Harm Reduction

Adopted by the Positive Living Society of British Columbia
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In Canada, harm reduction has been defined as “a public health response to reducing the negative consequences associated with risky behaviours” [1] with the goal of “keep[ing] people safe and minimiz[ing] death, disease and injury from high risk behaviour.” [2] Harm reduction programs vary depending on the behaviour(s) they address, but generally include outreach and education to specific populations that emphasize the individual’s ability to care for him or herself, education on the risks of specific behaviour, treatment resources, prevention resources, and the provision of materials that can lessen the potential for harm.

Previous programs and public health strategies addressing “risky” behaviours, such as drug use, were characterized by promoting a “zero tolerance” approach to the behaviour in question, with abstinence as the end goal. Harm reduction was initially developed as a public health response for adults with substance abuse problems and/or addictions for whom abstinence was not feasible or realistic.

According to the harm reduction approach, “risky” behaviour does not have to stop. Instead, it is modified in a way that reduces the potential for harm to the person engaging in it and/or their community, while also respecting an individual’s autonomy to choose to be engaged in certain activities. For example, a harm reduction program for injection drug users could include a public health program that provides the following:

- sterile needles and other harm reduction supplies through a needle exchange;
- substitution therapies that use non-injection or prescription substances;
- education and outreach on how to minimize risks of transmitting or becoming infected with sexually transmitted infections (STIs) when injecting drugs;
- peer support programs; and
- a supervised consumption site where people could use drugs in a secure, monitored location that provides sterile drug use paraphernalia and access to medical care and care providers, including nurses, counselors, peer support workers and mental health workers. Such a site could also provide access to withdrawal management services, such as a detox facility.

Today, harm reduction programs are used to promote health and reduce harm for a spectrum of people, including pre-adolescents and adolescents, as well as adults. Harm reduction as a public health strategy is applied to a variety of risk events, including alcohol consumption, drug use (particularly injection drug use), tattooing and piercing (especially in prisons), and sex. Harm reduction programs are also used to address gambling and other addictive behaviours, prevent teen pregnancies, prevent STI transmission, and promote sexual health. [3]

Research shows harm reduction programs work. In Canada, harm reduction programs for injection drug users have been shown to successfully reduce morbidity and mortality associated with risky health behaviours. For example, “areas that have introduced needle exchange programs have shown mean annual decreases in HIV seroprevalence compared with those
areas that have not introduced needle exchange programs. Access to and use of methadone maintenance programs are strongly related to decreased mortality, both from natural causes and overdoses, which suggests that these programs have an impact on overall sociomedical health. “[4] Furthermore, a 2011 study of Vancouver’s supervised injection site, Insite, found that “fatal overdoses within 500 meters of Insite decreased by 35 percent after the facility opened compared to a decrease of 9 percent in the rest of Vancouver.” [5]

Harm Reduction for People Living with HIV

The Positive Living Society of British Columbia believes that people living with HIV (PLHIV) in BC should be healthy and free to lead purposeful and actively engaged lives in an accepting, inclusive community. However, for some PLHIV, living with the virus can present formidable challenges. PLHIV are more likely to experience mental illness, social barriers, social isolation, and stigma—all of which can pose threats to a person’s health and wellbeing, and may also lead to engaging in risk events. Therefore, for some PLHIV, harm reduction supports can help safeguard their health. To this end, the following harm reduction supports should be available for PLHIV in BC through provincial government funding and our provincial healthcare system.

1. Increased mental healthcare access and mental health services for PLHIV

In BC, 77 percent of people living with HIV/AIDS and/or hepatitis C (HCV) report having experienced a mental health disorder, most notably depression. However, only 10.7 percent reported being able to access mental health support. [6] In addition to the difficulty of coping with mental health issues and the difficulty finding support, “mental health disorders put people at increased risk of contracting HIV/AIDS/HCV, and there is an additional level of increased risk of infecting others.” [7]

Reasons why PLHIV experience mental health issues, as well as difficulty in accessing treatment and support, are myriad. Mental health issues may be brought on by the stress and anxiety of diagnosis, the social stigma surrounding both HIV and mental illness, or by HIV medications used to treat the virus—efavirenz (Sustiva), rilpivirine (Edurant) have been known to cause psychological problems such as difficulty sleeping, nightmares, mood changes, or depression. [8]. Furthermore, when PLHIV seek mental healthcare and support, the lack of connection and communication between relevant service organizations, such as HIV/AIDS service organizations and mental healthcare providers, can impede efforts to receive support and treatment.

