Integrated and Person-Centred Harm Reduction Services

November 2021

HARM REDUCTION INTERNATIONAL

Harm Reduction International
61 Mansell Street, Aldgate, London E1 8AN
Telephone: +44 (0)20 7324 3535
E-mail: office@hri.global
Website: www.hri.global

What is an integrated harm reduction service?

In this report, we define an integrated harm reduction service as a site or organisation that provides one or more 'traditional' harm reduction services (such as opioid agonist therapy or a needle and syringe programme) alongside other health and social services. In doing so, they ensure that a wide range of services are available and accessible to their clients.

Key Lessons

Integrated services are better placed to treat people as people

- Treating clients as rounded individuals, rather than reducing them to 'symptoms' or 'challenges' encourages self-care and solidarity, and empowers them to demand their rights.
- Collaboration in multidisciplinary teams can ensure that integrated services are complementary.
- Providing a space where people can simply exist in comfort and safety is just as important as formal health and social services.
- Holistic care and support can build self-worth, pride and solidarity, and combat the effects of stigma and discrimination.

Integrating services makes them more accessible

- Service integration is about making services accessible and empowering people to use them, without pressure or obligation.
- Integrating services makes them easier for clients to navigate, and can support them to engage more effectively.
- Integrated services understand the barriers their clients face when accessing external services, and can ensure that clients are referred to the most appropriate options.
- Even complex services, like blood tests and consultations, can be delivered in a way that places minimal burdens on clients' time and resources.

Community leadership and involvement is transformational

- The leadership of peers eases the building of trusting relationships, and ensures that people are treated as human beings not just patients.
- Peer-leaders in integrated services have a unique insight into the lives and experiences of their clients, and can use that to provide compassionate and non-judgemental services.
- Working closely with clients and community improves the range and quality of services you can offer.
- Ensuring a culturally safe environment for Indigenous communities makes services more accessible and acceptable to people who may otherwise be marginalised.

Integrated services can adapt to their environment

- Enabling political and legal environments support greater integration and accessibility.
- Integrated services know their context and clients, and can make sure they have access to the most relevant and safest commodities.
- Sometimes it is necessary to recognise the limits of integration under one roof: some services might be better delivered separately.

Introduction

A person's health is multifaceted and interconnected. In order for any service to genuinely empower people to improve their health, it needs to recognise the various factors that contribute to it. Integrating health and social services enables these services to be responsive to the needs of their clients.

Where health and social services are disparate and disconnected, they can only address particular symptoms or conditions of a person's health. On the other hand, integrated services are capable of addressing a person's health in a broader context. This 'biosocial' approach to health acknowledges that different health and social issues are interconnected and need to be addressed holistically. This can range from biomedical knowledge about the interaction between certain medications, to acknowledging the impacts of discrimination, marginalisation and criminalisation on a person's ability to access good health. A failure to recognise any one factor in a person's health can dramatically impact the ability to address other areas.

For harm reduction, this means moving beyond the narrow frame of preventing and treating infections and overdoses through biomedical and bio-behavioural interventions.

The services profiled in this report show real world examples which have had excellent results. In some cases, this simply means making it easier for people to access the health services they need by providing them all in one place. In others, it means broadening what we mean by harm, and recognising the full range of what harm reduction can be. **They are person-centred services: organised around the person as an autonomous whole, not reducible to their drug use or specific medical conditions, but with intersecting needs linked to their personal social determinants of health.**[a]

Community leadership has always been central to harm reduction. It is the only way to provide the appropriate range of services in the appropriate way. It is also essential to consider those whose needs are commonly unmet. People who use but do not inject drugs, as well as people who use stimulants, are largely left out of a framing of harm reduction centred on injecting opioid use. Women, people of colour and Indigenous people are poorly served by services created with white men in mind. People from sexual minorities experience stigma and a lack of understanding in services not used to their practices and needs.

Photography courtesy of: The Muslim Education and Welfare Associated (MEWA).

a "Person-centred care" differs from the current World Health Organisation definition of "people-centred care by appreciating diversity and intersectionality between population groups and the unique circumstances that define each individual person's health needs and aims.[1]

What is an integrated service?

At its heart, an integrated service is one that provides multiple services at once, in a way that makes it easy for clients to move between them. In doing so, they can address the complex needs of their clients 'simultaneously, rather than in parallel or sequential fashion'.[2] In the context of harm reduction, this commonly means providing a continuum of prevention, diagnosis and treatment for blood-borne diseases tailored to the needs of people who use drugs, alongside broader health and social services. Central to this practice is the acknowledgement that the health consequences of drug use cannot be addressed in isolation, but must be considered in a social, economic and legal context.

Integration comes in different forms, each of which comes with its own advantages and disadvantages. A fully integrated 'one-stop shop' might provide a full range of services under one roof, provided by one multidisciplinary team. These services provide strong linkage to care, but might be more difficult to implement.[3] On the other hand, a service may function as an entry point to a network of service providers. The links between services in these cases might be weaker, but integration can be achieved more quickly and services can be more specialised.[3] The type of integration that is appropriate will depend on the context and the needs of clients.

In this report, we use a broad definition of an integrated service to demonstrate the range of possible models. All the services profiled in this report provide at least one 'traditional' harm reduction service (such as access to safer smoking or injecting equipment or opioid agonist therapy), while ensuring access to other health and social services by either sharing a site or providing strong referral pathways to other organisations and services.

Photography courtesy of: The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)

Global commitments and guidelines on integrated services

Integrated harm reduction services are a part of several global international commitments and guidelines, including:

- The **International Covenant on Economic, Social and Cultural Rights** obliges its 171 signatories to ensure people have access to 'the highest attainable standard of physical and mental health'.
- The latest **UNAIDS strategy (2021-2026)** places a strong emphasis on the need for integrated services. It commits countries to ensuring access to 'quality, integrated HIV treatment and care that optimises health and wellbeing.' Importantly, it also recognises the need for 'fully recognised, empowered, resources and integrated community-led HIV responses.' It also explicitly calls for the inclusion of 'medical and nonmedical' services.
- The **Political Declaration of the 2021 UN General Assembly High Level Meeting on HIV and AIDS** commits member states to providing context specific integrated services for HIV and other communicable diseases, non-communicable diseases, sexual and reproductive health, gender-based violence, mental health, alcohol and drug use, legal services, and other services they need for their overall health and well-being by 2025.
- The World Health Organization's guidelines on addressing HIV among people who use drugs recommends a **'comprehensive package'** of HIV services for people who inject drugs, including needle and syringe programmes, opioid agonist therapy, and HIV, viral hepatitis and tuberculosis services among others.
- The **Global Health Sector Strategies on HIV and viral hepatitis and sexually transmitted infections 2016-2021** commits to including the comprehensive package in integrated health services.

