The impact of COVID-19 on harm reduction in seven Asian countries

NOVEMBER 2020

HARM REDUCTION INTERNATIONAL

www.hri.global

The impact of COVID-19 on harm reduction in seven Asian countries

Dr Lincoln Choudhury

ISBN 978-1-8380910-4-0

Copy-edited by Hester Phillips

Designed by Corinne Welch

Published by Harm Reduction International,
61 Mansell Street, London, E1 8AN, United Kingdom

The research and analysis for this report was undertaken by Dr Lincoln Choudhury, New Delhi, India, independent consultant on behalf of **Harm Reduction International (HRI)**.

HRI is a leading non-governmental organisation dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

This report has been produced within the Harm Reduction Advocacy in Asia (HRAsia) project (2017-2020). The project is funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to enable access to HIV and harm reduction services for people who inject drugs in Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam. The views described herein are the views of HRI and do not represent the views or opinions of the Global Fund, nor is there any approval or authorisation of this material, express or implied, by the Global Fund.

The study's author has not been involved in Global Fund activities related to harm reduction or the current funding round. Neither has the author worked with any of the partners in the countries mentioned nor received funding support. The funding agency has no role in the study design, implementation, data collection, analysis or report writing process.

Acknowledgements

The author of the report would particularly like to thank Catherine Cook and Emily Rowe for their unconditional support and technical review of this study.

The author would also like to express thanks to Ira Madan, Tushimenla Imlong, Nguyễn Minh Trang, Pontip, Heng Kiry, Aditia Taslim, Subhan Hamonangan, Bishnu Fueal Sharma and Sushil Kumar Koirala for their kind and valuable support and deep insight in responding to the COVID-19 challenges. We would also like to thank three harm reduction service providers in Nepal and India who shared data on the service level impact of COVID-19.

Alliance India

The Global Fund

HR Asia
Harm Reduction Advocacy for Sustainable Interventions

Contents

Abbreviations and acronyms

ART	Antiretroviral treatment
CBO	Community-based organisation
CSO	Civil society organisation
EJAF	Elton John AIDS Foundation
HRI	Harm Reduction International
INPUD	International Network of People who Use Drugs
NGO	Non-governmental organisation
NSP	Needle and syringe programme
OAT	Opioid agonist therapy
PEPFAR	The President's Emergency Plan for AIDS Relief
PPE	Personal protective equipment
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organization

Executive Summary

The COVID-19 pandemic and the actions taken by governments to contain it have had a profound impact on health services around the world, including harm reduction. As the World Bank announced an unprecedented global recession, the World Health Organization (WHO) and UNAIDS warned of supply chain disruptions, which could lead to increased deaths among people living with HIV and reverse the hard-fought gains of the global HIV response.[1,2]

In April 2020, a civil society statement on COVID-19 and people who use drugs endorsed by over 300 organisations and individuals called upon the international community to 'ensure, through policy guidelines and financial and political support, that national, regional and global responses to this pandemic take the needs of people who use drugs into account and respect the fundamental rights of all.'[3] In May 2020, Harm Reduction International (HRI) and the International Network of People who Use Drugs (INPUD) called upon donors and governments to safeguard funding for harm reduction throughout the COVID-19 pandemic and support service providers to adapt to related restrictions.[4]

Understanding the impact of COVID-19 on harm reduction funding and service provision is essential for informing donor and government action as well as civil society advocacy.

Understanding the impact of COVID-19 on harm reduction funding and service provision is essential for informing donor and government action as well as civil society advocacy. This report compiles evidence from civil society in seven Asian countries (Cambodia, India, Indonesia, Nepal, Thailand, the Philippines and Vietnam) between January and July 2020. The burden of COVID-19 and the response to it at national and local levels differed between these countries. All implemented some degree of physical distancing, the use of masks in public places and promoted hand hygiene. Although most imposed short duration, locally-based physical distancing or lockdown measures, India and Nepal imposed more rigorous, country-wide requirements.

Ten key findings

1 **Harm reduction services, such as needle and syringe programmes (NSP), counselling, condom distribution and screening for sexually transmitted infections (STIs), were severely affected during the peak of physical distancing measures.** However the impact of COVID-19 on harm reduction has not been uniform across the seven countries. The methods for delivering harm reduction services have changed more in countries with more severe physical distancing measures, like India and Nepal.

2 **People who use drugs have faced disproportionate risks of exposure and susceptibility to COVID-19, alongside barriers to healthcare.** This is particularly true of those who are in prison or detained. People who use drugs have also been unable to access broader healthcare services and treatment, with the closures of hospitals and medical centres as well as quarantine and travel restrictions. However, due to limited data, it remains unclear whether disruptions to services have currently increased adverse health outcomes, such as fatal overdoses or AIDS-related deaths.

3 **COVID-19-related containment measures in most countries have led to difficulties in accessing illegal drugs, which has increased the number of people initiating opioid agonist therapy (OAT) such as methadone and buprenorphine.** But this may be a short-term reality for some. If a significant proportion of people resume earlier patterns of drug use once alternative drugs are available there is a risk of increased harms, including overdose.

4 **The COVID-19 pandemic has resulted in some positive changes, with harm reduction services quickly adapting and innovating in response to the altered conditions.** The most profound example of this is the change in OAT administration. In the majority of countries analysed, the criteria for take-home doses of OAT have been relaxed.

5 **In some settings, OAT will benefit only a fraction of people who use drugs or none at all. This is because many people who use drugs in the countries analysed use amphetamines or other non-opioid injecting drugs.** It is unclear how the harm reduction needs of non-opioid users are being met other than through existing health systems, which are hampered by physical distancing measures.

6 **The need for comprehensive and quality harm reduction services has increased.** At the same time, the needs of people who use drugs now also include more basic things, such as food and shelter. Contributions from the community of people who use drugs and individual donors, alongside support from local NGOs, is temporarily meeting the need for food and shelter in some places to a limited extent.

7 **Networks of people who use drugs have played an important role during the pandemic.** Increased leadership, engagement and participation from drug user communities in advocating for flexible services, appropriate government responses, and enhanced participation of peers in providing critical harm reduction interventions have all helped to ensure continuity of services.

8 **Ground-level operations to deliver harm reduction services, and thus spending, has changed.** Peers and outreach workers are doing a greater share of work to fill in for healthcare workers. But despite their efforts, peers and outreach workers are not being given 'frontline worker' status, meaning they lack personal protection equipment (PPE) and in some instances face travel restrictions.