A discussion paper published by BC’s Provincial Health Services Authority addresses this need and provides relevant recommendations on how to increase PLHIV’s access to mental health services. “Trap Doors/Revolving Doors: A Mental Health and HIV/AIDS Needs Assessment” advocates for the following action:

- increased personal support systems including peer support programs;
- increased community supports, such as community-based HIV/AIDS service organizations, that can provide mental health resources, groups, and referrals to mental healthcare programs; and
• increased cooperation and partnerships among community, public health, mental health and addictions service providers, and HIV/AIDS service organizations in order to provide programs and services such as increased access to clinical services, as well as targeted outreach services.

Increased access to psychologists, psychiatrists, or clinical social workers must also be part of this harm reduction strategy.

2. More peer support programs

Peer support is a system of “giving and receiving help founded on key principles of respect, shared responsibility, and a mutual agreement of what is helpful.” [9] Peer support programs among PLHIV, such as discussion groups and peer counseling, have been shown to reduce feelings of isolation and depression, as well as enhance personal and interpersonal connections and skills. [10] Such connections facilitate sharing information, skills development and increasing feelings of acceptance [11] as well as increase connections to, and uptakes in, accessing medical services and attending medical appointments. [12] Peer-to-peer support and interventions are also shown to assist in harm reduction strategies. [13]

3. Stronger anti-stigma efforts

In Canada, a 2012 study “found 69 percent of respondents felt that people may be unwilling to disclose their HIV status because of the stigma associated with HIV. Furthermore, 55 percent felt that people with HIV may experience difficulty with basic activities such as finding housing, healthcare or employment because of the stigma.” [14] Anti-stigma initiatives are an important component of a harm reduction strategy for PLHIV and should include:

• public education programs to increase basic knowledge about the HIV virus, including information on transmission, testing and treatment, as well as information stating HIV is a chronic, manageable illness;
• increased education on the rights of PLHIV in the workplace, and as a medical patient, parent, tenant, and sex partner; and
• updates to provincial laws that reflect the equal rights of PLHIV. Specifically in BC, new charge assessment guidelines regarding the criminalization of HIV non-disclosure are needed.

4. Increased access to Treatment as Prevention

Treatment as Prevention (TasP) refers to HIV prevention methods that use antiretroviral therapy to promote health and decrease the risk of HIV transmission by decreasing viral load to undetectable levels. TasP, accompanied by increased HIV testing, has been identified as a strategy to prevent HIV transmission and possibly eradicate the virus. TasP has drastically reduced HIV transmission between people at risk of transmitting or becoming infected with HIV, including serodiscordant couples and HIV-positive pregnant women. [15]
Harm Reduction for HIV Transmission/Infection Risk Events

While harm reduction supports are needed for some people in the general population who are living with HIV, harm reduction supports are also needed to in regards to certain behaviours that carry the risk of HIV infection and/or transmission. Behaviours that potentially carry a high risk of HIV transmission include drug use, needle use, and unsafe sex. It is doubly important that harm reduction programs address the aforementioned behaviours since certain communities more vulnerable to harm are also more likely to engage in these specific risk events, and, in addition, are also more likely to have higher numbers of PLHIV within their community. Vulnerable communities include sex workers, men who have sex with men, injection drug users, and inmates.

1. Drug use

People who use drugs, especially injection drugs, are at risk of contracting and/or transmitting HIV. In 2011, it was estimated that 16 percent of new HIV infections in Canada may have been caused by injection drug use, with the virus being transmitted through shared drug paraphernalia such as crack pipes or syringes. [16] Estimates state that among people who use injection drugs in Canada, 11 percent are HIV-positive, and up to nine percent are co-infected with HIV and hepatitis C. [17] In Vancouver, 2009 estimates stated about 17 percent of the city's injection drug users were HIV-positive, though 2013 statistics show that the number of new infections in BC among injection drug users has been steadily decreasing since 2007. [18]

