PITCH

Accelerating community-led HIV responses: adapting positive practice beyond the COVID-19 crisis

PITCH Partnership to Inspire, Transform and Connect the HIV response

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1. People who use drugs: the response from harm reduction services

Introduction

The COVID-19 pandemic and its related restrictions have brought many changes to the lives of people around the globe. Most notably, the pandemic's impact has magnified existing inequalities, stigma and repression faced by certain marginalised communities such as people who use drugs. However, the response to COVID-19 has also catalysed – or accelerated – some positive developments which are central to the wellbeing of people who use drugs. This report aims to provide a non-comprehensive review of some of the challenges, and the responses that have been applied to best protect the health and rights of people who use drugs.

It has been written to sit alongside a sister report focused on civil society advocacy during the pandemic: Innovation and Resilience in Times of Crisis: Civil society advocacy for drug policy reform under the COVID-19 pandemic.[1]

People who use drugs - Innovation and resilience

Closure of premises deemed non-essential

Various confinement and physical distancing measures have been introduced globally in response to COVID-19, such as curfews and lockdowns, as well as executive orders calling for

the closure of premises and activities deemed as non-essential. This has led to the closure of many harm reduction, health, and community centres and services catering to the basic needs of people who use drugs. Though such services have a critical, lifesaving purpose, in some countries they are not officially recognised as essential public services. In other jurisdictions, harm reduction services have been able to continue to support people who use drugs, but COVID-19 restrictions have often impeded their capacity, accessibility and efficiency. Outreach activities have also been disrupted by movement restrictions, further magnifying health risks for people who use drugs facing intersecting inequalities, such as street-based people who use drugs.[2]

Lack of coordinated public health efforts in response to COVID-19

Most governments acted relatively quickly in declaring a state of emergency, as well as in implementing restrictive measures to curb COVID-19 outbreaks. But only in a handful of jurisdictions have such measures been accompanied with coordinated public health programmes in response to COVID-19, particularly with regard to prevention, symptom screening, testing and treatment.[3]

Even before COVID-19, people who use drugs were likely to be particularly affected by inadequate public health responses, partly due to the prevalence of underlying medical conditions attributed to several factors, such as lack of access to healthcare and marginalisation. For example, injecting and smoking drugs is associated with a higher prevalence of HIV, hepatitis, tuberculosis (TB) and chronic obstructive pulmonary disorder, all of which may also leave people at greater risk of developing more severe COVID-19 symptoms. Similarly, public health directives such as social and physical distancing may be impossible for some groups of people who use drugs, such as people experiencing homelessness or otherwise unstable housing conditions.[4,5]

Growing repression and criminalisation

In some countries the implementation of COVID-19- related restrictions has encouraged highly punitive law enforcement (and even militarised) responses, resulting in increasing levels of criminalisation of people who cannot or do not comply with various national COVID-19 restrictions. These include people who use drugs, particularly those who are homeless or street-based (and hence become more visible and vulnerable during lockdowns), as well as those working in the informal sector, people of colour, and people from vulnerable socioeconomic backgrounds. As reported by the International Network of People who Use Drugs (INPUD),[6] punitive and restrictive measures have also been experienced by people who use drugs accessing harm reduction services during the pandemic. These measures include mandatory urine testing, forced reductions in medication levels, mandatory attendance in recovery programmes, nonconsensual discharge from treatment, and new age restrictions.

Furthermore, COVID-19 confinement measures and physical distancing rules have had significant impacts on democratic processes and spaces.[7] Bans and restrictions on gatherings and protests, for example, have further shrunk the space for civic mobilisation, and reduced opportunities for community-led organisations to effectively advocate for their rights or voice concerns about harmful policies.