Photography courtesy of: The Muslim Education and Welfare Associated (MEWA)

The Evidence

Integrated and person-centred harm reduction services increase engagement and improve health outcomes

When implemented well, integrated harm reduction services offer a more person-centred approach, giving clients more control over how they manage their drug use and access health and social services. By allowing for closer and more understanding relationships with clients and by placing fewer burdens on their clients' time and resources, the services are able to be more responsive, convenient and appropriate to the lives of people who use drugs. This also makes them better at reaching marginalised people and building trust.[4]

A wealth of international research finds that integrated harm reduction services are both more effective at reaching clients and at empowering them to improve their health. Reviews of evidence find that integrating HIV and substance use care not only increased the number of people accessing those services, but also improved their access to primary care in general.[2,4] Similarly, modelling in Mexico shows that integrating anti-retroviral therapy for HIV with opioid agonist therapy could boost uptake of both and reduce HIV infections and overdose among people who inject drugs.[5] Global studies find that where needle and syringe programmes provide HIV and viral hepatitis testing and linkage to care, they make a big contribution to the number of people who know their status and enrol in treatment.[6]

Research finds that client perspectives of integrated services are also generally positive. Clients highlight the holistic care that is provided, and the ability of integrated services to address unmet social needs.[4] In population-specific services, such as those that are female-centred, clients report an opportunity for the recognition of and solidarity with common challenges and experiences.[7] This contrasts with client perspectives of non-integrated services, which demonstrate the barriers to care, including fear and experiences of stigma and discrimination, unmet basic needs, unfriendly clinical environments and procedures, inadequate counselling, and a perceived lack of confidentiality.[4]

Not only are integrated services effective, they are also cost-effective. Evidence shows this is true of any type of integration of HIV services with sexual and reproductive health, tuberculosis or primary health care, and that this may make services cheaper for clients where that is a factor.[8]

Community-leadership and peer workers make integrated services even more effective

The involvement and leadership of the community is also important to integrating harm reduction services. From the early days of harm reduction practice, peers have been central to its development and delivery.[9] Peers are uniquely able to win the trust of clients and have the knowledge and expertise to understand their experiences.[10] Evidence shows that peer involvement in HIV and harm reduction services is linked to better health outcomes, including reduced incidence of HIV, increased accessibility, acceptability and quality of services, reduced risk behaviours and reduced experiences of stigma and discrimination.[10]

Integrated services can better meet the needs of women who use drugs

Integrated services are particularly effective in reaching women who use drugs. Where sexual and reproductive health and harm reduction services have been integrated (either through referral pathways or sharing a site), engagement in both has increased.[7] A study in Kenya found that women who use drugs had low use of sexual and reproductive health services, but that this can be improved by integrating them with outreach-based HIV and harm reduction services – a solution they found was both feasible and acceptable to the clients.[11] Evidence shows that integrated HIV and sexual and reproductive health services improve client satisfaction, reduce stigma and are better at reaching some more marginalised populations, such as sex workers.[12]

Acknowledgements

Harm Reduction International would like to acknowledge the contributions of all those people who contributed to this report: Maria Angélica Comis (É de Lei); Chris Gough (CAHMA), Gaby Bruning (VACCHO) and Sione Crawford (Harm Reduction Victoria); Prawchan KC (SPARSHA); Américo Nave, Rita Lopes, Maria Bento Carmona and Carlos Morgado (CRESCER); Fatma Jeneby (MEWA); DJ Laroche (Kontak) and Alexandre Fafard (RÉZO).

Integrated Services Demonstrated Their Unique Abilities During Covid-19

In the context of the global pandemic, harm reduction services were able to provide COVID-19 care to their clients, alongside core services. Even where integrated and person-centred harm reduction services have closed, they were able to remain in contact with their service population during the pandemic. For example, Pink House in Bulgaria provided COVID-19 information, face masks, disinfectant and food, even while their drop-in centre was forced to close temporarily.[13]

Harm reduction services that treat people with compassion and without judgement are uniquely positioned to encourage trust between clients and service providers. As such, they can play a crucial role in providing COVID-19 services to people who use drugs.[14,15] An example is ARCAD Sante Plus in Mali. The organisation integrated their responses to HIV and COVID-19 through the CovidPrev project. Using the long established and trusting relationship between the organisation and their HIV service clients, they were able to continue testing and treating for HIV while delivering COVID-19 prevention messages and restructuring their service to comply with social distancing.[16]

Additionally, because of the stronger relationships formed between integrated services and their clients, the services themselves are commonly more aware of the needs of their target population than standalone services. For example, services in Norway, South Africa and the United States recognised early on the possible confusion of COVID-19 and opioid withdrawal symptoms, and responded by expanding access to COVID-19 screening and information.[17–19]

São Paulo, Brazil

Centro de Convivência É de Lei[b]

✔	**Needle and syringe programme**
✔	**Safer smoking equipment**
✔	**Basic needs: water, food and hygiene**
✔	**Respite space**
✔	**Recreation: TV, music, sport and games**

✔	**Workshops and talks**
✔	**Linkage to health services**
✔	**Linkage to social services**
✔	**Linkage to legal services**

Background

É de Lei was first established in 1998 as a needle and syringe programme for people injecting cocaine in the Luz neighbourhood of São Paulo. However, in the early years of the twenty-first century, smoked crack cocaine emerged as the primary illicit substance used among people living on the streets. This required a new harm reduction response for a population for whom sharing injecting equipment was no longer a major concern. É de Lei primarily receives funding from philanthropic and non-governmental organisations.

Integrated services

É de Lei does not consider drug use to be a defining vulnerability of its clients (known as *conviventes* or 'cohabitants'), the majority of whom are experiencing homelessness, but one factor among many. As such, harm reduction is presented broadly as an "ethics of self-care," and combined with a set of several possible interventions to break the cycle of vulnerabilities. **By providing health and social services, while also encouraging self-care and solidarity, they seek to empower *conviventes* to demand their rights.** The services that É de Lei provide are broadly split between outreach and the community centre.

The outreach team distributes harm reduction materials. This includes safer smoking tools (such as silicone pipes, wire gauze, cigarette paper, lip protectors and lip balm), alongside other basic goods and harm reduction equipment such as soap, male and female condoms, lubricants, drinking water, menstrual hygiene products, and, since the onset of the COVID-19 pandemic, alcohol gel and masks. They also distribute information on harm reduction and psychoactive substances, as well as details of local health services, shelters and public defenders. Since the beginning, É de Lei has employed people who use drugs as peer workers, often people who started as *conviventes* and showed a particular affinity with harm reduction strategies. As of mid-2021, there were two former *conviventes* in the fiver-person outreach team.