When addressing drug use and harm reduction, it is important to mention pain management. Many PLHIV experience chronic pain as a symptom of the virus, and/or as a side effect of antiretroviral medications. For example, someone living with HIV might experience chronic pain due to persistent inflammation, or the chronic and painful nerve swelling and irritation of peripheral neuropathy, both of which are caused by the HIV virus. Peripheral neuropathy is also a side effect of antiretroviral medications such as the commonly prescribed non-nucleoside reverse transcriptase inhibitor, efavirenz. [19]

Opioids such as codeine and oxycodone (in the form of Percocet, OxyContin, or Tylenol with codeine) are commonly prescribed for pain management. However, such substances have been shown to be habit forming, leading to the concern that prescribing them as a means of chronic pain management will result in addiction. For people suffering from chronic pain that have a history of drug use, pain management and the prescription of opioids carries a heightened risk of addiction, due to the addictive nature of these medications. The recommended course of action is to treat patients suffering from chronic pain in accordance to their symptoms and medication tolerance. When patients have a history of addiction, or are at risk of addiction, it is recommended medical caregivers recognize these as co-existing conditions that must also be addressed and/or and treated.

Drug use and increased risk events: Drug use compounds the potential for harm, since it is linked to risk events such as unsafe sex. [20] Drug use can also reduce medication adherence.
[21] For PLHIV on antiretroviral therapy, this could increase the potential for transmitting the virus, or for HIV-negative people on pre-exposure prophylaxis, becoming infected with HIV. Further increasing the risk of HIV transmission or infection among injection drug users is the fact that about 25 percent of people who became infected with HIV through injection drug use are unaware of their HIV status, a condition that could potentially lead them to unknowingly transmit the virus. [22]

Vulnerable populations: All people are at risk of harm when using injection drugs; however, certain populations are more vulnerable than others. Women and indigenous peoples are especially vulnerable to contracting HIV through injection drug use. Recent research states that in Canada, about fifty-eight percent of new HIV infections in indigenous peoples were caused by injection drug use and 23 percent of new infections in women were caused by injection drug use. [23]

Supervised injection sites and Bill C-2: Part of providing harm reduction supports to injection drug users includes increasing access to supervised consumption sites throughout BC. Such facilities have been shown to save lives and reduce HIV transmission and infection. For example, in 2013 the BC Centre for Excellence in HIV/AIDS reported that Insite has helped to lower the number of HIV infections in the province, with 29 injection drug users in the province being diagnosed with HIV/AIDS in 2012, compared to more than 400 per year prior to 1996. [24] Currently in BC, two supervised injection sites exist — Insite and a supervised injection service at the Dr. Peter Centre.

As a vital component of and harm reduction program, supervised injection sites must be allowed to operate on a permanent basis and be protected by federal law. To this end, Bill C-2 must be abolished. Bill C-2, known as either the “An Act to Amend the Controlled Substances and Drug Act” or the “Respect for Communities Act”, intends to amend Section 56 of the Controlled Drugs and Substances Act.

Currently, Section 56 gives the Minister of Health the power to grant exemptions regarding the operation of supervised injection sites throughout Canada. Such an exemption has allowed Insite to exist since 2003. However, under Bill C-2, “the Federal government would also consider a range of factors, including the views of police, provincial ministers and local government officials before granting the exemption to drug laws that allows the clinics to operate.” [25] Furthermore, the current federal government has stated they are against supervised consumption sites, with Leona Aglukkak, then the Minister of Health, stating in 2013 that “our government believes that creating a location for sanctioned use of drugs obtained from illicit sources has the potential for great harm in a community.” [26]

BC Centre for Disease Control’s Harm Reduction Strategies and Services Policy: As another means of providing harm reduction for injection drug users, Positive Living BC recommends improving and increasing access to the supports, resources and infrastructure, on a province-wide basis, described within the BC Centre for Disease Control’s Harm Reduction Strategies and Services Policy. The policy states that “each Health Authority and its community partners must
work together to provide a full range of harm reduction services that promote safer sex and safer psychoactive substance use, including legal drugs such as alcohol. Core components of harm reduction programs include, but are not limited to: referrals to health and social services, advocacy, education, and supplies distribution.” [27]