Disruption in drug markets

People who use drugs have experienced disruptions in local drug supply and markets. These include reduced quality (including the growing appearance of adulterated substances), increasing prices, and a general decrease in availability, all of which have driven up health risks for people who use drugs. As reported by several respondents to the International Drug Policy Consortium (IDPC)'s COVID-19 survey, these trends in drug markets have been seen in Albania, India, the Netherlands, Nigeria and South Africa.[8] In June 2020, INPUD reported that 60% of respondents of its online

survey indicated that they (or their acquaintances) had experienced 'involuntary withdrawal due to changes in the drug market'. Comments included: 'People are trying any sorts of drugs to manage their withdrawals' and 'isolation has increased alcohol use to offset difficulties in acquiring drugs of choice'.[9] In addition, growing state control over people's movements and activities, including the intensifying of policing in the context of COVID-19 restrictions, has heightened risk of arrests, criminalisation, and various forms of harassment experienced by people who use drugs, in particular those interacting with local drug markets.[10]

COVID-19 measures and movement restrictions have also led to the suspension of many economic activities. This has resulted in the loss of both formal and informal incomes which some people who use drugs depend on for their basic needs. Options to apply for welfare schemes are available in some jurisdictions, but procedural and legal barriers often prevail, such as mandatory drug testing to qualify for benefits.[11]

Exacerbated risks in prisons and other closed settings

Across the globe, punitive policies towards drug use and possession have resulted in the unjust criminalisation and incarceration of people who use drugs, and hundreds of thousands are still detained in closed settings – in jails, prisons, pre-trial detention, or in compulsory drug detention and rehabilitation centres – despite various prison release measures taken in the context of the pandemic.[12] As frequently noted by communities, experts, civil society actors and policy makers for decades, people in closed settings generally have limited, unreliable or no access to basic health services, including harm reduction services. Opioid Agonist Therapy (OAT) in prisons can only be found in 59 countries (an increase of four since 2018), while needle and syringe programmes in prisons exist in just 10 countries.[13] Millions are forced to live in overcrowded cells where disease outbreaks and human rights violations often occur.

Since the World Health Organization declared COVID-19 to be a pandemic in March 2020,[14] over 548,000 prisoners in 122 countries have contracted COVID-19, and more than 3,968 prisoners in 47 countries have died due to COVID-19.[15]

These figures are likely to be a serious underestimate, as many countries do not provide appropriate testing in prison settings. While some countries have embarked on 'decarceration' programmes to release people from closed settings and pre-trial detention in response to COVID-19, this has largely not benefited people who use drugs (see below), and there remain around half a million people held in jails and prisons due to drug possession for personal use.[16]

Positive practices adopted during the COVID-19 pandemic[17]

Take-home medication

The most widespread positive reform introduced as a response to the pandemic has been the expansion of take-home OAT such as methadone or buprenorphine treatment for people who use opioids such as heroin. Permitting take-home doses gives people who use drugs greater flexibility and makes the service more accessible, while also limiting potential exposure to COVID-19 in (and travelling to and from) medical facilities. Out of the 84 countries worldwide where OAT is available, at least 47 have provided longer take-home periods since March 2020, and several introduced take-home OAT for the first time including India and Morocco. In some countries, this approach had been proposed by civil society well before COVID-19's arrival. This is the case in Ukraine (see case study) and in India, for example, where take-home OAT was supposed to be approved in mid-2019.[18]

The exact nature of reforms undertaken in 2020 varied – the take-home period ranged from just two days' supply to one month. Other innovations included shorter initiation times (the time that OAT must be prescribed before take-home doses are permitted) and increased distribution of

naloxone (a lifesaving medicine that can reverse the effects of an opioid overdose). In India, take-home buprenorphine and methadone have been approved as an emergency measure in some states, and the success of these measures is raising hopes for their continuation beyond the pandemic, offering greater flexibility for people who are prescribed OAT.