Close interaction with clients while providing this range of material has allowed É de Lei to develop and refine their offer. **For example, they worked closely with clients to develop silicone tubes with various diameters for use with improvised pipes to reduce damage to lips and lungs and the risks of sharing equipment.** The tubes have become one of the most popular items that they distribute. In addition to ensuring access to services and prevention materials, outreach brings people closer to the harm reduction team, and facilitates the development of a culture of respect, solidarity and self-care through dialogue with peers and outreach workers.

É de Lei's *centro de convivência* (community centre or 'centre for coexistence') is the first such space

b With thanks to Maria Angélica Comis, Director of Advocacy and Communications at É de Lei.

for people who use drugs in Brazil. In the absence of any widespread harm reduction interventions in the country, it is designed to be a space for social interactions that promote harm reduction, self-care, mutual respect, autonomy and citizenship. It is a low threshold service open to all, which works through a combination of structured and unstructured interventions.

Since it was founded, the centre has hosted sessions called *Chá de Lirio* or "Lily Tea." These are conversation circles, in which *conviventes* and other invitees discuss various topics, including harm reduction, health, citizenship, drug policy, gender, and experiences of stigma and prejudice. In some cases, these are held in conjunction with other health, cultural or social projects, which can lead to strengthened interactions between *conviventes* and those other projects. During and after the sessions, the organisation ensures that participants have access to information, referrals and follow ups for any issues that were discussed.
After increasing the number of female harm reduction workers at É de Lei, the organisation noticed a corresponding increase in the number of women and gender non-conforming people engaging with their outreach team and community centre. In response, in 2019, they launched a new series of gender-sensitive conversation circles.

Alongside structured sessions, the community centre also provides a space for people to have spontaneous social interactions. **This includes being able to ask for guidance and information about referrals to other health and social services, but is also an opportunity to use computers, listen to music, play dominoes or cards, or simply have a coffee and socialise with staff and other *conviventes*.** Such occasions increase integration and bonds of solidarity among people at the centre, and give *conviventes* a chance to share experiences and reflect on drug use, health and self-care.

Links to other services and organisations

Contact with clients through outreach and the community centre is an important means of connecting them to services provided by other organisations. Outreach teams are able to refer people to physical and mental health and social services, and even arranged to take a group to the *Copa da Inclusão* (Inclusion Cup), a football championship held in São Paulo by a collective of mental health organisations.

Brazil has a national health system with basic physical and mental health services based in communities. É de Lei cooperates closely with these centres, notably for psychosocial care in community mental health services that cannot be provided by the community centre. They are able to refer and accompany *conviventes* and ensure that their needs are attended to.

Brazil is also the only country in the world where there is a constitutionally guaranteed and government funded office of lawyers mandated to provide legal assistance to those who need it for free. Staff from É de Lei accompany people to this state public defender's office for support with legal situations and to report violent violations of their rights by police.
Additionally, É de Lei has a strong presence in national and international networks, including the national harm reduction network and the Brazilian Drug Policy Platform, a network of community groups and non-governmental organisations advocating for progressive changes to drug policy.

Key lessons

- Treating clients as rounded individuals, rather than reducing them to 'symptoms' or 'challenges' encourages self-care and solidarity, and empowers people to demand their rights.
- Working closely with clients improves the range and quality of services you can offer.
- Providing a space where people can simply exist in comfort and safety is just as important as formal health and social services.

Photo courtesy of: Centro de Convivência É de Lei

Photo courtesy of: Centro de Convivência É de Lei

CAHMA AND THE CONNECTION[c]

✔	**Opioid agonist therapy**
✔	**Naloxone programme**
✔	**Drop-in community centre**
✔	**Respite space**
✔	**Culturally safe services**
✔	**Workshops and group activities**

✔	**Primary health care**
✔	**Incentivised linkage to hepatitis C care**
✔	**Linkage to health services**
✔	**Linkage to social services**
✔	**Volunteer training programme**

Background

CAHMA (Canberra Alliance for Harm Minimisation and Advocacy) is a peer-led organisation established in 2000 in the Australian Capital Territory (ACT), Australia. In 2004, CAHMA launched The Connection, a service tailored to the needs of the Aboriginal and Torres Strait Islander community while maintaining full integration with the rest of CAHMA's services. The Connection, like the rest of CAHMA, is peer-based and peer-led. Across CAHMA and The Connection, the aim is to promote the health and human rights of people who use drugs (or who have used drugs) in the ACT.

All staff at CAHMA and The Connection are peers: people with current or past experience of drug use. **Staff at CAHMA emphasise that the leadership of peers contributes to a person-centred environment in which people are supported and encouraged to speak on their own behalf and participate directly in decisions about their own health and lives.** CAHMA and The Connection are primarily funded from public sources at both the territorial and federal level, but staff report that they are drastically underfunded.

Integrated services

A guiding principle of CAHMA is that people who use drugs should be treated with dignity and respect. This means not only respecting them as a consumer of health services, but also as human beings. **Providing holistic care that touches on all aspects of health and social wellbeing is important in instilling a sense of self-worth, pride and community that can be damaged by discrimination and stigma experienced elsewhere.** All services provided at CAHMA and The Connection are highly integrated. Most staff are trained to work across the programmes, and the organisation operates in a way that minimises barriers (such as paperwork) to moving between different services.

The community drop-in centre is the primary point of contact for most clients. It is open five days a week from 10:00 to 16:00. The centre provides a space where people can drop-in without an appointment and relax, talk to peers (both staff and clients) and have a tea or coffee. Crucially, they can also engage with other services that CAHMA offer or get information about and referrals to services provided elsewhere. It ensures that people who use drugs in the ACT have a space that is safe and non-judgemental.

The drop-in centre also hosts The Connection. This consists of three self-identified Aboriginal peer workers who work across CAHMA's services. **Their**

c With thanks to Chris Gough, as well as Gaby Bruning and Sione Crawford

purpose is to ensure that services are fully accessible and acceptable to Aboriginal and Torres Strait Islander clients by ensuring that they have culturally secure support. A culturally safe environment also helps to build trust and rapport between staff and clients, and increasing mutual understanding by building on common experiences.