9 **Most of the funding requirements have been met locally by bringing flexibility to allocated budgets and through support from the broader social ecosystem.** New donor funds were not made available to meet the needs of people who use drugs during this study period (January to July 2020). Civil society organisations have expressed concerns that the pandemic might affect donor priorities and lead to programmatic changes, with significant consequences for the health and rights of people who use drugs.

10 **Information technology, particularly online video and audio calls, are been used extensively to bridge the communication gaps in service provision.** This innovation has shown positive results in reaching people who use drugs effectively, but it is not a catch-all solution.

Recommendations

- **Donors and governments must support harm reduction service providers to adapt to the 'new normal' of the COVID-19 era.** Enough evidence is now available to indicate what is working and what is not when it comes to delivering harm reduction in the present context. Donors and funders need to respond by systematically funding community level solutions which address challenges, such as the poor distribution of sterile needles and syringes and declining rates of HIV testing and STI screening. Donors must also support successful innovations, such as information technology systems, to ensure continued quality counselling services. Donors need to prioritise response and recovery over mitigation.

- **Some COVID-19 adaptations to OAT administration can increase access to services and should remain in place.** Long-awaited changes in harm reduction service delivery took place during the pandemic. Longer take-home periods for OAT and less restrictive initiation procedures have been set up in some countries and provide evidence that these are feasible and beneficial.

- **Immediate attention must be given to improve the quality and content of harm reduction services, to reduce the risk of HIV transmission.** Strategies to provide comprehensive, high quality harm reduction services in the COVID-19 era are needed, as is capacity building support for those delivering services to meet these new challenges. Greater emphasis should be given to low-threshold community settings in the distribution of harm reduction commodities as well as testing and treatment for HIV, viral hepatitis and tuberculosis. There is an urgent need to analyse the needs of people who use drugs and ensure harm reduction coverage is back to pre-COVID-19 levels, at the very least.

- **Changes in capacity building, mentoring and follow-up are already underway and should be incorporated into harm reduction approaches with the help of user-specific information technology platforms.** Considerable investment in information technology platforms is needed to improve their design, content, protocols and evaluation so that quality care, which is safe and confidential, can be provided.

- **There is now a need to recognise the task shifting that has occurred in the context of COVID-19 and to formalise peer involvement in harm reduction service provision.** This will ensure services provided are more accessible and better tailored to the needs of people who use drugs. This can be done by investing in short-duration, high-frequency trainings to improve knowledge and practices among peers and outreach workers. Both groups should be given frontline worker status and provided with additional travel costs, plus travel exemptions, adequate personal protective equipment (PPE) kits and COVID-19 tests as required.

- **More flexible approaches should be introduced to improve local supply chains in relation to NSP, HIV testing, STI screening and treatment and OAT.** Governments need to ensure medication and commodity stock outs caused by COVID-19-related disruptions do not happen again. Greater flexibility is required at all levels, including within procurement guidelines to enable local procurement solutions.

1. COVID-19 and harm reduction in seven Asian countries

Around the world, countries are taking action to tackle COVID-19. Initiatives include a ban on international travel, local travel bans, physical distancing of various degrees, shutting down public places, the use of masks in public, promoting handwashing and hand hygiene, testing for COVID-19, contact tracing, isolation of cases and suspected cases, and treatment. Uncertainty over the necessary duration of these measures and their secondary impacts remains a concern.

In August 2020 a modelling study forewarned that a six-month disruption of ART services would increase the HIV-related death rate by 1.63 times in sub-Saharan Africa within 12 months.[5] Similar grim situations were predicted by other modelling studies.[6] Based on these findings, the WHO has emphasised how important it is that funding for HIV prevention and treatment continues.[1]

1.1 A growing crisis for harm reduction funding

As countries reel from the impact of COVID-19, the World Bank has reported the largest economic decline in more than 150 years. The global economy has shrunk by 5.2% overall, which equates to a 7% decline in high-income countries and a 2.5% decline in low- and middle-income countries.[2] This economic slowdown and global recession is expected to damage the finances of donor countries and individuals. Inevitably, this will affect HIV funding, including for harm reduction.[7]

Harm reduction funding is already extremely precarious. While a few countries benefit from government investment, mainly in OAT, coverage remains low. International donors are still the predominant source of support for harm reduction, particularly for needle and syringe programmes (NSP).[8]

COVID-19 makes this situation worse. Services are being affected by national and international measures to stem COVID-19 transmission, while funding may not be sufficient to enable services to adapt and continue running and may be redirected to COVID-19. As a result, the COVID-19 pandemic represents a significant threat to harm reduction in terms of outreach, service provision, linkages to broader health systems, and the sustainability of funding.[9]

Harm reduction funding gaps and service closures result in more people who use drugs contracting HIV, hepatitis C and other blood-borne viruses. Interruptions also decrease the cost-effectiveness of services, so there is a strong economic argument for consistent investment.[10] Harm reduction services must continue during the pandemic and in the context of a future recession. Harm reduction funding must continue and be flexible enough to allow services to adapt so that provision and quality of services is sustained.

Harm reduction services must continue during the pandemic and in the context of a future recession. Harm reduction funding must continue and be flexible enough to allow services to adapt so that provision and quality of services is sustained.

1.2 Providing the evidence

An evidence-based understanding of how the COVID-19 pandemic has affected people who use drugs, harm reduction services and funding – and what actions civil society, communities, donors and governments have taken to mitigate and protect against these disruptions – is necessary to guide future programming and policy decisions.

This pilot study gathered evidence on the impact of COVID-19 on harm reduction in Cambodia, India, Indonesia, Nepal, the Philippines, Thailand and Vietnam. The findings were used to form recommendations for donors and governments on the protective action they can take throughout the pandemic and the recession to follow. The key findings and recommendations can also be used to inform advocacy for sustainable harm reduction financing throughout the COVID-19 era.

2. The damage to harm reduction service delivery during COVID-19

Harm reduction is a package of services that aims to reduce the harms associated with drug use. Although harm reduction is often built around the core components of risk-reduction counselling and access to sterile needles and syringes, it also includes screening and treatment for STIs, screening and treatment for HIV, and risk-reduction approaches such as OAT. (In regards to OAT, it is important to be aware that there are a substantial number of people who use drugs who do not use opioids, for whom opioid-based therapy would be of no benefit.[11] For non-opioid users, being able to access sterile injecting equipment and other interventions is key.[12])

> *"Lay testing for HIV was not as available as before due to COVID-19. Only [when] clients with really high risk requested, outreach workers can come and do the testing for them."*
>
> **Community-based organisation, Vietnam**

While most governments have allowed harm reduction services to function during the pandemic and throughout lockdown, severe limitations on mobility have prevented many people who use drugs from accessing services. This is something the majority of community-based and civil society organisation (CBOs/CSOs) respondents reported. For example, in Thailand local checkpoints between villages, which were set up by police, military, administrative and local agencies to reduce the spread of COVID-19, were also used to search people for drugs, needles and syringes. At some checkpoints, people suspected of drug use were made to undergo urine tests. This prevented many people who use drugs from travelling to access harm reduction services.