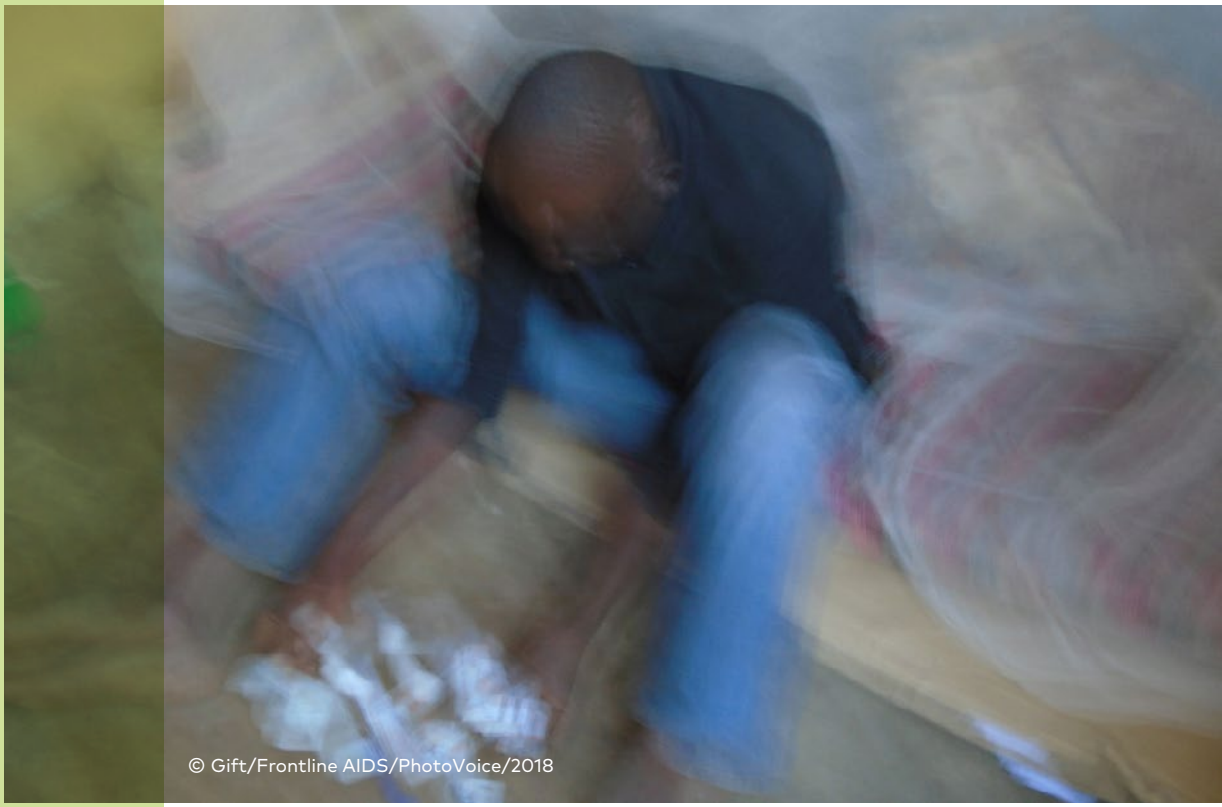
However, this expansion was by no means universal, and almost half of the countries where OAT was available prior to the pandemic have failed to expand the availability of take-home doses. For example, such alterations were rejected by health authorities in Argentina despite civil society advocacy.

Home delivery, outreach, online services, and increased flexibility

Home delivery of services and harm reduction commodities, combined with expanded outreach, helped to ensure that people who require harm reduction services did not have to attend fixed-site services and risk potential exposure to COVID-19. In at least 23 countries, distribution became more accessible with home delivery of OAT medication, offering dosing at community pharmacies, or distributing OAT in outreach settings. In many of these countries, other harm reduction services were also provided on this basis, including needle and syringe programmes (NSP) and naloxone distribution.

OAT home delivery has been recorded in every world region, including in Kazakhstan, Palestine and Senegal. In Russia, civil society organisations ensured that kits including masks, disinfectant and other hygiene materials were delivered directly to clients through courier services.

Home delivery has also provided a unique opportunity for integrated services. For example, the Centre de Prise en Charge Intégrée des Addictions de Dakar (CEPIAD) in Senegal set up a delivery service for some OAT clients, delivered sterile injection equipment and picked up used equipment. Home delivery, outreach and online services for harm reduction have ensured continued and expanded access among those in need, while minimising the risk of COVID-19 transmission.



"As a drug user, I deserve a better life like the rest of the young. Methadone services are essential."

