EHRA Position Paper on the Quality of Harm Reduction Services

Harm reduction is a comprehensive evidence-based approach to drug use. When accessible to those who need them and implemented at high quality, harm reduction programmes have a wide range of health and social impact for people who use drugs, their communities and society as a whole. In the countries of Central and Eastern Europe and Central Asia (CEECA), the accessibility and quality of harm reduction programmes are often limited due to repressive drug policies, legal constraints and the lack of funding. Yet there is another reason why the quality harm reduction is hindered in the CEECA - a narrow understanding of harm reduction goals and impact and their orientation merely at HIV prevention targets or as a pathway to abstinence with no respect to its wider health and social outcomes for people who use drugs and society at-large.

EHRA calls for its members and partners to overcome this barrier to the development of harm reduction and establish a regional system of quality assurance based on a renewed definition of harm reduction and its core principles, an approach that combines and unites the community, provider and funder perspectives and assessment tools based on community feedback.

Redefining “harm reduction”

Harm reduction began as a community-led intervention to address the health risks of drug use in the 1970s before the discovery of HIV. But it became an internationally recognised public health approach with the outbreak of HIV among people who inject drugs. The interest of global donors to fund harm reduction in the CEECA as an effective tool for HIV prevention helped to start and scale-up many needle/syringe programmes but, at the same time, led to a very narrow understanding of harm reduction goals, instruments and its value for individuals and communities.

Not only the agenda of global donors but also repressive drug policies shaped the understanding of harm reduction as primarily an HIV prevention tool in the CEECA. High stigma and criminalisation of people who use drugs have influenced the way in which harm reduction was promoted in the CEECA. The HIV prevention agenda was often ‘politically safer’ than protecting the rights and health of people who use drugs, especially in countries with harsh drug propaganda laws, even though it led to a situation whereby many country stakeholders equate harm reduction to HIV prevention among people who inject drugs.

But the benefits of harm reduction go beyond HIV prevention and cover prevention and management of viral hepatitis, tuberculosis, STI’s, drug overdose and poisoning and access to mental health services, etc. Harm reduction saves lives and improves the social reintegration of people who use drugs and their quality of life. Harm reduction promotes the human rights of

people who use drugs and community empowerment, which helps people gain responsibility for their health and to gain access to public resources for health and social wellbeing. Acknowledgment of the impact beyond HIV prevention will help to garner greater support for harm reduction among governmental stakeholders in the course of transition from donor to domestic funding.

It should also be noted that criminalisation of drug use and possession increases drug-related health risks and leads to stigma, social exclusion and discrimination in access to health and social services. Anti-drug legislation creates major barriers to harm reduction availability (especially to opioid substitution treatment), accessibility and quality. The funds currently allocated by the State for anti-drug operations and prison detention could be reallocated to support harm reduction programmes and increase the range and quality of services. Thus, harm reduction service providers should always advocate for the decriminalisation of drugs directly or through partnerships with community-led advocacy, and wider civil society, groups.

EHRA stands for defining harm reduction as a comprehensive approach with positive influence in health and social spheres and for setting measurable targets for the impact of harm reduction on health, social and legal aspects of the life of people who use drugs. EHRA calls for organising discussions with various groups of stakeholders to redefine harm reduction for the CEECA region and to use the renewed understanding of harm reduction outcomes to find new allies for harm reduction accessibility, quality and sustainability.

Responsiveness of harm reduction

In 2009, WHO, UNODC and UNAIDS published a list of nine interventions to address HIV among people who use drugs; later, prevention of overdose deaths was added to the list[1]. While these interventions are essential, especially in countries of the CEECA region with a high prevalence of HIV, they are insufficient for many harm reduction clients as they do not take into consideration the needs of people who do not inject or who use new psychoactive substances; the specifics of people who use drugs with special needs, including mental health support; lesbian, gay, bisexual, transgender and intersexual (LGBTI) people who use drugs; migrants and diverse ethnic groups; and do not include online outreach. The list also completely misses the human rights dimension of harm reduction despite its huge potential to improve access to legal services and the enjoyment of human rights. The list of nine interventions also undermines the social support aspects of harm reduction and its critically important outcomes related to social support and case management.