In Nepal, India, Cambodia, Vietnam and Thailand service providers and CBOs have adapted outreach to overcome this challenge, contacting people who use drugs by phone to ensure that medications and commodities are regularly delivered to them. Emergency passes were issued by authorities to NGO staff to enable relatively free movement. In one site in Punjab, India, the government provided ambulance services to deliver OAT to clients.

Despite the efforts made to continue harm reduction services uninterrupted, an overwhelming majority of respondents reported a significant decline in service delivery due to the COVID-19 pandemic. Reductions in outreach, clinic/drop-in-centre attendance, HIV testing, and the distribution of commodities were all observed. CBOs in Vietnam, for example, said they had received fewer needles, syringes and condoms during the pandemic and that people who use drugs were underserved compared to other people most affected by HIV.

In general, harm reduction systems are well tested and designed to work in tandem, with peers, counsellors and medical professionals all having different, yet essential, roles and responsibilities. But the changing environment has led to the closure of facilities or reduced access to medical and social professionals while shifting most of the burden to peers.

"The supply for health products was not sustained. The community-based organisations have reported they received fewer needles and syringes during COVID-19. Condoms were reported to be provided to people who use drugs less than to other populations"

Respondent, Vietnam

2.1 Statistical snapshot: six-month findings from Nepal and India

The following section shows changes in harm reduction service delivery between January and June 2020, using data from three service provision sites in Nepal and India.

Needle and syringe distribution: There was a sudden decline in services in April, followed by gradual recovery. The number of needles and syringes distributed reflected almost the same pattern as the number of clients receiving services (Figures 1 and 2).

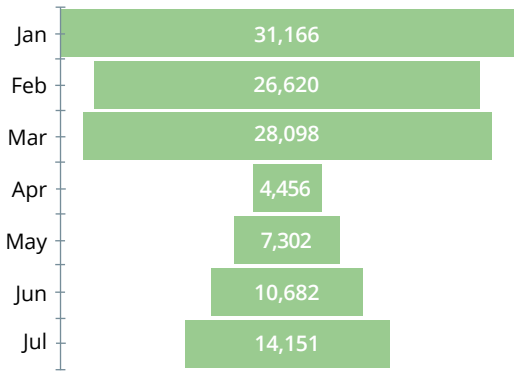

Figure 1: Number of needle and syringes distributed (January to June 2020), combined three sites

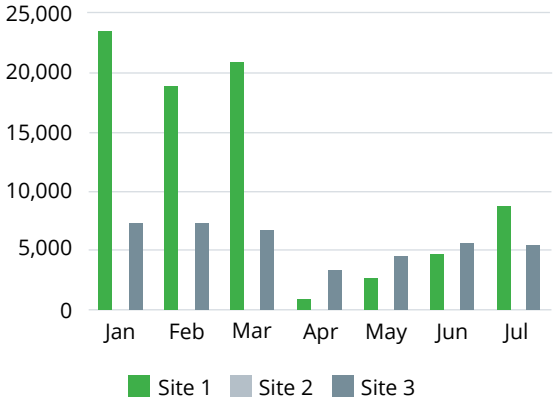

Figure 2: Number of needle and syringes distributed at each site (January to June 2020)

Needle and syringe programme coverage: The trend analysis (Figure 3) shows a sudden decline in NSP coverage, coinciding with physical distancing measures that were active in April 2020. Coverage gradually improved, reaching half the average monthly coverage by June 2020. A similar pattern occurred in all three sites, but was most pronounced for site 1 (Figure 4).

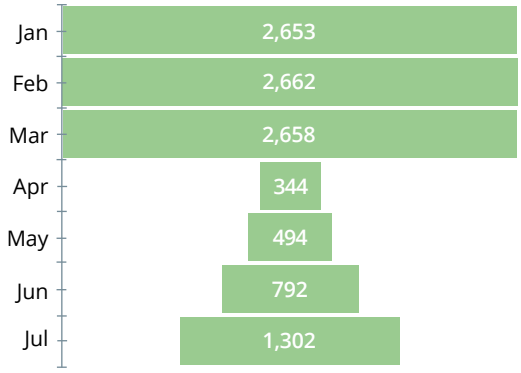

Figure 3: Trend of NSP coverage (January to June 2020), combined three sites

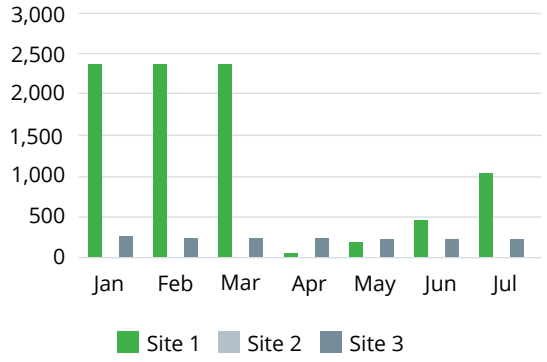

Figure 4: Number of clients that received needle and syringe packages per month

It is clear that the distribution of needles and syringes declined during large scale physical distancing measures.

HIV testing: HIV testing is a critical part of a harm reduction service package and contributes to the first 90 of UNAIDS' 90-90-90 target. Yet there was a substantial decline in HIV testing in April and May, which started recovering in July (Figure 5).

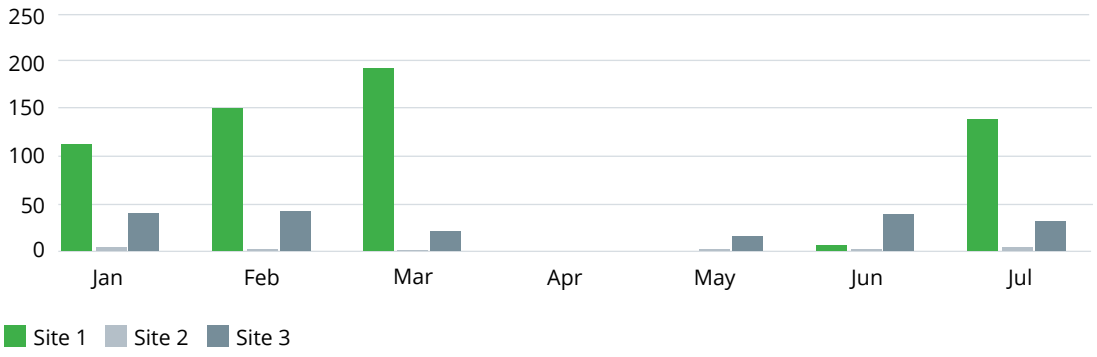

Figure 5: HIV testing among clients

Opioid agonist therapy: There has been an increase in the number of people initiating OAT between January and July 2020. This included the period of April - July when other harm reduction services were negatively affected. However, this increase was not uniform across the sites (Figure 6 overleaf).