Elements of culturally safe care at The Connection include employing people from the community to provide services, ensuring that representations of the culture are present in services (for example, artworks and colour schemes), and ensuring that all staff are aware of the cultural, social and political context and history of Indigenous communities in Australia. Alongside the other services at CAHMA, The Connection arranges wellbeing groups and group art workshops built around Aboriginal techniques (that are open to both Aboriginal and non-Aboriginal clients).

Health services on-site at CAHMA are delivered in collaboration with publicly funded organisations. For example, the CAHMA Clinic is a weekly clinical 'in-reach' programme with support from Directions Health Services, seeking to ensure CAHMA clients have easy access to primary health care without a need to travel to or make appointments at an independent health centre. Every Wednesday, clients can access opioid agonist therapy, hepatitis C screening and treatment, general and sexual health check-ups, mental health consultations and specialist referrals.

On-site health services are complemented by extensive outreach: CAHMA puts on an outreach barbecue and primary health clinic at a different location five days per week. People from marginalised groups can have a meal at the barbecue and engage with CAHMA peer workers, building a trusting and supportive environment. At the same time and location, Directions Health Services attend with a mobile clinic, where people can access the same primary health services that are available at the weekly drop-in clinic.

In 2012, CAHMA launched Australia's first peer-administered naloxone programme. The programme, provides overdose response and naloxone training and doses of intranasal naloxone to anyone likely to witness an overdose, in particular targeting people leaving prison, Aboriginal and Torres Strait Islander people, and people who use opioids and their families, friends and carers. Finally, CAHMA runs a volunteer and community development programme. This consists of structured training across five modules covering peer-based harm reduction interventions, partnerships with other community organisations, and employment and professional skills.

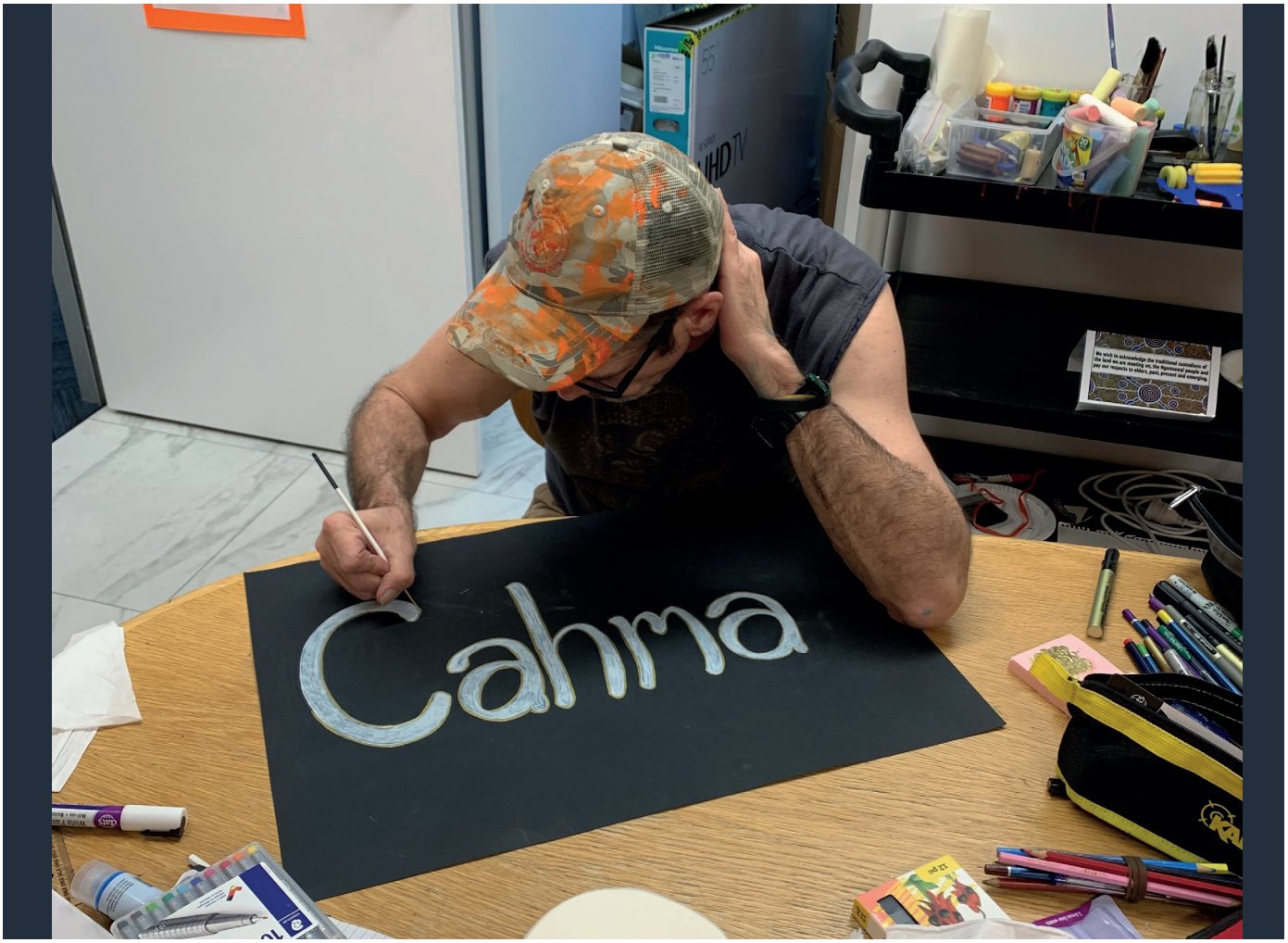
Links to other services and organisations

Aside from extensive collaboration to with Directions Health Services at the drop-in centre and in outreach, CAHMA provide extensive support to clients when engaging with the broader health system, as well as social and legal services. This includes providing linkage to youth services, women's services (such as for women experiencing homelessness or gender-based violence), and services for people experiencing homelessness or extreme poverty. All of the services CAHMA works with make specific adaptations for Aboriginal and Torres Strait Islander communities.

The Peer Treatment Support Service pairs up clients and peer workers to put together a personal support plan incorporating all of the client's health and social needs. Working with this plan, peers can support clients to access and navigate the health system and housing, legal and other community services, including providing transport to appointments and attending appointments with the client (where requested and appropriate).

Key lessons

- The leadership of peers eases the building of trusting relationships and ensures that people are treated as full human beings, not just patients.
- Ensuring a culturally safe environment for Indigenous communities makes services more accessible and acceptable to people who may otherwise be marginalised.
- Holistic care and support can build self-worth, pride and solidarity, and combat the effects of stigma and discrimination.