Alongside home delivery, in many countries outreach work has been expanded to ensure that services reach those who need them, without increasing the risk of exposure to COVID-19. For example, in Palestine and Morocco, outreach workers were provided with permits for travel movements, allowing them to Coavpetircoonm peen ndaintigonal and local isolation measures.

Online services were also expanded in many locations to reduce in-person interactions. The New Zealand Needle Exchange Programme set up an online shop for purchasing sterile injecting equipment for those unable or unwilling to access services during the pandemic. In many countries online meetings replaced face-to-face counselling, support groups and consultations although these are limited by the need to access stable internet connections.

Meanwhile, there are examples of both government and civil society-run services making their operations more flexible to address the challenges of COVID-19. In Algeria, Bahrain and Palestine, as well as in many European countries, services increased the number of syringes a client could receive in a visit to an NSP. Drug consumption rooms and harm reduction centres in Europe have also increased their capacity and/or adjusted their operating hours in order to continue serving those in need while complying with COVID-19 restrictions.

Peer-led support and services

In many countries, peer involvement became more pronounced in service delivery. Peer networks provided secondary needle exchange and outreach services, and disseminated information on lockdown measures and COVID-19.

In the city of Tshwane, South Africa, the Community Oriented Substance Use Programme (COSUP) coordinated the community-oriented provision of health services, including COVID-19 symptom screening primary care services, and OAT (methadone), for approximately 2,000 homeless people who use drugs residing at a temporary shelter created in response to the pandemic. Meanwhile, members of the South African Network of People Who Use Drugs (SANPUD) have been providing harm reduction services for street-based people who use drugs, including needles and syringes, stimulant packs, hygiene and educational materials, as well as symptomatic medication packs for those experiencing opioid-related withdrawal.[19]

The Kenyan Network of People who Use Drugs and VOCAL Kenya have collaborated to equip peers to respond to rising violence against women who use drugs in Nairobi during the pandemic. The peers have been trained in counselling, mediation and conflict resolution, and are able to act as first responders in cases of violence and provide linkage to health and legal services.[20] In Tanzania, local community-led organisations such as the Tanzania Network of People who Use Drugs and SALVAGE have been working together, with the support of UNAIDS, to continue peer-led support for women who use drugs and their families living in often overpopulated camps and settlements in Dar es Salaam, particularly by providing food, hygiene materials and COVID-19 protective equipment, as well as various health services, including TB screening at the local OAT clinic.[21]

Prison releases and harm reduction expansion in prisons

More than 11 million people are imprisoned worldwide, and more than half of national prison systems operate beyond their capacity. There are currently around half a million people held in jails and prisons due to drug possession for personal use – as noted by the United Nations Office on Drugs and Crime in June 2020.[22] Prisons, particularly those that are overcrowded, represent high risk environments for the transmission of infectious diseases, not least COVID-19, and people in prison are also more likely to be living with chronic health problems, including TB and HIV.

To address this risk, countries across the world have committed to releasing significant numbers of people from prison either permanently or temporarily. According to data from June 2020

collected by Harm Reduction International, more than 66,000 people had been released in India, more than 39,000 in Indonesia, and around 19,000 in South Africa, while as of July 2020, more than 26,000 people had been released from US jails.[23] While these early releases are welcome, they also pose new challenges which must be addressed to ensure continuity of care and prevent the increased risk of overdose and homelessness.

However, these decongestion measures only reduced the global prison population by around 6%. Additionally, a quarter of countries implementing these so-called 'decarceration' programmes explicitly excluded people incarcerated for drug offences, thereby prioritising punitive drug control over the health of individuals in prison and the prison population as a whole.[24] These release measures have also not reached compulsory drug detention and rehabilitation centres and the disproportionate criminalisation and punishment of people who use drugs continue to represent a significant threat to global health.

Civil society and community-led organisations have played a vital role in advocating for decarceration, as well as for the protection of human rights and health of people in jails and prisons. In Nigeria[25] and the Philippines,[26] for example, activists have engaged with key stakeholders (such as prison authorities) and taken up legal cases to secure the release of people from prisons, especially people held for drug-related offences.