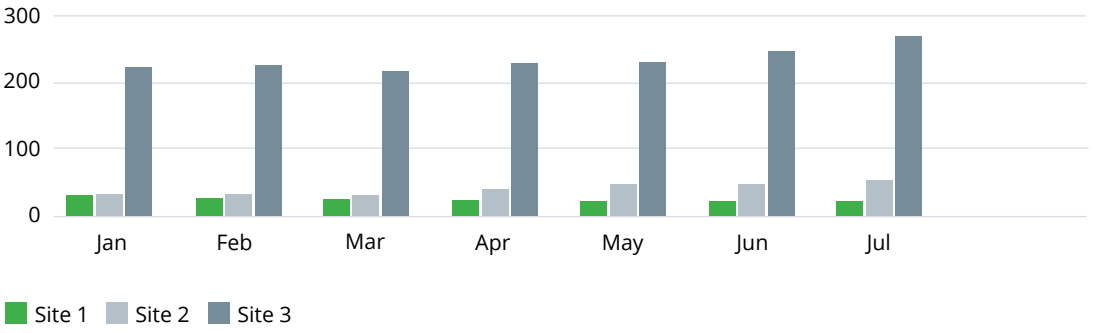

Figure 6: Clients who received opioid agonist therapy

2.2 How COVID-19's impact on harm reduction varies between countries

Opioid agonist therapy: In six of the seven countries analysed (Nepal, India, Cambodia, Vietnam, Thailand and Indonesia) the government issued directives for take-home doses of OAT for between a week to 10 days. However, respondents from Indonesia and Vietnam reported that many people were unable to access this service as they were still required to pay hospital/clinic charges, and it was difficult for them to pay for multiple days' doses at once. This resulted in people needing to make more frequent visits to services, which increased their risk of exposure to COVID-19. Some countries reported that state-level programmes did not fully cooperate in implementing national directives, resulting in constraints to service access. In Vietnam and India some methadone clinics reduced the number of new people initiating OAT, sometimes admitting only one per month. People who use drugs also reported experiencing restrictions imposed by local vigilante groups and law enforcement personnel while travelling to service centres.

Community members reported a substantial increase in the number of people receiving OAT as the COVID-19 pandemic unfolded. This echoes the quantitative data from India and Nepal reported above. However, it is unclear if this change was driven by a lack of opioids in the market due to physical distancing measures and people shifting to OAT to avoid withdrawal. Comprehensive needs assessment and induction to OAT can reduce the likelihood that someone will discontinue OAT and begin injecting drugs again.[13,14]

"MMT [methadone maintenance therapy] clinics are few in each province. During COVID, MMT clinics do not respond, although the agency has already made a letter to the ministry."

Community-based organisation, Thailand

"During the pandemic, the opioid agonist treatment (OAT) clinics reduced the number of dose induction [initiation of OAT] for clients. Some clinics reported only induce doses one time per month."

Community-based organisation, Vietnam

INDONESIA

At the end of 2019 Indonesia reported low stock of ART, due to the cancellation of an earlier contract. Other stocks, including condoms and syringes, were also low.

In response to the pandemic the government increased the take-home dosage of methadone up to seven days. But in order to access take-home methadone, people had to pay hospital and clinic charges for seven days at a time, which was not feasible for all. As a result, many chose to visit their OAT clinic at least once every two to three days, which increased their risk of COVID-19 infection. Most of the COVID-19 clinics and the methadone clinics were located in the same hospital sites, and by this point COVID-19 was prevalent among hospital staff.

The government made provisions for take-home ART for more than one-month, raising it to two to three months, which made the stock conditions more vulnerable. In addition, the global shutdown of international flights resulted in delays in transporting medicines by sea, and need began to exceed supply.

International donor funds are used to support ART and OAT. But needles, syringes and condoms rely on a more conventional supply chain system, which depends on older protocols and local funds. This made it difficult for clients to continue accessing these items.

In several of the countries, people who use drugs regularly experience significant human rights violations. These violations include being denied access to harm reduction services and being sent to compulsory drug detention, something that is reported to have increased due to COVID-19-related measures. In addition, in India people living with HIV were required to carry special travel papers to obtain their medication if they lived outside the geographic jurisdiction where they were receiving treatment. In Nepal, there were attempts to force people who use drugs into rehabilitation centres in some locations, although timely advocacy and intervention by networks of people who use drugs ensured such practices were stopped. In Vietnam, networks of people who use drugs have been actively advocating with government authorities to stop sending people who use drugs to compulsory detention centres during the pandemic. Although official guidelines have not yet been issued, authorities' response to this request has been positive.

"The distribution of needles by NGO staff uses a one-to-one method to find people who use drugs at home... but there are obstacles in the journey because... police, military, administrative and related agencies have jointly set up a checkpoint in different areas between villages."

Community-based organisation, Thailand

"In some sites, it was also reported that women who use drugs who had been engaged in transactional sex work were severely impacted following the imposition of COVID-related restrictions and could be more likely to engage in high-risk sexual practices to earn income."

Respondent, India

2.2.1 Harm reduction in prisons

Harm reduction services for people who use drugs in prisons or detention/police custody continued in most countries in which these services were pre-existing. Some respondents reported constraints in access to ART and legal assistance for people in prisons and detention centres as family members who normally arrange these services were unable to visit during lockdown. While the Indonesian government issued a directive for the early-release of prisoners to help reduce COVID-19 transmission, no specific provision was given for people charged with drug-related offences, and the incarceration of people who use drugs remained high during the pandemic. NGOs and networks of people who use drugs, particularly in India, tried to ensure that OAT was provided wherever possible to people in police custody and further linked these people to regular OAT services after they were released.