Photography courtesy of: The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)

SPARSHA NEPAL[d]

✔	Needle and syringe programme
✔	Opioid agonist therapy
✔	Tuberculosis screening, testing and treatment
✔	HIV screening, testing, treatment and counselling
✔	Sexually transmitted infection screening

✔	Hepatitis C screening, testing and treatment
✔	Opportunistic infection treatment
✔	Temporary accommodation
✔	Linkage to health services

Background

SPARSHA Nepal (Society for Positive Atmosphere and Related Support to HIV and AIDS in Nepal) has its origins in a peer support group of people living with HIV in 2002 in Lalitpur, Nepal. They registered as a non-governmental organisation in 2004, and began to lobby for community-based anti-retroviral therapy (ART) at a time when the government only had capacity to treat 30 people at a time. The organisation's funding is primarily international and non-governmental, though their ART and tuberculosis (TB) treatment is funded by the national and local government.

Integrated services

SPARSHA's integrated services grew in accordance with the needs of their clients. First and foremost, integration is a recognition that people require a range of services, and these were most easily accessible in a single 'one-stop shop'. They found that integration reduced confusion and supported adherence, by simplifying the process of accessing several different health services at once. From its origins as a peer support group, SPARSHA has always been based in and led by the community. The services they provide emerged in response to the observed and experienced needs of people living with HIV and people who use drugs. With each new service, more clients were reached with different needs, which the organisation adapted to meet.

Peer-led outreach is the means by which the vast majority of clients are first reached, mostly through the needle and syringe programme (NSP) or community-led testing. From that initial point of contact, clients are referred to the other services SPARSHA can offer according to their needs. For example, if someone tests positive for HIV, TB or hepatitis C, they are linked to SPARSHA's primary health services at the drop-in centre. Volunteers are also available to accompany people to services where appropriate. Outreach is complemented by 'in-reach' – where peers can refer people in contact with one of SPARSHA's services to another. For example, a client on ART may be referred to the opioid agonist therapy (OAT) programme if it is appropriate to their needs and aims.

At the 'one-stop shop' drop-in centre, the medical and social support team work together to assess the health and psychosocial status of each client, and develop individual plans that respect the client's wants and needs. This might include testing, treatment or counselling for HIV, hepatitis C or TB, as well as OAT. Care is co-ordinated where there are comorbidities; for example, for someone who tests positive for both TB and HIV, ART may be delayed until after TB treatment in accordance with international guidelines.

SPARSHA is the only non-governmental organisation in Nepal that provides an ART clinic. Before the COVID-19 pandemic, multi-month dispensing of ART was already available for those for whom it

d With thanks to Prawchan KC, Senior Programme Manager at SPARSHA Nepal.

was necessary, either from the drop-in centre or through home delivery by the outreach team. This was expanded after the pandemic, and there was also a shift from clinic-based distribution to home delivery. In normal times, to support adherence and habit-building, there is also the possibility for clients initiated on HIV or TB treatment to stay overnight at the drop-in centre.

From 2015, SPARSHA has provided OAT. In the early period, integrating OAT into the other established health services raised community concerns about the congregation of people who use drugs in the area. However, once the OAT programme was established, these concerns were quickly assuaged by the professional delivery of the service and its positive impact not only on the lives of those accessing it, but also on perceived crime and disorder in the neighbourhood. OAT is usually provided through daily attendance at the clinic (providing another opportunity for linkage to other services), though during the COVID-19 pandemic take-home doses for up to seven days were permitted by the Nepali Ministry of Home Affairs for the first time. Despite the success of this programme, SPARSHA expect this to be limited again by the government once pandemic-related restrictions are lifted. OAT clients meet once per week with a trained counsellor, and regularly see a doctor who can monitor or adjust their dosage according to their preferences.

Integration with other organisations

SPARSHA place significant emphasis on the integration of their services with the wider community, and their role in reducing stigma and discrimination towards people who inject drugs and people living with HIV. This is done partly through 'social marketing': providing education and awareness-raising to local people and institutions, such as the police or during festivals. For example, during religious festivals SPARSHA have collaborated with youth clubs to provide free HIV testing and information on SPARSHA's activities and clients.

SPARSHA also maintain strong links with other health services. They collaborate with teams of doctors to provide HIV testing services in resource-limited settings and rural areas outside the range of their outreach teams. In those cases, the doctors inform clients about SPARSHA's drop-in centre and the services they provide, including HIV, hepatitis C and TB prevention testing and treatment as well as harm reduction. More broadly, SPARSHA refer their clients to other health services where issues cannot be addressed internally.

Women make up around one in ten people who inject drugs in Nepal. Recognising that harm reduction services in Nepal are largely targeted at men, and that coverage among women was extremely low, SPARSHA recently expanded their offer for women. They opened a specific drop-in centre for women, serving almost 200 women. However, they have since handed over the management of this centre to a women-led organisation, recognising the importance of being able to understand the needs and concerns of clients in order to provide them with holistic care.

Key lessons

- **Integrating services makes them easier for clients to navigate, and can support them to engage more effectively.**
- **Collaboration in multidisciplinary teams can ensure that integrated services are complementary.**
- **Sometimes it is necessary to recognise the limits of integration under one roof: some services might be better delivered separately.**

Photograph courtesy of: Society for Positive Atmosphere and Related Support to HIV and AIDS in Nepal (SPARSHA Nepal)

Lisbon, Portugal

CRESCER[e]

✓	Needle and syringe programme
✓	Safer smoking equipment
✓	Housing First
✓	Hepatitis C testing and treatment
✓	Safe space
✓	Basic needs: Clothes, showers and snacks
✓	Recreation: Library, computers and TV
✓	Condoms and lubricants
✓	Prescription delivery

✓	Health consultations
✓	Psychosocial, psychological and psychiatric consultations
✓	Employment programmes
✓	Linkage to opioid agonist therapy
✓	Linkage to health services
✓	Linkage to social services
✓	Linkage to legal services

Background

CRESCER is a non-governmental organisation in Lisbon, Portugal. Founded in 2001, they provide harm reduction and other services for approximately 2,000 people annually, including people who use drugs and people experiencing homelessness. In 2002, they began an outreach project, É UMA RUA ('It's a street'), and in 2013 they established a drop-in centre, Espaço Âncora ('Anchor Space'), and a housing first programme, É UMA CASA, Lisboa Housing First ('It's a home'). Each of CRESCER's 15 projects have their own funding, with support primarily coming from public bodies including local and national government bodies and the European Union. Paid peer workers have been included among CRESCER's staff since 2002, and account for around a quarter of employees.

