LESSONS FROM HISTORY:
Advocating for harm reduction in challenging environments

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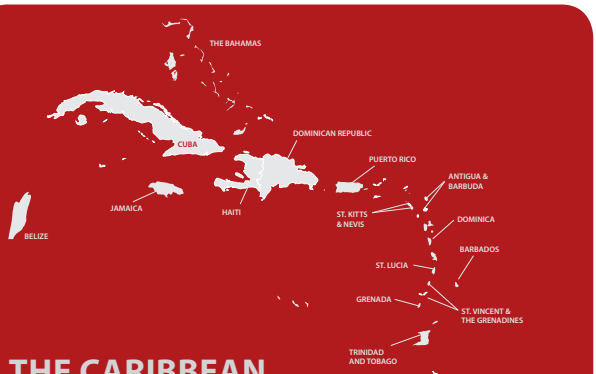
INTRODUCTION

The reasons for starting and scaling-up harm reduction services are multifaceted, compelling and well established. If policy-making were a purely scientific, objective and methodical process, harm reduction would already be the global norm. However, this is not the case. Section 1 lists 158 countries that report injecting drug use (IDU), of which 94 support harm reduction in policy and/or practice to help individuals stay safe, manage or end their drug use and avoid blood-borne viruses (BBV). The other 64 countries still do not support and/or implement harm reduction. What accounts for these variations in response? What makes one country adopt harm reduction in policy and practice, while a neighbour continues to ignore the evidence?

This chapter highlights four examples from around the world where harm reduction has been endorsed to varying degrees: from early adoption and nationwide scale-up in Switzerland and Macedonia, to opening the harm reduction debate in Malaysia and overcoming strong ideological resistance in the Caribbean. Each case study explores how harm reduction came to be accepted and documents the events and actions that were key to this process. It is hoped that this chapter will inform ongoing advocacy efforts for harm reduction elsewhere in the world and provide encouragement to those who are working to promote change in their own countries — including those in both governmental and nongovernmental positions. At the same time, it should be equally relevant for countries that are seeing their existing services come under threat (see Chapter 3.6 for a more in-depth discussion of this).



THE CARIBBEAN

Injecting drug use is reported to be rare in the Caribbean region, with the notable exception of Puerto Rico. The harm reduction response in the region remains very limited, with needle and syringe exchange and opioid substitution therapy only available in Puerto Rico. The response in the rest of the region is predominantly characterised by abstinence-based, high-threshold services. The use of illicit drugs is highly criminalised, with harsh sentencing resulting in large numbers of people who use drugs in Caribbean prisons. This case study illustrates the emergence of harm reduction advocacy in the region and describes the various efforts which have contributed to its wider acceptance.

Drug policy in the Caribbean has always been heavily influenced by the USA, and its historical antipathy toward harm reduction approaches as 'capitulation' to drug use. In the 1990s, any mention of the term 'harm reduction' would lead to the loss of US State Department funding for drug demand reduction programmes. In 1997, the European Commission contracted a situational assessment of drug treatment in the Caribbean, which remains an influential work to this day.[1] The following year, Deutsche Orden Hospitaller (DOH) International received a grant from the European Commission to expand low-threshold programmes for street-engaged people who use drugs.

In the absence of prevalent drug injecting, harm reduction in the Caribbean often refers to services that treat people who use drugs with respect and dignity: providing food, clothes, showers, referrals and a supportive, listening ear. However, when the first drop-in centres began implementing this approach, service providers were forced to label them as 'public health approaches' to address HIV among the homeless, rather than harm reduction for people who use drugs. The first drop-in centre in the Caribbean was opened in Castries (Saint Lucia) in 2000, followed by centres in Santo Domingo (Dominican Republic) in 2001, Kingston (Jamaica) in 2002 and Port of Spain (Trinidad) in 2003.

Meanwhile, work was being done by leading activists in the halls of the Caribbean Community (CARICOM) Secretariat to place harm reduction on the agendas of various Councils of Ministers. In particular, as a result of the work and advocacy efforts of a handful of researchers and service providers, there was a growing acceptance by the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), the UNAIDS Regional Office and others of an overlap between non-injecting crack cocaine use and HIV infection, with five to 10 times the national prevalence among this population.[2] This countered the common argument that 'Caribbean people do not inject, so there is no link with HIV'.