2.2.2 Increased vulnerability of women who use drugs

Efforts were made to ensure that women who use drugs were not left behind in the COVID-19 response. Women who use drugs have been disproportionately disadvantaged and face increased vulnerability due to COVID-19. Some respondents reported that women who use drugs who engage in transactional sex work were severely impacted by the loss of income resulting from the pandemic and were therefore more likely to engage in high-risk sexual practices. While not specific to women who use drugs, in Indonesia an increase in domestic and sexual violence experienced by women was reported. In India, some women who use drugs reported that they were reluctant to openly access services at home unless these were discreetly delivered because they had not informed their families they were using drugs.

Despite these challenges, most respondents reported that services for women who use drugs continued to be provided, and that there was an increase in the number of women initiating OAT to cope with withdrawal due to opioids being unavailable or increasing in price. In Nepal, shelters were created for women who use drugs as part of the country's emergency COVID-19 response.

3. The emergency response to COVID-19

An emergency management cycle can generally be classified into four broad areas: prevention, preparedness, response and recovery.[15] Mitigation measures fall between the prevention and preparedness phase.[16] COVID-19, however, is more complex than the natural disasters that call for emergency responses. While natural disasters are shorter in duration, COVID-19 is ongoing and is expected to continue into 2021. In contrast to natural disasters, where aid and relief are rushed to the site of emergency, the tools that are available to respond to COVID-19, such as physical distancing and travel bans, also limit the scope and nature of response. This analysis found most of the preparedness and mitigation measures were taken by local governments, community members and faith-based organisations (as reported in India).

3.1 Preparedness and mitigation for harm reduction

To make informed decisions to effectively respond to the COVID-19 crisis, programme managers and networks engaged with community members and stakeholders to carry out rapid needs assessments and various mitigation strategies. As a result of this work, CBOs, CSOs and NGOs advocated with governments to issue directives on take-home doses of OAT, developed emergency guidelines for harm reduction services, arranged for OAT and NSP services to be delivered to people who use drugs where they were, adopted new strategies such as the use of virtual meeting platforms and information sharing, and lowered the threshold criteria for accessing harm reduction services to cover new and hard-to-reach populations.

3.2 How communities drove the emergency response for harm reduction

In the context of harm reduction services, the COVID-19 pandemic called for immediate action to deal with multiple crises simultaneously. Initially, people who use drugs faced severe constraints in accessing essential harm reduction services, such as OAT, needles and syringes and ART. Most were unable to travel to service centres due to a lack of public transport or as a result of living in containment zones (areas with more intense physical distancing measures). Harm reduction services were often located in healthcare centres that were also treating people with COVID-19, increasing people who use drugs' risk of exposure to the virus.

Many people who use drugs are reliant on daily wages or work in the informal sector and have seen a significant loss of income during the COVID-19

INDIA

The period of time between the first case of COVID-19 being identified in India and a national lockdown allowed the community of people who use drugs to advocate at local and national level to ensure adequate stock of ART and OAT. The National AIDS Control Organisation responded positively and proactively by providing early guidance on allowing take-home dosage for ART and OAT.

Wide use of internet-based trainings and meetings ensured services continued despite lockdown measures. ART and OAT clinics were moved outside major hospitals to avoid excess exposure to COVID-19. Community leaders and network members played a key role here as they shouldered the burden of delivering these essential medicines to people's doorsteps, having sought special permissions to do so.

There were many challenges during this phase. Some people came out of their homes to search for drugs, thereby violating lockdown measures, and harassment from local vigilantes and at times the authorities ensued. The needle syringe programme and counselling service were negatively affected.

Many people who inject drugs switched to OAT during this time as drugs were unavailable in the market.

Although peer educators and outreach workers provided direct harm reduction services during this time, which required them to travel, they were not considered frontline workers and so PPE was not made available for them.

pandemic. Many people who use drugs in the countries studied were unable to meet their basic needs, such as rent and meals, let alone health services. Respondents also reported that the rapidly-rising cost of drugs, and their unpredictable quality and availability, were leading to an increase in withdrawals and overdoses.

In all the countries, communities worked with civil society and government systems to initiate an emergency response mechanism for people who use drugs who are also living with HIV. In Indonesia, this response included cash transfers, paid for through crowd funding, to support essential medications plus additional funds to support people's living costs, such as rent and food. In India, the response involved developing community forums of people who use drugs to fill in for the severe shortage of paramedics and health workers, and utilising partnerships with faith-based organisations to address stigma, and to supply food, money and naloxone.

Respondents from Nepal, India, Cambodia, Indonesia and Thailand reported that the community of people who use drugs was involved in processes to respond to COVID-related needs initiated by CSOs, CBOs and networks, particularly through phone calls, social media platforms and other virtual forms of communication. People who use drugs proactively highlighted the issues they faced and engaged in persistent advocacy with stakeholders to ensure community-based solutions. People who use drugs were also instrumental in raising funds from individuals and organisations to pay for PPE and meals for people who use drugs and their families. In Vietnam, people who use drugs helped raise money that went towards the monthly methadone fees of almost 600 people.

People who use drugs proactively highlighted the issues they faced and engaged in persistent advocacy with stakeholders to ensure community-based solutions.

While harm reduction service sites were temporarily closed in a few of the countries studied, they remained open in the majority of places. In countries where sites closed, alternative arrangements were made to ensure a continuity of services, which relied on outreach workers or peers. Yet, in many places, PPE were not readily available or guaranteed for these frontline harm reduction workers. Fortunately, none of the study respondents nor anyone in the partner NGOs included in this analysis contracted COVID-19.

Most of the respondents expressed satisfaction that their recommendations had been incorporated into harm reduction efforts, particularly in terms of government directives allowing take-home doses of OAT and ART and the issuing of emergency passes.

In Manipur, India the recommendation to set up a quarantine centre exclusively for people who use drugs where harm reduction services could be provided was also accepted. People returning from other states at the start of the pandemic were housed in quarantine centres for weeks before they were allowed to go home. The Association of Drug Users in Manipur (ADUM) was frequently called upon to provide support to people experiencing withdrawal and overdose within the centres. ADUM's call to open a separate quarantine centre for people who use drugs where harm reduction services could be provided was granted by the Health Department. This centre also supported people referred from other quarantine centres and linked to services that could be accessed following quarantine.

3.3 Continued support in the absence of comprehensive needs assessments

Conducting comprehensive needs assessments should be part of any standard emergency response system. This is done regularly to assess the changing needs of people over time. Yet so far, a comprehensive needs assessment relating to people who use drugs in the context of COVID-19 has not been conducted. In this study people who use drugs stated that, in addition to existing undiagnosed and untreated mental health issues, the pandemic has magnified mental health problems, such as depression, stress, insomnia, panic, fear and anxiety. The consequences of this are far reaching and include increased use of drugs and alcohol, self-isolation, neglecting health, missing medication doses or ceasing ART or OAT, and engaging in risky behaviour like sharing injecting equipment and not practising safer sex.