Integrated services

Each of CRESCER's projects operate independently, but with strong pathways of referral and access between them according to their clients' needs. According to staff at CRESCER, the focus on integrated services reflects a holistic approach to their clients. Services are focused on the person as a whole and their priorities, rather than identifying individual 'problems'. This produces effective responses that are grounded in the lived experience of individuals. Co-ordination between clients, teams, projects and organisations means that clients have easy access to all the services they need and they can cultivate warm, trusting and respectful relationships.

É UMA RUA is CRESCER's outreach programme for people who use drugs and people experiencing homelessness. They deliver harm reduction commodities, including sterile injecting equipment and safer smoking equipment, naloxone (when available), information on harm reduction and health promotion, and sexual and menstrual health products. In 2020, they delivered almost 40,000 injecting kits. The multidisciplinary outreach teams include peer educators, nurses, social workers, psychologists and a psychiatric doctor (once a week), and can also carry out mental and physical health consultations and deliver prescription medication on their daily routes. Since 2018, É UMA RUA has been accompanied by the REACH-U project, targeting micro-elimination of hepatitis C in the community. **Through this project, clients can access the entire continuum of hepatitis C care without ever needing to attend a hospital or clinic.**

e With thanks to Américo Nave, Rita Lopes, Maria Bento Carmona & Carlos Morgado.

É UMA CASA, Lisboa Housing First was launched in 2013, and now has 120 apartments scattered across Lisbon. The project provides immediate access to permanent, independent and individual housing, in apartments that are rented by CRESCER from the private rental market. CRESCER's outreach teams, as well as other non-governmental organisations working with people experiencing homelessness, are essential to identifying people who would benefit from É UMA CASA, Lisboa Housing First. **Tenants are generally chronically homeless, use drugs in a way that causes them health or social problems, have comorbidities (such as HIV or hepatitis C), and are otherwise extremely vulnerable due to factors like social isolation and a lack of trust in health and social services. There is no requirement that they abstain from drug or alcohol use or that they are Portuguese nationals (or even have documented migrant status), and they can bring pets with them.**

Each tenant has 24-hour individual support, for long term issues and acute crises. CRESCER provide tenants with harm reduction materials and information, and can refer and accompany them to other harm reduction, health and social services. Apartments come fully furnished, and CRESCER also support tenants with redecoration and maintenance to create a home. Case managers can also assist tenants to manage their finances in accordance with the clients' ambitions and if they request assistance. If people want to move out of CRESCER's apartments, they can be supported to search for new accommodation in the private market, if necessary.

All clients in contact with É UMA RUA and É UMA CASA, Lisboa Housing First can also make use of Espaço Âncora (Anchor Space), CRESCER's drop-in centre. The range of services and activities available is broad, including access to safe injecting and smoking equipment, clothes, a library, computers, showers, televisions and snacks. They also put on guided activities to promote social skills, new interests and friendships, including workshops, theatre groups and painting studios. Above all, the emphasis at Espaço Âncora is on trust. **This makes it a place of unconditional support, care and learning, where clients can take advantage of services and activities as they wish and based on their personal needs and objectives.**

Links to other organisations and services

CRESCER maintains close links to other organisations and services, ensuring strong referral pathways for their clients. **The frameworks established after the 2001 decriminalisation of drugs in Portugal are particularly focussed on health.** For example, the *equipas de tratamento* ('treatment teams') enable referral to low threshold OAT services or drug treatment where appropriate to the objectives of the client. The outreach teams refer clients to infectious disease testing, treatment and counselling where this cannot be delivered by CRESCER. In 2020, the team made more than 800 such referrals.

Alongside this, CRESCER also links to social services. They can refer people to shelters or employment services. They also have connections with the *Santa Casa da Misericordia*, an organisation with an important role in the provision of social security in Portugal. In 2020, the outreach team recorded more than 260 referrals to social services. Each time a new tenant joins É UMA CASA, Lisboa Housing First, one of the first things the team does is to register the person at the parish council, so that they can benefit from potential support and services, and at the health centre in their area of residence.

CRESCER ensures that clients and tenants have access to legal services where necessary. This means supporting them to obtain identification documents

or normalise their migration status, including engagement with embassies. CRESCER partner with Pro Bono, a network of lawyers who work for free for third sector organisations; clients in need of legal support can be referred to this network.

Key lessons

- **Even complex services, like blood tests and consultations, can be delivered in a way that places minimal burdens on clients' time and resources.**
- **Service integration is about making services accessible and empowering people to use them, without pressure or obligation.**
- **Enabling political and legal environments support greater integration and accessibility.**

MUSLIM EDUCATION AND WELFARE ASSOCIATION[f]

Coast Province, Kenya

✔	Needle and syringe programme
✔	Opioid agonist therapy
✔	Opioid agonist therapy in prison
✔	Overdose first aid training
✔	Tuberculosis screening, testing and treatment
✔	HIV screening, testing, treatment and counselling
✔	STI screening, testing and treatment
✔	Hepatitis C screening, testing and treatment

✔	Gender-based violence services
✔	Sexual and reproductive health services
✔	Legal support
✔	Linkage to health services
✔	Drug rehabilitation services
✔	Advocacy work on drug policy reforms
✔	Entrepreneurship skills building

Background

The Muslim Education and Welfare Associated (MEWA) was founded in 1994, with the aim of providing education and health services for local communities in Mombasa, Kilifi and Lamu on the Kenyan Coast. In 2007, the organisation began its harm reduction programme, recognising that people who use drugs (and particularly those who inject), were at increased risk of getting HIV and hepatitis C. MEWA is funded by a range of international donors, including state bodies, international organisations and non-governmental organisations.

Integrated services

According to MEWA staff, integrating services means you have a one-stop shop for all services. It aids in optimising client care and can help to bridge any missed opportunities to provide services. Integrated services creates an enabling environment to provide a continuum of health, harm reduction and legal rights, further accelerates drug policy reforms. The involvement of people who use drugs has been a key part of MEWA's success. The organisation employs paid peer workers in the community-based harm reduction services, as well as those working on a voluntary basis.

MEWA's services are extensive. They include: a needle and syringe programme (NSP); screening, testing and treatment for HIV, tuberculosis (TB), sexually transmitted infections (STIs), and hepatitis B and C; training and capacity building for peer networks; temporary shelter for women; entrepreneurship programmes; paralegal and prison services; documentation of human rights violations; and research and advocacy for drug policy reform. These services are delivered through an outreach programme and drop-in centre, with both branches integrating a range of services, and facilitating linkage between the two.