Beyond these decongestion measures, the primary way in which states have attempted to prevent the spread of the virus in prison settings has been to completely isolate prisons from the community. For people who remained incarcerated throughout the pandemic, in many cases this has meant the suspension of family visits, and restricted access to legal aid, health and drug services. For instance, civil society in Colombia have reported that the situation in women's prisons worsened significantly at the outset of the pandemic, as women had previously relied on family visits to provide essential health and hygiene products, including menstrual pads, and state authorities did not replace them.[27] In Ireland, the NGO Fusion Community Links, which works with people who use drugs in prisons, noted that ten months after the pandemic social workers were solely getting limited access to clients in some prisons through video calls. By December 2020 there were still clients with whom they had had no contact at all since March 2020, despite repeated efforts.[28]

In April 2020, Kenya's first in-prison methadone dispensing clinic was opened at the Shimo La Tewa Prison in Mombasa County, which has helped reduce the flow of clients – and thereby also risks of COVID-19 transmission.[29] However, in at least some prisons in countries like Canada, Kyrgyzstan or Moldova, harm reduction services were restricted, or suspended, at the outset of the pandemic.[30]

Effective civil society responses

During the pandemic, civil society and community-led organisations have shown themselves to be adaptable, effective and resilient – both in service provision and in stepping up advocacy for essential services for people who use drugs. One organisation in Algeria established a mask manufacturing unit managed and staffed by women living with HIV.[31] Masks manufactured are distributed to key populations including people living with HIV and people who inject drugs.

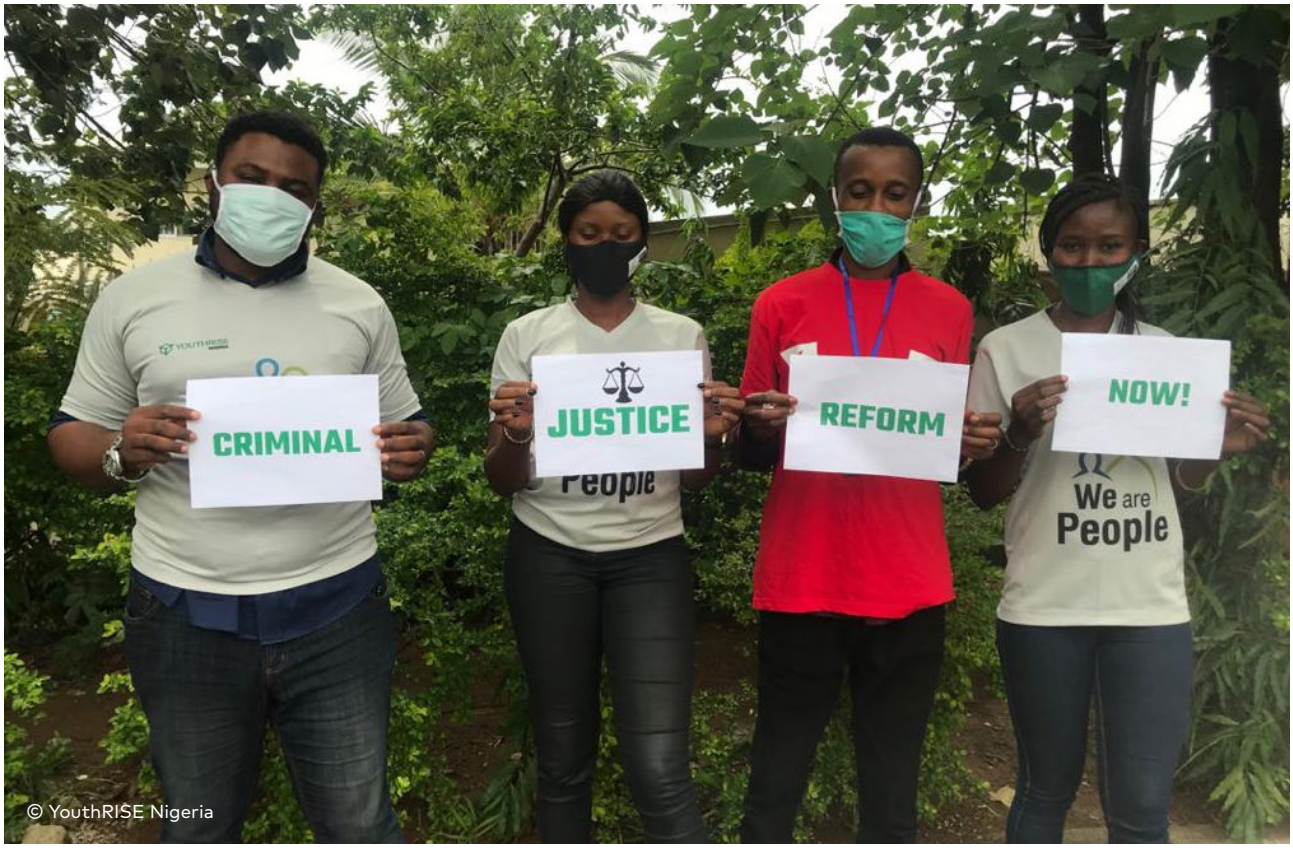
In March 2020, Rebirth, a civil society organisation in Iran, created a COVID-19 prevention and control working group, bringing together cvil society, community representatives, academics, medical professionals and policy makers. Its aim is to strengthen collaboration between government and non-government sectors and develop an equitable COVID-19 response among people who use drugs.[32] The West Africa Drug Policy Network, a coalition of more than 600 NGOs from 17 countries, has been an active advocate for the rights of people who use drugs. The coalition has supported the continuity of harm reduction services, disseminated messages on COVID-19