Instead of adding new interventions to this list, *EHRA calls for a focus on client-centredness of harm reduction and its responsiveness to the health and social needs of people who use drugs as the cornerstone of harm reduction quality assessments.*

[1] There have been other important guidance issued by the UN system since, such as UNODC, WHO, UNAIDS (2019) HIV prevention, treatment, care and support for people who use stimulant drugs and WHO (2016) Consolidated Key Populations Guidelines. However, it is the list of nine interventions that are normally used by donors as the grounds for funding decisions.

Regional quality standards should ensure that a harm reduction service provider:

- Commits to harm reduction principles
- Puts the rights and health and social needs of clients at the centre
- Respects the values of clients
- Reaches people who use drugs in their diversity with respect to intersectionality
- Engages people who use drugs in service planning, implementation and quality assurance
- Is able to predict emerging needs of clients and to plan how to address them
- Sets service targets based on local health and social specifics
- Uses the arsenal of evidence-based tools to reach targets and address client needs
- Builds local partnerships and increases the network of friendly service providers for client referral

Operationalising harm reduction quality assurance

Quality assurance should take into account the complexity of health and social issues faced by people who use drugs and the multi-layered effects of harm reduction. Quality should not be defined only through an HIV lens, but should also capture other health issues, social support and case management, human rights protection and access to legal services.

Community leadership is fundamental for harm reduction quality. Globally, 80% of harm reduction services should be led by people who use by 2025[2]. Community leadership can take various forms - from services fully led by people who use drugs to community-led monitoring by external groups of people who use drugs. In any case, the engagement of people who use drugs should include their participation in decision-making on programme targets, the composition of a service package and resource allocation, planning and the provision of regular feedback on the scope, quality and reach of services. The main tool of harm reduction quality assessments should be the use feedback from clients and other communities concerning access to, and the quality of, services and the enjoyment of human rights including, by not limited to, community-led monitoring.

Domestic funders and support by global donors for a wider scope of harm reduction goals and interventions is instrumental for the development of harm reduction in the CEECA. At the same time, the perspectives of funders on harm reduction quality should not dominate in the setting of goals and quality standards.

Thus, EHRA will promote a combined approach to quality assurance. This approach will, on the one hand, look at the impact of harm reduction from the point of view of locally defined health priorities and social inclusion indicators and, at the same time, from the perspective of the quality of life of clients and their satisfaction. This approach will also combine the perspectives of individual clients and communities of people who use drugs, service providers themselves and funders, both domestic and global.

[2] UNAIDS (2021) Global AIDS Targets

EHRA calls for coordinated harm reduction quality standards in countries of the CEECA region that are shared by all communities, service providers and domestic and global funders and encourages all of these stakeholders to invest in the quality of harm reduction services.

The role of providers in improving harm reduction quality

Discussions of how to improve harm reduction quality started some time ago. It is already clear that rigid, externally set targets and standards do not help to improve the quality of service provision. High coverage targets do not work for quality improvement either, because they can motivate service providers to reach many clients with a minimal package of services or to reach 'low hanging fruit' and leave clients with special needs behind. Moreover, the focus on high coverage targets can compromise the human rights dimension of harm reduction and community empowerment because people who use drugs are regarded as an object of the services and not as the subject of change.

Business models of quality improvement through competition among providers have limited use for harm reduction in the CEECA region because, in many places, there is only one harm reduction provider. However, communities and funders need to be notified if an organisation claims to be a harm reduction service provider but does not share the values and principles of harm reduction and does not act in the best health and social interests of its clients.

As an association of harm reduction service providers and advocates, EHRA will promote the establishment of a system of voluntary certification based on the assessment of the compliance with regional quality standards and the provision of technical assistance to increase the quality of social support and the integration of components of harm reduction. Such certification will be valid for a specific duration, following which a reassessment will be undertaken, leading to a new certification being issued in whole or in part. Upon request by the community of people who use drugs, EHRA will also develop a disqualification procedure for providers that do not comply with the standards that need to be applied.