of PWUD. Autonomous funding mechanisms are clearly a common need to allow harm reduction advocates to function as 'community watchdogs'. Moreover, in Russia it is clear that international donors are the only hope for the survival of harm reduction services, not only as funders but also as independent bodies with some influence over resistant

<sup>9</sup> Andrey Rylkov Foundation (2012). Information note regarding retaliation of the Government of the Russian Federation against the Andrey Rylkov Foundation for Health and Social Justice (ARF) for promoting the recommendations made by the UN Committee on Economic, Social and Cultural Rights (CESCR) to the Russian Federation in its Concluding Observations

governments to put in place evidence-based strategies for HIV prevention for PWID.

Another key theme that emerges from the case studies is the importance of involving PWUD in advocacy activities. In Australia the scale-up of harm reduction can be attributed in part to the activities of networks and organisations of drug users, including self-organising, advocating and peer support. In Vancouver the Eastside community and service users of Insite and drug user organisations such as VANDU played a vital role in keeping the facility open. In Thailand ongoing advocacy from PWUD has been vital in ensuring the expansion of harm reduction services, as well as ensuring that the regressive policies and practice of the Thai government are recorded and highlighted to donors and the international community.

The Australian case study discusses the potential threat posed by the emergence of the 'new recovery' movement. It is particularly threatening to harm reduction in Australia, as it uses the language of harm reduction yet deviates from the key principles of pragmatism, evidence-based interventions and the meaningful involvement of PWUD. It is, therefore, extremely important for harm reduction professionals internationally to ensure that harm reduction messages are delivered in clear and coherent ways to ensure they cannot be co-opted.

The Australian case study also raises concerns about mental health providers taking the lead in harm reduction services. It notes that, although mental health provision is an extremely important component of a comprehensive package for drug users, it is dangerous to subsume all drug services under this label, as it suggests that PWUD are 'unwell' and unable to make informed decisions, thereby undermining efforts to support active drug users to self-organise and advocate.

In conclusion, threats to the continued implementation of programmes at a level that can impact on epidemics among PWID are a challenge to harm reduction practitioners and advocates in various political and economic contexts. The strategies to overcome these threats are multiple and varied, but all require strong and strategic advocacy for harm reduction, particularly in the current context of uncertain international financing and wavering or poor political support for harm reduction in many parts of the world. These case studies underline the importance of donors, governments and civil society organisations themselves recognising and prioritising advocacy as key to ensuring sustainable and scaled-up harm reduction responses.

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