prevention, and supplied food to people who inject drugs who are unemployed or experiencing homelessness.[33]

Advocacy work by civil society has also continued despite the disruptive impact of reduced travel on interpersonal relationships and face-to-face interactions. Indeed, this has led to new, creative and innovative – and sometimes even more inclusive – forms of advocacy and organising. For example, COVID-19 restrictions did not prevent organisations from participating in the Support Don't Punish Global Day of Action on 26 June 2020 – with many creatively combining awareness, education and advocacy campaigns around humane drug policies in the COVID-19 context. Activities were organised in 85 countries, many addressing the intersecting vulnerabilities experienced by the highly diverse communities of people who use drugs.[34] For example, in Senegal, activists from the Association Sénégalaise de Réduction des Risques infectieux (ASRDR) provided protective kits and information on COVID-19 to streetbased people who use drugs.

Mobilising funds

Across the world, civil society and donor organisations are mobilising funds to purchase prevention tools, ensure uninterrupted service delivery and respond to emerging needs. Key donors have responded by offering rapid emergency grants to a range of implementing organisations – although in some instances, this has been at the expense of existing programmes and grantees. International NGOs have also assisted in securing new funding: for example, IDPC has secured small grants from the Open Society Foundations, Aidsfonds and the Elton John AIDS Foundation to directly support local-level work by partners in Brazil, Hungary, Indonesia, Malaysia and Thailand. Peer-led groups such as INPUD have also mobilised funding to safeguard and/or reallocate funds for communities, and to ensure that resources are available to grassroots communities.



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YouthRISE Nigeria campaigns to change the criminal justice system in Nigeria to support the rights of people who use drugs.