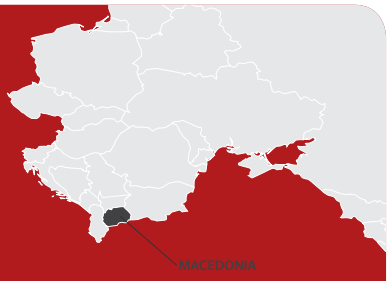
In 2001, the Foreign and Commonwealth Office commissioned an evaluation of demand reduction programmes in the Caribbean, which confirmed the link between crack smoking and unsafe sexual behaviours, leading to increased HIV infections.[3] In the Nassau Declaration on Health 2001, Caribbean Heads of Government committed to Phase II of the Caribbean Cooperation in Health Initiative, which explicitly

classified substance use as a mental health and public health issue.[4,5] A steady stream of US-funded interventions continued to undermine harm reduction by focusing solely on drug use prevention and high-threshold abstinence-based services. However, harm reduction programmes remained successful in reaching and supporting 'hidden' populations in the region.

Several events led to 2001 being a pivotal year for civil society advocacy. A number of Caribbean treatment professionals attended the International Harm Reduction Conference in Delhi, India, and the US Harm Reduction Conference in Miami later that year. At the latter event, the Caribbean Harm Reduction Coalition (CHRC) was formed during a special satellite meeting. CHRC set out to promote the emerging experiences in the region and support research to increase the evidence base for interventions. The Caribbean Drug and Alcohol Research Institute was then formed to work alongside CHRC and provide the necessary evidence to support advocacy efforts. In 2004, the Caribbean Vulnerable Communities Coalition was formed, of which CHRC was a founding member, and allowed for the expansion of harm reduction to other vulnerable groups such as sex workers and men who have sex with men.

Despite the weight of US drug policy in the region, contributions from a range of international donors and partners have proven invaluable for the success of harm reduction efforts. The original European Commission funding got the ball rolling, while support from the Open Society Foundations and the UK Department for International Development (via Harm Reduction International) enabled the exchange of information, ideas and experiences across the region and internationally. In 2008, the Caribbean Vulnerable Communities Coalition began work on a successful multi-country proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria.[6] Although injecting and opioid use is less common in the Caribbean than in many parts of the world, non-injecting crack cocaine users were included as a target population, and programmes began in 2011. As a result of a rapid assessment conducted by CHRC that documented heroin injecting, efforts are also underway to provide sterile injecting equipment and to advocate for the adoption of opioid substitution therapy (OST) interventions by Caribbean governments.

Overall, the HIV crisis in the region facilitated the emergence of harm reduction as a proven public health response. Governments were presented with a harsh economic reality: they would experience a significant drop in Gross National Product if the HIV epidemic were left unaddressed. With the establishment of the Caribbean Vulnerable Communities Coalition, CHRC became part of a Caribbean-wide movement advocating for the adoption of a human rights-based agenda to augment the public health arguments previously espoused. Although the HIV epidemic remains, responses to HIV are presently more practical and evidence-informed. Agencies that previously were resistant to adopting harm reduction strategies a decade ago began to embrace and implement variations of harm reduction adapted to the contextual realities they experienced. Trinidad adopted harm reduction as part of its national drug policy, supporting the continuation of the drop-in centre started with European Development Fund (EDF) funding in 2003. Jamaica carried this one step further when the National Council for Drug Abuse received support from the Ministry of Health to operate a mobile outreach project targeting homeless street-engaged crack smokers. As this report shows, three of the countries in the region now embrace harm reduction in policy and/or practice (see Section 1: Global Overview). Advocacy efforts are ongoing, but the Caribbean example shows how harm reduction can be promoted even under the shadow of a major global detractor such as the USA.



MACEDONIA

The timely introduction of harm reduction interventions is credited for averting an HIV epidemic among PWID in Macedonia. This case study outlines the antecedent factors which contributed to the adoption of a harm reduction approach in the country, including well-timed research and well-placed civil society actors funded to take forward research recommendations. In addition to this, international technical assistance and the continued engagement of decision-makers, civil society groups and people who use drugs have been critical factors in developing the national harm reduction response.