Outreach in locations of drug use is peer-led, and provides access to commodities including condoms and sterile injecting equipment. At the same time, they also provide information on HIV and STIs, gender-based violence, sexual and reproductive health (SRH) services, and OAT. The programme also has infrastructure to distribute naloxone, but scarcity

f With thanks to Fatma Jeneby, Programme Clinical Coordinator

of the medication in Kenya means this is rarely operationalised. MEWA continue to train outreach workers and peer educators on how to recognise overdose, apply first aid and use naloxone.

Case managers and peer navigators in the outreach teams work to identify clients, maintain contact and provide support and referrals where needed. Around two thirds of screening for HIV, TB and STIs takes place at outreach locations, and 90% of that in locations of drug use. Outreach workers use syndromic management — essentially a conversation with clients about their symptoms and experiences — to identify possible cases. People who need a full test are then referred to the drop-in centre, where they can also access treatment and counselling in case of a positive test (see below). **Outreach workers frequently even take clients to the drop-in centre themselves by motorbike.**

Services available at or through the drop-in centre include testing, screening and treatment for HIV, STIs, viral hepatitis and TB, OAT with either methadone or buprenorphine, psychosocial services, family planning, SRH and gender-based violence services, and legal and juridical services.

MEWA's legal and juridical services include assistance in court cases, support with acquiring legal documents (including identification), and following up on cases of police violence towards people who use drugs. **By providing these services in an environment in which drug use is accepted and not stigmatised, and staff have a pre-existing relationship with clients, MEWA can serve people who may otherwise be deterred from seeking such support.**

Integrated services specifically tailored to the needs of women who use drugs are another crucial part of MEWA's offer. Through its community-based outreach and 'in-reach' (referring clients between the different services within MEWA), the organisation has integrated family planning and other SRH services. For example, in 2020, 432 women accessed family planning services at the drop-in centre. With regard to gender-based violence, MEWA ensures that all cases reported to anyone in the organisation are recorded. Women can also access a women-only temporary shelter at the MEWA centre.

Integration with other services and organisations

MEWA maintains strong links with other organisations and institutions, providing another way of ensuring that their clients have access to a full range of services. For example, local political and cultural institutions, such as religious and community leaders, district commissioners and village elders all work closely with MEWA to refer clients in need of health and harm reduction services.

MEWA also work closely with the national Ministry of Health. In terms of service integration, MEWA acts as a first port of call that can refer people onwards to services of the national health system. Close collaboration with the Ministry of Health also strengthens MEWA's own integrated services: HIV and TB medication, condoms and contraceptives are provided by the ministry, as well as data collection and reporting tools that are essential to MEWA's monitoring and evaluation of their services.

Working relationships with law enforcement and the judicial system are also important in MEWA's ability to provide or facilitate the right range of services for their clients. For people in prison, MEWA is mandated to provide OAT with methadone. **To do this effectively, MEWA used their knowledge of the community and particularly their experience with challenges in maintaining OAT in the transition between the community and prison.**

Key lessons

- Small actions can make a big difference to accessibility, for example, bolstering service integration by offering transport to fixed sites.
- Providing integrated services means organisations are more attuned to the needs and challenges of their clients.
- Treating people with respect and dignity supports trusting relationships, and broadens the range of services that are possible.

Photography courtesy of: The Muslim Education and Welfare Associated (MEWA)

Montréal, Canada

KONTAK[g]

✔	Needle and syringe programme
✔	Safer smoking equipment
✔	Naloxone kits
✔	Fentanyl testing strips
✔	Counselling

✔	Workshops
✔	HIV & STI information
✔	Condoms, lubricants and sex equipment
✔	Linkage to health services

History and context

Kontak is a programme run by AIDS Community Care Montréal, a non-governmental organisation in Montréal, Canada. It is a harm reduction programme by and for gay, bisexual and queer men who have sex with men, with a special focus on people who use drugs during sex and sex parties (often known as chemsex or party'n'play). The service was launched in its current form in 2013 in response to the growing presence of a chemsex scene in Montréal. Since its foundation, Kontak has been community-led. Staff and volunteers all have experience of the intersection between sex and drug use, and all are drawn from the community of men who have sex with men.

Integrated services

By launching a programme providing a range of relevant services, and ensuring linkage and accompaniment to those services provided by other institutions, Kontak make the full package of services more accessible. Vitally, the peer-led nature of the project means they are well placed to build compassionate, non-judgemental and trusting relationships with their clients. In treating their clients as rounded people, and not concentrating exclusively on particular concerns (such as drug use or HIV status), they are better able to challenge the stigma that their clients can experience in non-specialised and non-integrated services.

Kontak primarily engages clients directly through outreach. This includes attending neighbourhood circuit parties, LGBT community spaces (such as clubs), and private parties when invited. During this outreach, Kontak staff and volunteers are available to answer questions about sexual health and harm reduction, and distribute a range of free harm reduction commodities. Among the commodities are condoms and lubricants, needles, syringes, cookers, alcohol swabs and tourniquets, and safer smoking equipment designed for use with crack cocaine or crystal methamphetamine as appropriate. **In addition, Kontak also sell (at cost price) specific equipment relevant to chemsex and sex parties, such as silicon-based lubricants, Latex gloves and silicon sex toys, all of which can contribute to a lower risk of STI transmission.**

In cases where clients may be at risk of fentanyl contamination in their stimulants, Kontak distributes fentanyl test strips (that can identify if fentanyl is present in a substance), and can provide naloxone training and distribution.

Alongside harm reduction commodities, Kontak also educates their clients about staying safe during chemsex. When attending sex parties, they give impromptu workshops on request on a range of subjects, from safe injection to how to care for sex toys. This is paired with an online presence, where they collate information and resources from other

g With thanks to DJ Laroche and Alexandre Fafard

organisations (as well as their own advice) on a broad range of issues related to sex, sexuality and drug use. They can also be accessed directly online through Facebook Messenger instant messaging and extend their outreach to hook-up apps and websites. Crucial to all this education is a strong emphasis on mutual respect, consent and non-discrimination: sections of Kontak's 'tips'n'tricks' website are dedicated to 'looking out for each other' and 'looking out for yourself'.

During outreach, Kontak also make clear to clients that they are available for non-judgemental, peer-led counselling sessions. These can cover any subject that might be causing people problems, including sex, sexuality and gender identity; sexual violence; stigma and discrimination; alcohol, drugs and harm reduction; STIs, HIV, testing and pre- and post-exposure prophylaxis (PrEP and PEP); or self-care, social life and community building. **Though they are not licensed counsellors, as a peer-based service all workers are members of the LGBT community and have lived experience with many of the concerns faced by their clients.**

Finally, Kontak also provide four streams of workshops relevant to the needs of their clients. They cover topics such as harm reduction, sex and pleasure and issues faced by trans men, as well as any other subject on request from clients. These workshops can be provided as one-off trainings or as a structured series. They are available to individuals and community organisations.