Although it is too early to accurately assess the adequacy of the COVID-19 response for people who use drugs, some study respondents have started conducting surveys with community members affected by the pandemic (Vietnam), while others are gathering informal feedback from the community at state and national levels. Mostly, community members have shared their needs with local managers, outreach staff and networks of people who use drugs, who in turn have taken this feedback to government authorities at the local and national level, health ministries, donors, law enforcement agencies, UN agencies, faith-based organisations and other NGOs. Respondents mentioned the significant roles played by their respective health ministries, donors such as Global Fund to Fight AIDS, TB and Malaria (Global Fund) and PEPFAR, organisations such as Alliance India, Frontline AIDS, the International Training and Education Center for Health, the United Religions Initiative, Save the Children, Youth Lead, INPUD and the Red Cross Society as well as state and national networks of people who use drugs.

VIETNAM

The majority of people who use drugs requiring OAT were self-employed and lost their jobs during the pandemic. In response, an organisation for people who use drugs was able to raise funds that went towards paying the fees for 600 people to initiate OAT, without which they could not have afforded to do so. This has resulted in some people who had left OAT previously being able to return to the programme.

To sustain these interventions, the organisation utilised funds from projects that allowed flexibility. It also called for financial assistance from individuals and other organisations to purchase PPE.

The organisation coordinated with an established crowdfunding initiative called One Egg a Day to raise funds for nutrition support. This is a platform where vulnerable people share their concerns through powerful storytelling and compelling images. It has mainly been employed to raise support for food, clothes and cash. In the context of support for people who use drugs, food and drink rations were provided to hundreds of families thanks to the participation of CBOs and volunteers. As a result, people who use drugs have been able to address issues of food insecurity, treatment access and survival during lockdown.

4. The financial requirement

This section captures information gathered during the following three time phases: (i) before physical distancing measures were introduced (ii) the time when serious lockdown measures were in place, (iii) the time when some lockdown measures were relaxed.

4.1 The need for flexibility in current funding allocations

There were temporary reductions in expenditure of budget lines. For example, in Vietnam the cost of organising workshops, training and travel significantly reduced between March and July 2020. Staff salaries were paid even though outreach workers could not do as much outreach and testing as before. Outreach work includes peers travelling to an area, engaging in communication, and distributing items such as condoms and syringes.

The cost of travel varied as the COVID-19 crisis unfolded. Initially, as travel was restricted, outreach work centred around the delivery of interpersonal communication, and thus the expenditure incurred for these services reduced by a small amount (Vietnam). But as restrictions eased and peers were allowed to deliver medicines to people at home, the cost of travel increased. This is due to the limited availability of transport, which made it more expensive (India).

Across the region, hands-on capacity building support for networks of people who use drugs has been impacted with the cancellation of trainings, meetings and events requiring travel. Although this has reduced costs, the effectiveness of online meetings and training remains limited. Efforts are gradually being made to invest in re-designing training courses to adapt to virtual modes of communication and learning.

> *"The cost to organise workshops, training and travel were reduced significantly during the COVID-19 pandemic. During March and April of 2020, we were not allowed to organise workshops and big trainings."*
>
> **Programme manager, Nepal**

4.2 Repurposing existing funds

In most countries, local government systems have responded by making guidelines on the allocation of funding for harm reduction flexible and encouraging networks and civil society to draw resources from the main health systems. Some respondents said they have re-programmed activities, and adapted training and other activities for online delivery/administration, to recover lost time and complete crucial activities to meet the gap.

In Vietnam and India some funds, either from existing budgets or money raised through donations, were used to buy masks and hand sanitiser for both outreach workers and people who use drugs who are homeless or have lost their jobs during the pandemic. The additional expenditure to meet the cost of local travel for outreach staff was re-purposed from existing budgets.

In a few of the countries where people who use drugs had access to quarantine centres, some special provisions were made. This included the supply of OAT for withdrawal management, training healthcare providers at quarantine centres on administering naloxone to prevent overdoses and virtual counselling on OAT initiation and dosage.

The most significant shift reported in service delivery has been the increased use of virtual communication platforms and social media. Some respondents are exploring the possibilities of expanding the scope of existing mobile applications used in their projects to meet emerging needs. Although 'going virtual' is a solution, it will not work for all people who use drugs in these country contexts as not everyone has access to a smartphone. Having face-to-face contact with those who need it must also continue.

Consistent community advocacy towards respective governments to increase the stock of essential harm reduction items, such as needles and syringes, buprenorphine, methadone and ART, has shown positive results in most of the countries. National governments in Nepal, India and Indonesia issued directives for take-home OAT, ART and the provision of harm reduction commodities. These directives have been well-received by the community of people who use drugs. However, this resulted in sudden stockpiling of the above items, which increased pressure on existing supply chain procurement systems. But some instances of low stock and stock outs at country level have also been reported.[17]

4.2.1 Reallocating funds to prevent COVID-19 among people who use drugs

Several measures have been taken to reduce the exposure of people who use drugs to COVID-19. These included providing take-home doses of OAT and supplying adequate numbers of needles and syringes to avoid overcrowding at service points, employing ambulances to provide OAT at specific locations, maintaining physical distancing while providing services, providing PPE kits to people who use drugs, raising funds to ensure people who use drugs can afford to eat, and making effective use of telephone calls and online modes of communication.

During lockdown, while some staff were required to work from home, outreach staff were provided with PPE and other preventative measures so they could continue community visits. For example, a respondent from Indonesia reported that travel budgets for harm reduction service delivery were reallocated to pay for COVID-19 tests for staff members delivering services.

Overall, it was reported that international donors were prompt to give their consent for re-allocating programme budgets, and governments issued timely protocols and directives for HIV-related services. Service providers also ensured access to treatment and networks of people who use drugs shared crucial information with the community.

The emergency fund mechanism

Community members, networks and managers all agree that no one was prepared for the COVID-19 pandemic and no one was expecting the pandemic to last for as long as it has.

Unlike other natural public health emergencies resulting from things such as floods, cyclones and earthquakes, where some governments and donors have emergency plans and funds in place, COVID-19 took everyone by surprise, both in its magnitude and duration.