In Macedonia, harm reduction began with the provision of OST to a very small group of people from the early 1980s, growing into an organised state-run programme from 1990 onwards. In addition, however, two key milestones stand out in the development of broader harm reduction policies and programmes.

The first of which was the research of Jean-Paul Grund and Dusan Nolimal in 1995 entitled *The Heroin Epidemics in Macedonia*.[7] This report for the Open Society Foundations was perfectly timed — HIV had not become established in Macedonia, but research indicated that widespread high-risk injecting behaviours such as syringe sharing could drive the emergence of an HIV epidemic among people who inject drugs (PWID). One of the report's recommendations was to open needle and syringe exchange programmes (NSPs). As

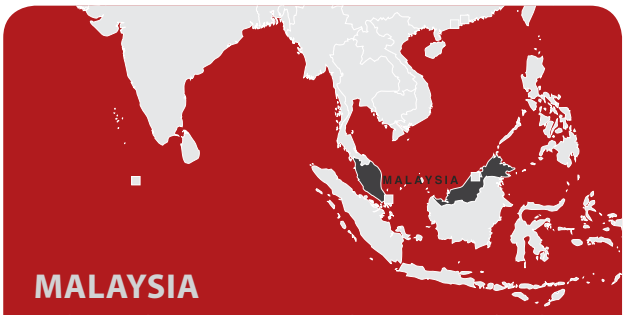
a result, the first service opened in 1996 via the Macedonian Association for Socio-Culture Activities (MASKA). This move was initiated by people who use drugs and supported by the Open Society Institute in Macedonia.

The second key milestone was the founding in 1997 of the Healthy Options Project Skopje (HOPS), a nongovernmental organisation (NGO) that continued the work undertaken by MASKA. Since then, HOPS has developed or supported all 16 harm reduction programmes in 13 towns across Macedonia. Because of this work, harm reduction programmes can be seen even in towns with populations of just 20,000 people. Harm reduction programmes have also been developed for the Roma suburbs, as well as for sex workers who inject drugs.

HOPS has played a key role in promoting harm reduction in Macedonia through these services, by promoting and respecting the meaningful involvement of people who use drugs in all programmes and insisting on a wide spectrum of services being made available (beyond just needles, syringes and condoms). At present, the majority of harm reduction programmes also provide medical, social and psychiatric services, and legal aid and court representation in cases of human rights violations. Experience has shown that only this comprehensive approach can achieve the coverage and results that are needed. Annually, these programmes serve more than 3,000 PWID — approximately one-third of the estimated number of people in need.[8]

The feared HIV epidemic in the country has been avoided. This has been largely attributed to the immediate implementation of harm reduction programmes, according to the latest available evidence. Only 10 of the 142 registered HIV cases are among PWID, and there have been just two cases of HIV among PWID in the last eight years.[9] Intolerance of drug use and harm reduction programmes was overcome by engaging and bringing together decision-makers, authorities, civil society groups and people who use drugs.

A key strategy used to achieve a shift in initially hostile attitudes was the inclusion of state and local government bodies in joint project activities financed by the Global Fund and the Open Society Foundations. Cooperation with the international community was also important. Experts and agencies such as UNAIDS, WHO, UNICEF and the European Union were all involved in advocating for changes to state policies on HIV and drugs. Macedonia's EU candidacy also played a role in pushing the finalisation of the National Drugs Strategy 2006–2012 and its reflection of international guidance on harm reduction.[10] With this collective support, harm reduction was first mentioned in official government documents as part of the National Strategy on HIV/AIDS in 2003 and, subsequently, as part of the National Drugs Strategy in 2006. In 2011, for the first time, small quantities of the needles, syringes, condoms and lubricants needed for harm reduction programmes were purchased through the state budget. Another important element has been the inclusion of state and local government bodies such as the Ministry of Health, Ministry of Social Policy, the National Drug Coordinator and the Departments for Social and Health Protection in activities within local municipalities, which has helped to shift the initial attitudes to drug use and harm reduction. Local municipalities are also supportive of harm reduction approaches, including through the provision of local funding for such programmes. Slowly but surely, harm reduction is becoming ingrained within national health and social care systems.