Integration with other organisations

Ensuring that people know where they can go for health and social services is a core part of Kontak's work. Both online and during outreach, peer workers are available to refer people to a range of services, provided both by the public health system and by other non-governmental organisations. This can include referrals for HIV testing and treatment, PEP and PrEP, drugs services, counselling and sexual health services. **By seeking a referral from the Kontak team, clients are assured that they will be referred to a service that understands their needs, is non-judgemental and non-stigmatising: what Kontak's website call "our favourite non-discriminatory clinics".** Examples include Clinique L'Actuel, a public sexual health clinic, and Ça Prend Un Village, a peer-led programme for people seeking to reduce their methamphetamine use.

In addition, Kontak's parent organisation, ACCM, is a community-based organisation that exists to support people living with HIV and hepatitis C. Kontak's clients can be referred to ACCM for peer support, practical assistance, and information on accessing treatment through Canada's public health system. They also co-ordinate sex education projects that promote wellbeing and self-confidence. While ACCM primarily serves Quebec's English-speaking population, Kontak is also closely associated with ACCM's French-speaking equivalent organisation, RÉZO.

Kontak also engages with other organisations to educate and train them on the needs of people engaging in chemsex, including other community organisations, sexual health clinics, universities and the provincial Department of Public Health. They run trainings on subjects such as chemsex intervention and the sexual health of queer Trans men. Finally, they maintain an outreach and educational presence at major events and locations in Quebec, such as Black & Blue (a large 'LGBT party festival'), Bal-en-Blanc (an annual rave in Montréal) and Camping Plein Bois (a resort specifically designed for gay men).

Key lessons

- Peer-leaders in integrated services have a unique insight into the lives and experiences of their clients, and can use that to provide compassionate and non-judgemental services
- Integrated services understand the barriers their clients face when accessing external services, and can ensure that clients are referred to the most appropriate options
- Integrated services know their context and clients, and can make sure they have access to the most relevant and safest commodities

REFERENCES

1. International AIDS Society. IAS statement at the Seventy-fourth World Health Assembly: Follow the science [Internet]. 2021;Available from: https://www.iasociety.org/The-latest/News/ArticleID/271/IAS-statement-at-the-Seventy-fourth-World-Health-Assembly-Follow-the-science
2. Soto TA, Bell J, Pillen MB, For The Hiv/aids Treatment Adherence HO, Group CS. Literature on integrated HIV care: a review. AIDS Care 2004;16(sup1):43–55.
3. Legido-Quigley H, Montgomery CM, Khan P, Atun R, Fakoya A, Getahun H, et al. Integrating tuberculosis and HIV services in low- and middle-income countries: a systematic review. Tropical Medicine & International Health 2013;18(2):199–211.
4. Haldane V, Cervero-Liceras F, Chuah FL, Ong SE, Murphy G, Sigfrid L, et al. Integrating HIV and substance use services: a systematic review. Journal of the International AIDS Society 2017;20(1):21585.
5. Cepeda JA, Bórquez A, Magana C, Vo A, Rafful C, Rangel G, et al. Modelling integrated antiretroviral treatment and harm reduction services on HIV and overdose among people who inject drugs in Tijuana, Mexico. Journal of the International AIDS Society 2020;23(S1):e25493.
6. Rich KM, Bia J, Altice FL, Feinberg J. Integrated Models of Care for Individuals with Opioid Use Disorder: How Do We Prevent HIV and HCV? Curr HIV/AIDS Rep 2018;15(3):266–75.
7. Shirley-Beavan S, Roig A, Burke-Shyne N, Daniels C, Csak R. Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain. Harm Reduction Journal 2020;17(1):78.
8. Sweeney S, Obure CD, Maier CB, Greener R, Dehne K, Vassall A. Costs and efficiency of integrating HIV/AIDS services with other health services: a systematic review of evidence and experience. Sex Transm Infect 2012;88(2):85–99.
9. Marshall Z, Dechman MK, Minichiello A, Alcock L, Harris GE. Peering into the literature: A systematic review of the roles of people who inject drugs in harm reduction initiatives. Drug and Alcohol Dependence 2015;151:1–14.
10. Chang J, Shelly S, Busz M, Stoicescu C, Iryawan AR, Madybaeva D, et al. Peer driven or driven peers? A rapid review of peer involvement of people who use drugs in HIV and harm reduction services in low- and middle-income countries. Harm Reduction Journal 2021;18(1):15.
11. Ayon S, Jeneby F, Hamid F, Badhrus A, Abdulrahman T, Mburu G. Developing integrated community-based HIV prevention, harm reduction, and sexual and reproductive health services for women who inject drugs. Reproductive Health 2019;16(1):59.
12. Church K, Mayhew SH. Integration of STI and HIV Prevention, Care, and Treatment into Family Planning Services: A Review of the Literature. Studies in Family Planning 2009;40(3):171–86.
13. EHRA. Harm reduction programmes during the COVID-19 crisis in Central and Eastern Europe and Central Asia. Vilnius: Eurasian Harm Reduction Association; 2020.
14. Enos G. Harm-reduction groups in prime position to combat multiple epidemics locally. Alcoholism & Drug Abuse Weekly 2020;32(42):1–8.
15. Iversen J, Sabin K, Chang J, Thomas RM, Prestage G, Strathdee SA, et al. COVID-19, HIV and key populations: cross-cutting issues and the need for population-specific responses. Journal of the International AIDS Society 2020;23(10):e25632.
16. Sagaon-Teyssier L, Yattassaye A, Bourrelly M, Dembélé Keïta B, Spire B. The COVID-19 response must integrate people living with HIV needs in Sub-Saharan Africa: the case of Mali. Tropical Medicine and Health 2020;48(1):41.
17. Marcus TS, Heese J, Scheibe A, Shelly S, Lalla SX, Hugo JF. Harm reduction in an emergency response to homelessness during South Africa's COVID-19 lockdown. Harm Reduction Journal 2020;17(1):60.
18. Welle-Strand G, Skurtveit S, Clausen T, Sundal C, Gjersing L. COVID-19 survey among people who use drugs in three cities in Norway. Drug and Alcohol Dependence 2020;217:108302.
19. Heimer R, McNeil R, Vlahov D. A Community Responds to the COVID-19 Pandemic: a Case Study in Protecting the Health and Human Rights of People Who Use Drugs. J Urban Health 2020;97(4):448–56.