Case study

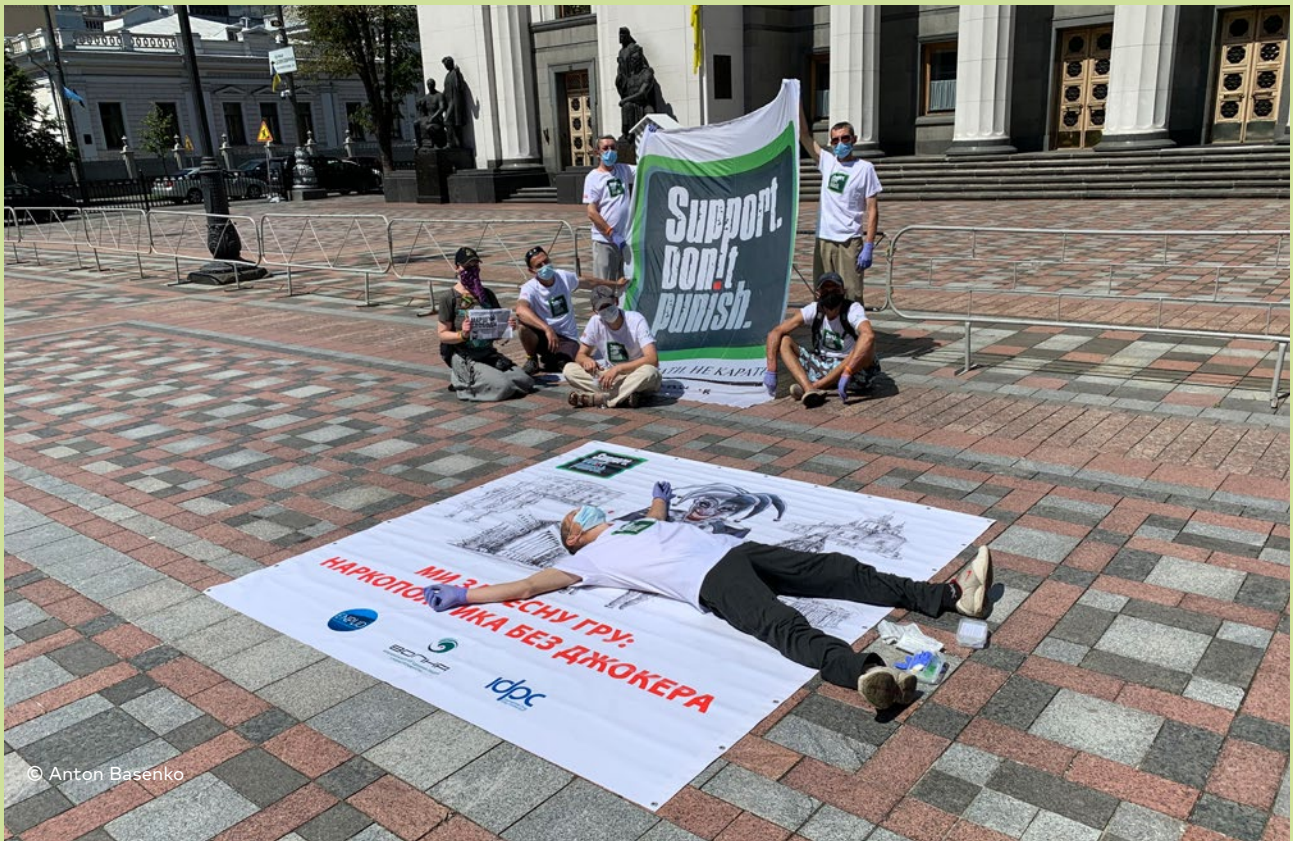
Take-home treatment and other positive developments in Ukraine

Thanks to many years of civil society advocacy, innovation and delivery, Ukraine currently serves the highest number of OAT clients in Eastern Europe and Central Asia. Ukraine's OAT programmes are fully funded by the government, reaching a total of 13,700 people. Nevertheless, a number of barriers prevail, such as the requirement to receive approval from a medical facility (regarding the need for the person to access OAT), the need to collect and consume their medicine from the treatment centre on a daily basis, and the obligation to cease drug use during OAT. Take-home dosages are mainly reserved for people who have been enrolled in an OAT programme for at least six months.

For years, people who use drugs in Ukraine have advocated for reforms to abolish these barriers and to improve accessibility for take-home dosages. These advocacy efforts have been made possible, and have become more meaningful and impactful, thanks to the inclusion of people who use drugs. For example, people who use drugs participate in decision-making mechanisms such as the Cabinet of Ministers' advisory body where they 'have equal seats/votes to the Ministry of Health, Ministry of Justice, or even the Vice-Prime Minister', as explained by Anton Basenko of Alliance for Public Health and Country Focal Point of PITCH in Ukraine.