MALAYSIA

Malaysia is home to an estimated 170,000 PWID[4], with the latest reported HIV prevalence among them being 8.7%.[4] Hepatitis C prevalence among PWID remains high at 67.1%.[11] In recent years, Malaysia has refocused efforts into scaling up harm reduction services and is now reported to have 'medium' NSP coverage and increasing OST coverage.[12] This case study catalogues developments leading to the policy shift towards harm reduction, including strong civil society advocacy, and the important approval of a harm reduction approach by Islamic scholars. Also described is the recent movement towards evidence-based treatment options in favour of drug detention centres.

For many decades, Malaysia has employed a punitive and prohibitionist drug policy, characterised by a statutory presumption of trafficking when possessing more than a certain quantity of drugs (such as 200g of cannabis and 15g of heroin), mandatory death sentences, incarceration for personal drug use offences and a vision of a drug-free nation by 2015.[13] However, since the turn of the century, there has been a policy shift toward harm reduction.[14] This was a response to HIV epidemics among PWID. At the height of the epidemic, Malaysia recorded approximately 7000 new infections in 2002, 75% of which were due to injecting.[15] The shift in approach was certainly facilitated by international and internal pressure to achieve all eight Millennium Development Goals (MDGs), the prerequisites for being categorised as a developed nation.[16] Malaysia has achieved seven of these goals, the exception being the goal related to HIV.

Although the policy decisions were made by the federal government, they were clearly influenced by strong voices from patient groups and NGOs such as the Malaysian AIDS Council (MAC). In 2002, a grant was obtained from the US National Institutes of Health for exploratory research and a rapid situational analysis on HIV and drug use.[17]

A Harm Reduction Working Group was then formed, hosted by MAC, which used the data and findings to advocate to the relevant government agencies. The Working Group also worked with Islamic scholars to obtain their buy-in, and the Institute for Islamic Understanding of Malaysia pronounced harm reduction to be a public health issue which did not violate *shariah* law.[18]

At around the same time that the MDG results were released, the case for NSPs and OST was presented to the Prime Minister, Deputy Prime Minister and a governmental committee on drugs. Approval was given for methadone treatment and later, from the Minister of Health, for needle and syringe distribution. Free antiretroviral treatment (ART) was introduced in 2004, methadone pilot projects began in 2005 (and have since been expanded nationwide to include community and prison programmes, as well as a pilot clinic within a mosque setting), and NSPs began in 2006. Between 2006 and 2010, Malaysia saw a decline in the annual number of recorded HIV cases,[19] although this cannot be solely attributed to the introduction of the harm reduction programmes. Additional factors that may have contributed to the overall decline in HIV prevalence include the decreasing purity of heroin, which has led some PWID to switch to inhaling or to consuming methamphetamine tablets or buprenorphine, the increasing influx of amphetamine-type substances from East Asia,[20] and improved coverage of awareness and prevention programmes for other key populations at higher risk of HIV.[21]

In recent years, dialogue around Malaysian drug policy has begun to move away from HIV as the sole reason for reform. Arguments are increasingly being made based on an understanding that policies focusing on incarceration and corporal or capital punishment do not work. Malaysia has seen increased cooperation between NGOs and police and anti-drug agencies, which has helped to promote the humanitarian and health perspectives of drug use and dependency. While 'hard-line' perspectives and rhetoric still obviously exist, they are being broken down over time. Even among senior members of the police force there is a growing realisation that the 'war on drugs' has failed, and an openness to discuss alternatives such as police referrals into health services. Although HIV remains a concern, it has now become easier to argue for harm reduction on the basis of the dignity, health and productivity of the individual person who uses drugs.

These approaches contributed to the introduction of state-run 'Cure and Care' clinics in early 2010 by the National Anti-Drugs Agency. These facilities are voluntary clinics which provide integrated healthcare for PWID, including methadone treatment and counselling. This represents a significant paradigm shift for an agency that has traditionally focused on compulsory detention centres (or 'Pusat Serenti'). These centres still exist across Malaysia, but the number of people held in them is in decline.