2. Unsafe sex

In Canada, unsafe sex accounts for the highest rates of HIV exposure, between heterosexual people and between men who have sex with men. Research conducted in 2012 shows that among adult males who tested positive for the virus, 63.3 percent were exposed to the virus as men who have sex with men, and 20 percent were exposed to the virus via heterosexual sex. Among women, 65.5 percent were exposed to the virus via heterosexual sex. [28]

Harm reduction supports to address unsafe sex include providing education on the virus and its transmission, as well as safer sex materials, such as condoms and pre-exposure prophylaxis. However, basic methods of HIV prevention, such as condom use, do not work for many people who are vulnerable to acquiring or transmitting HIV. Strategies to reduce HIV transmission and/or infection among such communities must include increased STI testing to make people of their status, offering Treatment as Prevention, offering pre-exposure prophylaxis and post-exposure prophylaxis, as well as culturally appropriate messaging delivered by peers through current technology and online services.

3. Sex workers

People who provide sex for money are at great risk of harm. Risk events associated with sex work also increase the risk of contracting or transmitting HIV, and include drug use. In a 2008 study of female sex workers in Vancouver, over 59 percent of the survival sex workers interviewed reported drug sharing with clients, with crack cocaine being the most common drug shared. [29] The study found these behaviours “to be associated with other factors previously linked to an increased likelihood of infectious disease transmission, including multiple unprotected sexual encounters and intensive crack cocaine smoking.”[30]

Unsafe sex practices are also documented as a factor that increases harm and the likelihood of HIV infection or transmission among sex workers. Unsafe sex practices are often linked to situations in which sex workers have a lack of power. This lack of power can lead to the inability to negotiate safer sex practices, such as condom use, or sex workers may face pressure to engage in risk events, such as having unprotected sex in exchange for more money. As well, the entrenched stigma and social isolation experienced by sex workers makes them vulnerable to harm. Physical conditions associated with sex work, such as genital trauma caused by frequent intercourse, can also greatly increase the risk of contracting HIV.

Canadian estimates on the prevalence of HIV among sex workers vary widely depending on factors including age, geographic location, and gender. For example, a recent study conducted by the BC Centre for Excellence in HIV/AIDS found that 26 percent of Vancouver's up to 520 female commercial sex workers are HIV-positive [31] while among a population of male street
youth involved in survival sex in Montréal, HIV prevalence was 2.1 percent, compared to 0.3 percent among those who have never been involved in survival sex. [32]

Decriminalization of sex work and sex workers has the potential to reduce harm among sex workers, including HIV transmission and/or infection. The 2014 series of articles published in The Lancet under the title “HIV and Sex Workers” studied sex workers in Canada, Kenya and India. The study states that HIV infections could be reduced by 33 to 46 percent in those countries if prostitution were made legal. [33]

The study pointed out that HIV transmission could be more likely to occur in countries where prostitution is illegal because prostitutes suffer social isolation and stigma. As a result, they are not likely to access appropriate healthcare such as STI testing and treatment, fearing arrest or discriminatory treatment. Prostitutes may also fear getting arrested for possessing condoms and/or having sex, and as a consequence, rush sex with clients without discussing or taking safer sex precautions. [34] According to one sex worker advocate, “Criminalization can have a direct impact on access to health care. Treatment, such as antiretroviral therapy, requires stability and consistency. Being at risk for criminalization disrupts this.” [35]

Countries that have decriminalized sex work have seen reductions in HIV infections among sex workers. In Brazil, where prostitution is legal, the country’s HIV prevention program has included collaborating with, educating and supporting those most at risk of HIV infection, including sex workers. This strategy has resulted in increased condom use among sex workers and increased knowledge about the importance of HIV testing and where such testing can be accessed. [36] The Sonagachi Project, based in Calcutta, India, defined HIV as an occupational health problem, thus helping to de-stigmatize and decriminalize the profession—the project also included improving sex workers’ skills, knowledge and practices related to HIV prevention and treatment. The Sonagachi Project has been associated with lower HIV rates among sex workers as compared to other urban centers in India. [37] In New South Wales, Australia, sex work has been decriminalized since 2009. Currently, sex workers in that state have a lower HIV prevalence than the general population. [38]