Though rarely acknowledged, formal and informal networks of people who use drugs and allied NGOs have played a significant role in the expansion of take-home OAT during COVID-19. At the beginning of the pandemic, the community-led organisation Hope and Trust – which also manages Ukraine's national OAT hotline – submitted an official written appeal to the Ministry of Health, resulting in an official call for all OAT providers 'to move all

Advocates bring attention to the health and rights of people who use drugs during the 'Support Don't Punish' global day of action



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patients to take-home for the period of lockdown', according to Anton Basenko.[35] Before COVID-19 restrictions proliferated, only around half of all the people enrolled in OAT were able to access 10 days' worth of take-home dosages of their medicines.

By late April 2020, the number of people granted access to take-home dosages rose to 90% of all OAT clients. The amount of take-home dosage also increased – some were able to receive up to 15 days' worth of medicine, and one region provided up to 30 days' worth.[36] This has helped minimise in-person contact at treatment centres and therefore the risk of COVID-19 transmission, while ensuring that more clients have continued to access treatment.

In addition to making take-home OAT more accessible, COVID-19 has also led to the adoption of home delivery of ART medications (of four to nine months' worth of supply) – managed by an NGO – in six regions of the country. Similar developments occurred for TB and, to a lesser degree, hepatitis C medications.[37] However, unlike for OAT, these changes did not require specific approval from the Ministry since these medications are less tightly controlled than those used in OAT.

Online and phone counselling services for people who use drugs have also expanded during COVID-19. The NGO VOLNA has become an important model for this kind of peer-led harm reduction delivery.[38] Andriy Klepikov, Executive Director of Alliance for Public Health in Ukraine, also noted that the 'PITCH project created a unique partnership which allowed bringing changes and innovations not where it is easier to do, but where is the most relevant and needed! With prioritising [a] person focused approach nowadays in the time of COVID pandemic [the] PITCH project helps communities and patients to have even improved access to services using technologies and Apps, having access to 24/7 hotline and chatbots'.

People who use drugs in Ukraine will continue to advocate towards policy makers to maintain access to take-home OAT and other life-saving harm reduction programmes, recognising the essential roles of peers and community-led networks in managing – and sustaining – these programmes during and beyond COVID-19. As Anton Basenko remarked in INPUD's Peers in the Pandemic campaign, take-home OAT 'is simply a constitutional right'.[39]

Recommendations

Maintain harm reduction services

The pandemic has demonstrated that harm reduction services are responsive and innovative, and can effectively connect marginalised populations to other key social and health services. Harm reduction must therefore be recognised as essential services and included in basic healthcare packages.

Expand access to harm reduction in prisons

Even though people deprived of liberty are fully entitled to their right to health, in most countries access to harm reduction in prisons is far more limited, and of worse quality, than in the community. In many countries, measures taken to prevent the spread of COVID-19 in prisons have led to even further restrictions. As the pandemic continues to develop, states must ensure the sustainable and safe provision of harm reduction in prisons.

Continue adaptations in OAT, NSP and other health services

Many of the changes provoked by the COVID-19 pandemic have long been advocated for by civil society and community-led organisations. New approaches with longer take-home periods, less restrictive initiation procedures and home delivery have shown that these interventions are feasible and beneficial.

Extend and strengthen community and peer involvement

Formal and informal networks of people who use drugs have played an important role during the pandemic, expanding service delivery, providing expert advice to professionals working in harm reduction, and disseminating crucial health information to other people who use drugs. Peer involvement must also be extended to provide more accessible services tailored to the needs of the community.

Safeguard funding for harm reduction and health programmes for people who use drugs

COVID-19 has prompted donors and governments to reallocate funds to address the pandemic. Though this is important, it should not be done at the expense of existing grants and programmes for harm reduction and related services, especially as these were already struggling to secure sustainable funding before COVID-19. More support – financial or otherwise – is required to ensure that harm reduction and health services reach all those in need.

Remove all legal and administrative barriers to welfare programmes

COVID-19 has led to a significant loss of income and livelihoods, as well as access to basic needs such as food, housing, and medicine. All barriers, such as mandatory drug testing and criminal record screening, should immediately be lifted to make sure that welfare programmes reach those most in need.

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