Since the introduction of harm reduction programmes, Malaysia has seen a positive shift toward evidence-based prevention and treatment for people who use drugs. These programmes have continued to expand nationwide, and have led to increased collaboration between health workers and law enforcers. Today, MAC and numerous partner organisations continue to work toward reducing HIV infections among PWID and raise awareness about harm reduction, safe sex and the destigmatisation of people living with HIV. However despite these major advances, challenges still remain amidst a legal and policy environment that continues to heavily criminalise drug use.

SWITZERLAND

There are an estimated 31,653 PWID in Switzerland.[22] The early introduction of harm reduction measures had a dramatic impact on the HIV epidemic among PWID, which in 1990, was the most severe in Europe. Switzerland now maintains a low HIV prevalence among this group at 1.4%.[23] This case study describes the factors which culminated in the development of a pioneering and committed harm reduction response, including advocacy from professionals in the health and social sectors and Swiss professionals taking opportunities to learn from international experiences.

In the 1980s, Switzerland experienced a steady rise in the number of people using drugs, the amount of seized drugs, drug-related crimes (including organised crime leading to higher drug prices, delinquency and prostitution) and deaths related to overdose.[24] By 1990, the HIV infection rate in Switzerland was the highest in Europe.[25] Despite the alarming trends, prominent psychiatrists and officials remained opposed to harm reduction.[26] This led to protests from health professionals, social workers, some politicians and the media, all of whom accused officials of exacerbating the problem. In 1985, for example, a heated debate broke out when the Chief Medical Officer in Zürich prohibited NSPs and threatened severe sanctions against any organisation that offered them. Around 300 physicians signed a declaration challenging this stance.[27] A parliamentary investigative committee also reproached the Chief General Attorney for remaining passive while crime rates and organised crime increased.[28] That same year, the Swiss AIDS Federation was founded to advocate strongly for key services,[29] and numerous attempts were made

by activists to try to improve the health and social situation of people who use drugs.

Crucially, the Federal Subcommittee on Drug Questions (EKDF) published a report in 1989 proposing various measures to reduce harm, including widespread OST.[30] The Federal Office of Public Health (FOPH) sent this report to the major stakeholders for consultation.[31] In 1990, several Swiss professionals attended the first international harm reduction conference in Liverpool, and an FOPH delegation to England, the Netherlands and Sweden further supported the roll-out of harm reduction. The well-documented harm reduction work being done in Australia was also a major inspiration.

As a result of this work, at a national drug conference in October 1991,[32] 'survival assistance/harm reduction' was confirmed as one of the four pillars of the new Swiss drug policy (alongside 'repression', prevention and treatment).[33,34] This decision was particularly informed by the measurement of various drug-related indicators to compare the efficacy of different measures.[35] During this process, EKDF helped to bridge the gap between activists, professionals and the government. Its report proposed viable solutions later adopted by the government and implemented by the FOPH, while an Advocacy Coalition Framework helped to make the decision possible.[36]

During the last two decades, harm reduction in Switzerland has been held up as an example of best practice in the field. All levels of government have entrusted public services and civil society to provide comprehensive support for people who use drugs. The first authorised drug consumption room (DCR) opened in 1986 in Berne, and similar facilities soon opened in Zürich and Basel, providing contact points, food and basic medical care.[37,38] Low-threshold OST became widely available in most of the country, and methadone prescriptions rose steadily from a few hundred in 1975 to 10,000 in 1991, and then stabilised at around 17,000 per year.[39] The various cantons (districts) offer DCRs, NSPs[40] (including in pharmacies) and night services.[41] Heroin assisted treatment is also provided (and is considered as treatment rather than harm reduction) despite initial opposition from the International Narcotics Control Board[42] and the WHO. This intervention now reaches around 1000 of the estimated 30,000 people who use heroin. The FOPH also supported the creation of projects, including safer night-life programmes, and cities and cantons have assured sustainability by integrating activities into their budgets.[43]