While decriminalization of sex work and sex workers is a critical part of a harm reduction strategy, other tactics and programs that could be implemented and/or expanded in order to promote harm reduction for sex workers living with HIV include the following:

- education on STI prevention/transmission;
- occupational health and safety training;
- interventions and outreach, including peer education;
- training in condom-negotiating skills; and
- harm reduction and safer sex tools including male and female condoms. [39]

4. Incarceration

In Canadian federal and provincial prisons, “estimates of HIV prevalence range from 2 to 8 percent, while studies of HIV prevalence in individual prisons report rates of between 1 and
Many people who are or have been imprisoned have also experienced social marginalization and suffer from mental health and/or addictions issues, making them even more vulnerable to harm. And while in prison, people are affected by conditions that increase the likelihood of being involved in behaviours and activities that carry the risk of HIV transmission or infection. Participants in the Vancouver Injection Drug Users Study (VIDUS) who had recently been incarcerated reported having engaged in the following behaviours while in jail: tattooing (21 percent of adults; 43 percent of youth); piercing (9 percent; 5 percent); and injecting drugs.” [41]

Though research shows many inmates engage in potentially harmful activities that involve needles, harm reduction programs are severely hampered by Canadian law, which states that prisons are prohibited from distributing sterile needles, and prisoners are prohibited from possessing needles for the purposes of injecting drugs or performing activities such as tattooing.

To promote harm reduction in provincial and federal prisons, Positive Living BC suggests the adoption and implementation of key harm reduction supports recommended by the Prisoners’ HIV/AIDS Support Action Network (PASAN). These include:

- safer injection and safer tattooing materials (i.e. prison-based needle and syringe programs, tattoo parlor pilot programs);
- sexual health counseling and testing;
- access to condoms, lubricant, dental dams;
- sterile injecting, piercing, and tattooing equipment;
- drug testing and methadone maintenance testing;
- education on harm reduction practices for staff and prisoners;
- drug-free living units; and
- harm reduction programs for specific populations such as transgender people, indigenous peoples and women.

The harm reduction programs and supports described in the pages above can help safeguard the health of people living with HIV. Such harm reduction supports and programs are important tools that can help empower people living with HIV to care for their wellbeing and to lead healthy lives.
Footnotes

10. Ibid, page 3
11. Ibid, page 2
12. Ibid, page 4
17. Ibid

23. Ibid


30. Ibid


34. Ibid


Recommendations

1. The provincial government should provide the following for people living with HIV (PLHIV) in British Columbia, in order to promote health and facilitate harm reduction:
   - increased access to mental healthcare services;
   - increased personal access to peer-based support systems such as peer support groups and programs;
   - increased HIV/AIDS anti-stigma education campaigns; and
   - increased community supports, such as community-based AIDS service organizations, which can provide mental health resources, peer support groups, and referrals to mental healthcare programs.

2. Cooperation, communication and partnership must be increased among public health service providers, mental health service providers, addictions service providers, and AIDS service organizations in order to provide programs and services to PLHIV. Such programs and services include increased access to clinical services, as well as targeted outreach services.

3. The following harm reduction supports should be provided in communities, including communities inside prisons, where significant levels of unsafe needle use, injection drug use, unsafe sex, and/or sex work occur:
   - Treatment as Prevention;
   - increased outreach and education on harm reduction practices;
   - free harm reduction materials such as condoms, lubricant, dental dams, and sterile drug paraphernalia. In prisons, sterile tattooing, injecting, and piercing equipment must also be provided;
   - peer-based support programs;
   - substitution therapies for injection drug users; and
   - increased access to healthcare professionals who can provide healthcare supports and services such as STI testing, referrals, counseling, and wound care.

4. Canadian prison legislation and policy prohibiting inmates from possessing needles for the purposes of injecting drugs, tattooing and/or piercing should be changed to allow inmates access to sterile needles for these purposes.

5. The section of Bill C-2 (known as either the “An Act to Amend the Controlled Substances and Drug Act” or the “Respect for Communities Act”) that proposes to amend Section 56 of the Controlled Drugs and Substances Act should be abolished.

6. Existing supervised injection sites should be allowed to operate on a permanent basis.

7. New supervised injection sites should be opened in communities where a significant amount of injection drug use takes place.