Respondents from Nepal, India, Cambodia, Indonesia and Thailand reported receiving support from the following:

- **Non-traditional stakeholders:** faith-based organisations and individuals provided food and other health services for people who use drugs, including women who use drugs, their families and partners.
- **Government:** directives allowing take-home doses of OAT and ART, the establishment of a separate COVID-19 quarantine centre for people who use drugs, a mobile van to distribute OAT, travel passes for field workers for service delivery, approval to register new clients into OAT programmes, links to free food supply schemes.

4.3 The new COVID-19 funds

Respondents stated that most donors, particularly the Global Fund through their Principal Recipients, have been supportive in allowing project funds to be reallocated to support people who use drugs during the COVID-19 pandemic, and most individual donors have been quick to respond to proposals from the community and NGOs. For example, the Elton John AIDS Foundation (EJAF) allocated new funds to respond to COVID-19.

> *"The financial situation of outreach workers and their clients are both difficult. Lots of clients reported that they lost their job during the pandemic. The outreach workers, even though they still received their allowances from the projects, they have lost their side jobs as well."*
>
> **Community-based organisation, India**

For most countries, a large portion of the funding for harm reduction comes from donors. However, in some countries like India central government allocates budget for various activities, such as the distribution of commodities including needles, syringes and condoms. As a result, competing interests from other government-funded programmes, such as those addressing tuberculosis or malaria, must be taken into consideration. Despite announcements of COVID-19-related funding allocations, the community of people who use drugs and service providers participating in this study said they were worried funds would be inadequate, particularly for harm reduction. There was also apprehension about whether the funds that are made available will meet people's basic needs or whether existing provisions for things such as travel, OAT, ART and trainings will need to be reallocated to cover this.

As one network member from India described the situation *"they are expecting us to take ART when we do not have food to eat"*.

4.3.1 Sustainability: local funds and international support

People who use drugs may belong to close-knit networks that depend on each other during times of crisis. In most of the countries, the networks have put on multiple hats to combat the challenge of the COVID-19 epidemic. To play a supportive role, most have carried out advocacy with local government officials and businesses to improve support for community members (India, Vietnam). Undoubtedly, this

has helped services to continue. These efforts also include raising funds through crowdfunding, plus donations in cash, in-kind and from their own pocket (Vietnam). Some CBOs have taken the initiative of raising funds through crowd-funding to provide food for people who use drugs and have utilised money from flexible project budgets to support poor community members to maintain methadone treatment. Some respondents reported that they incurred additional travel costs as staff had to deliver services to people who use drugs, while others stated that extra-budgetary funds had to be raised for the provision of food, sanitisers, naloxone and other essential items. For this, resources were either mobilised from organisational core funding or by engaging with non-traditional stakeholders, such as faith-based organisations.

In Vietnam, it was reported that additional grants were received from agencies such as EJAF and Coaches Across Continents, as well as through crowd-funding initiatives such as One Egg a Day. The Global Fund is one of the largest donors for harm reduction programmes, and it has allocated a substantial amount of mitigation funds which were yet to reach harm reduction service providers at the time of this study. Although funds are available from PEPFAR's grants for the COVID-19 response they are not specifically for harm reduction.

4.4 The new normal

COVID-19 and the response to it has changed the way harm reduction services are being delivered. This paradigm shift is expected to have a lasting impact as we move from business as usual to the new normal. Harm reduction service providers have adapted during the pandemic, however this has also highlighted potential areas of weakness/gaps that require donor and government support.

Community-based and community-led organisations have been at the heart of the harm reduction response during the pandemic, ensuring the needs of their communities are met. Donors and governments should recognise the value of these community responses and provide them with the necessary funding to sustain services and protect workers. COVID-19 has raised two challenges: task shifting and the discontinuation of traditional classroom-based training and/or mentoring. Many organisations are shifting to a virtual way of working, although this is not a catch-all solution.

Understanding the needs of people who use drugs during COVID-19

Market availability and price have a major influence on which drugs people will or will not use. When the price of any particular substance goes up, people may switch to an alternative option to cope with craving and avoid withdrawals. When prices go down, they may go back to their original drug of choice.

Study participants highlighted the critical need for harm reduction services to continue uninterrupted, particularly in the light of changing patterns of drug use during the pandemic and the escalating price of heroin and other opioids (Nepal, Indonesia).

The increase in people signing up for OAT to meet their immediate needs should be understood from the individual perspective, which is likely to be influenced by the external market. This is expected to increase the demand for OAT and other pharmaceuticals, and there are worries that the limited stock of buprenorphine and methadone in some countries might mean OAT cannot be provided to all who need it (Nepal). Participants were also apprehensive that the supply of non-prescription drugs will increase in the region once physical distancing measures are lifted. This may lead people to abruptly stop OAT, which increases potential harms including overdose.

There is an urgent need for technical input in developing this system and ensuring the capacity of harm reduction workers is continuously built to meet these new challenges.[18] A key focus must be to ensure the provision of all the components of harm reduction, not only ART and OAT. Thus, appropriate changes in policies and financial guidelines will be required to ensure harm reduction can successfully adapt to the new normal.

The following description of the new normal is drawn from a review of literature on COVID-19 and harm reduction, along with the experience of stakeholders from all of the countries.

Harm reduction component	Old/existing strategy	New normal
SERVICES		
Registration of beneficiary	On-site	Virtual
Needle syringe requirement	On-site	Virtual
Needle syringe distribution	On-site or peers	Peers
Counselling	On-site and peers	Peers and virtual
OAT	On-site/direct observation by medical staff	Take-home dosage, self or at-home care observation
Overdose management	Trained medical professionals	Emergency naloxone with peers or at home
Clinical progress	On-site	Peers and virtual plus reduced frequency of on-site visits
HIV testing	On-site	Peer-led screening
Abscess management	On-site	Peers and home-based or nearest nurse
Testing for sexually transmitted infections	On-site	Peer/home-based
Personal protection	Non-existent	PPE
Masks	Non- existent	Masks for clients
ART	On-site initiation and monthly medication	On-site initiation and three to six monthly medication
SYSTEMS		
Training/capacity building	In-person classroom	Virtual space, clinical vignettes. New training systems and methods for home-based caregivers and peers
Monitoring	In-person	Virtual, plus peer, plus reduced frequency of direct clinical observation
Travel	Available budget	Increase in travel budget by 30-60%
Group counselling and meetings	In-person	Virtual (via Skype, Zoom, WhatsApp etc.)
Advocacy method	In-person community consultation	Video-based feedback system and platform for sharing issues
Workforce	Peers, counsellors, healthcare workers	Increasing the ratio of peers to clients

5. Methodology

The objective of this pilot study was to understand the impact of COVID-19 on harm reduction funding in selected countries. A mixed method design was used. A desk review of published literature was conducted to gather existing knowledge. To capture the ongoing experience of different stakeholders, a semi-structured questionnaire was used to collate responses from targeted participants.