The results of this approach are clear, not least in the downward trend in HIV transmission – an estimated 1.4% of PWID are currently living with HIV.[44] Just 4% of new HIV infections were associated with IDU in 2007, compared with the late 1980s and early 1990s when this was the primary mode of transmission.[45] Illegal drug use in public spaces is now less of an issue, and the number of deaths from overdose has declined markedly over the last 20 years.[46,47] Whereas public health and public order arguments were the most prominent in the early stages of the Swiss debates, ethical considerations and human rights were also a key part of the discussion. Harm reduction is considered a means to save lives and support people to survive their drug use, and this overcame the convictions that drug consumption violated other fundamental values of Swiss society.[48]

More than 25 years after opening its first DCR, Switzerland has firmly embedded harm reduction within its drug policy. The actions of activists, advocates and professionals helped to mainstream this approach, while the concrete evidence and data provided by researchers empowered the public and politicians to agree on pragmatic steps. Harm reduction in Switzerland no longer faces opposition from international organisations such as the WHO, and numerous referenda and popular initiatives have confirmed continuing support from the Swiss public (the most recent being in 2008). Although many aspects of this example may be considered 'typically Swiss', there remain numerous lessons that can be applied by other countries.[49]

CONCLUSION

This chapter highlights the successes achieved in advocating for harm reduction in the Caribbean, Macedonia, Malaysia and Switzerland. There are numerous other countries that could have also been featured, but the highlighted examples successfully draw out several key themes. Across all these case studies, it is clear that scientific research and the collection and communication of data are essential to make strong and evidence-based arguments to policymakers. The role of dedicated civil society groups is also clearly pivotal. Organisations such as CHRC, HOPS and MAC have all helped to engage and convince governments and religious leaders through innovative service delivery, organising or attending key meetings and events (including the International Harm Reduction Conferences) and generating and communicating sound evidence.

In all four examples, high rates of HIV transmission among people who use drugs was a key factor in the early conversations around harm reduction, and this remains the case in many countries around the world. While some countries such as Malaysia needed to react in order to control and reverse existing epidemics, others such as Macedonia were able to generate action to avert potential crises. This latter approach may be particularly important now for sub-Saharan Africa, where injecting-driven epidemics are beginning to emerge. Crucially, dialogue around HIV vulnerability, prevention and treatment has also helped to open doors to broader conversations around human rights, the overall health and well-being of PWID and the development of supportive policy environments.

These four case studies also demonstrate the need to carefully tailor approaches to the local situation. For example, whereas Switzerland embraced heated public debates to negotiate the issue in the 1980s, a more subtle approach was taken in the Caribbean to allow services to be delivered under the watchful gaze of the USA. Effective advocacy has to reflect the local context and should ideally be driven by local groups who best understand this context (meaning that these groups should be appropriately funded and empowered to perform this role). The relevant groups, whether governmental or nongovernmental, must acknowledge and understand the factors that guide policy decisions. Interestingly, these examples also allude to a diversity in the motivations of policy makers in adopting harm reduction, including ensuring national productivity, improving public health and order, and achieving MDGs and consequent 'developing country' status. Crucially, advocates must also decide and focus on which factors they can realistically influence or control. Although the ultimate 'tipping point' may come from factors beyond their control (such as changes in political leadership), their work will lay the foundations for policy shifts for change. Finally, the four examples highlighted here also demonstrate the need for patience. In the Caribbean, Macedonia, Malaysia and Switzerland, there will undoubtedly have been times when it seemed like fighting a losing battle. The policy shifts described here happened over a prolonged period and as the result of tireless and dedicated activism and advocacy.

Factors Influencing Successful Local Advocacy for Harm Reduction

- Carefully tailor responses to local contexts
- Involvement of strong, local civil society organisations
- Innovative services opened (with or without official support or permission)
- Commissioning or conducting research
- Evidence made accessible for policymakers and the public
- Clear articulation of costs, benefits, and risks of inaction
- Empowerment and meaningful engagement of people who use drugs
- Key groups united for discussions and debate: policymakers, academics, civil society, religious groups, the media and people who use drugs
- Conferences, events and exchanges (international, regional and national)
- Support from international or regional donors and organisations
- Emphasis of international goals, commitments and targets (for public health, human rights and other issues)
- Alliances built with other fields and groups

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