The questionnaires were reviewed in detail by HRI staff, who provided critical inputs to improve the data collection process. All HRAsia national partners were contacted directly by the researcher before receiving the questionnaire and confirmed their comfort with the English language. After receiving confirmation, the questionnaire was sent by email to each participant with detailed guidance on consent and an option to answer the questions anonymously. Each participant was given the choice of responding by email or having a direct call by WhatsApp or Skype. A minimum of one week was given to each of the respondents. All participants were called and sent reminder emails as per the agreed protocol of the study. To clarify any issues, direct communication was carried out with participants who indicated they were open to further discussions.

This is a rapid exercise to capture the changes that have happened in 2020. It serves to add to the evidence base on the situation before COVID-19 as well as assessing the impact of COVID-19 and the response within the respective countries.

Information collection was conducted between 1st January 2020 to 31st July 2020. The study lead reached out to existing international donor agencies and HRAsia partners in Cambodia, India, Indonesia, Nepal, the Philippines, Thailand and Vietnam. HRI sent the initial list of contacts and an introductory communication to each participant. Through the country-level partners, harm reduction service providers and representatives of networks of people who use drugs were contacted to share their experiences.

A total of 15 participants from six project countries provided inputs for the study (with the Philippines being the exception). One participant provided information through a WhatsApp call and one through a direct telephone interview; the rest responded by email. Although the response rate was good, this could have been further improved by direct communication channels between the researcher and the project managers. Prior identification and sharing advance information with a larger number of donor agencies would have added more detail and rigour to the study.

The study tool included a detailed informed consent form with the option of responding anonymously. Any identifiers of individuals or institutions are removed to maintain the confidentiality of the respondents.

References

1. World Health Organisation, "The cost of inaction: COVID-19-related service disruptions could cause hundreds of thousands of extra deaths from HIV," 2020.
2. The World Bank, "COVID-19 to Plunge Global Economy into Worst Recession since World War II," 2020. [Online]. Available: https://www.worldbank.org/en/news/press-release/2020/06/08/covid-19-to-plunge-global-economy-into-worst-recession-since-world-war-ii. (accessed Sep. 2020].
3. International Network of People who Use Drugs, Harm Reduction International & International Drug Policy Consortium, "In the time of COVID-19: civil society statement on COVID-19 and people who use drugs," 2020. https://www.inpud.net/en/time-covid-19-civil-society-statement-covid-19-and-people-who-use-drugs (accessed Sep. 2020).
4. Harm Reduction International "We can't stop now: safeguarding funding for harm reduction during COVID-19," 2020.https://www.hri.global/files/2020/05/12/HRI_INPUD_Statement_on_Funding_for_Harm_Reduction_-_COVID19.pdf (accessed Sep. 2020).
5. B. L. Jewel et al., "Potential effects of disruption to HIV programmes in sub Saharan Africa caused by COVID-19: results from multiple mathematical models," LANCET HIV, vol. 7, no. 9, pp. e640, Aug. 2020.
6. A. B. Hogan et al., "Potential impact of the COVID-19 pandemic on HIV, tuberculosis, and malaria in low-income and middle-income countries: a modelling study," Lancet Glob. Heal., vol. 8, no. 9, pp. e1132–e1141, Jul. 2020, doi: 10.1016/s2214-109x(20)30288-6.
7. T. T. Oladele, B. O. Olakunde, E. A. Oladele, O. Ogbuoji, and G. Yamey, "The impact of COVID-19 on HIV financing in Nigeria: a call for proactive measures," BMJ Glob. Heal., vol. 5, no. 5, p. e002718, May 2020, doi: 10.1136/bmjgh-2020-002718.
8. Harm Reduction International, "Summing it up: Building evidence to inform advocacy for harm reduction funding in Asia ," Jul. 2020.
9. M. Karamouzian, C. Johnson, and T. Kerr, "Public health messaging and harm reduction in the time of COVID-19," *The Lancet Psychiatry*, vol. 7, no. 5. Elsevier Ltd, pp. 390–391, 01-May-2020.
10. Harm Redution International, "Making the investment case: Cost-effectiveness evidence for harm reduction," 2020
11. L. Degenhardt *et al*., "Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review," *Lancet Glob. Heal*., vol. 5, no. 12, pp. e1192–e1207, Dec. 2017.
12. ASIAN Secretariat, *Module 5 Participant Manual Treatment and Care for HIV-Positive Injecting Drug Users Treatment and Care for HIV-Positive Injecting Drug Users*. 2007.
13. G. Armstrong, M. Kermode, C. Sharma, B. Langkham, and N. Crofts, "Opioid substitution therapy in manipur and nagaland, north-east india: Operational research in action," *Harm Reduct. J*., vol. 7, no. 1, p. 29, Dec. 2010.
14. W. Ling, "Buprenorphine implant for opioid addiction," *Pain Manag*., vol. 2, no. 4, pp. 345–350, Jul. 2012.
15. WHO/Europe, "Health emergencies – Emergency cycle." [Online]. Available: https://www.euro.who.int/en/health-topics/health-emergencies/pages/about-health-emergencies-in-the-european-region/emergency-cycle. [Accessed: 27-Sep-2020].
16. "Disaster Management Cycle | UN-SPIDER Knowledge Portal." [Online]. Available: http://www.un-spider.org/glossary/disaster-management-cycle. [Accessed: 27-Sep-2020].
17. L. Hendry, F. Wayan Dede, M. Pande Agung, W. Frank Stephen, I. Irwanto, and G. Keerti, "SEvolving ART crisis for people living with HIV in Indonesia," *Lancet*, vol. 7, 2020.
18. J. Peabody, R. Shimkhada, O. Adeyi, H. Wang, and E. Broughton, *Quality of Care*. 2018.

HARM REDUCTION
INTERNATIONAL

Harm Reduction International is an international non-governmental organisation that works to reduce drug-related harms by promoting evidence-based public health policy and practices, and human rights-based approaches to drug policy through an integrated programme of research, analysis, advocacy and partnerships. Our vision is a world in which individuals and communities benefit from drug laws, policies and practices that promote health, dignity and human rights.

www.hri.global

Alliance India

The Global Fund

HR Asia
Harm Reduction Advocacy for Sustainable Interventions