FACILITATOR GUIDE

CAPACITY BUILDING PACKAGE FOR HARM REDUCTION, COVID-19 AND VACCINES TECHNICAL GUIDANCE

INTRODUCTION

The aim of this capacity building package is to build the capacity of harm reduction service providers, community and civil society organizations, decision makers, managers, physicians, and drug treatment professionals to:

1. Integrate the provision of accurate COVID-19 safety measures to lower client and harm reduction worker risk of COVID-19 infection
2. Advocate for the provision of COVID-19 vaccines to people who use drugs without discrimination
3. Facilitate the provision of COVID-19 vaccines at harm reduction services, (where law and policy allow)
4. Conduct COVID-19 vaccine outreach among clients of harm reduction services.

As the target audience is diverse, the facilitator should tailor the content according to the participants' characteristics. Harm reduction workers (harm reduction service staff, peers, outreach workers, administrators and volunteers) could benefit from more empowerment and advocacy-oriented training focusing on their experiences working on the ground, while a heterogenous group (different actors of the public health scene, e.g. harm reduction workers and physicians or decision makers) could highlight the central role of harm reduction services in reaching public health goals and focus on cooperation between different actors.

An important rationale to integrate COVID-19 vaccines to harm reduction services is that people who use drugs have multiple vulnerabilities to COVID-19, and they are often stigmatised and discriminated against in traditional health care settings. Harm reduction services are able to engage people who use drugs because they work with people without judgement or discrimination and without requiring abstinence as a precondition of support, treating people who use drugs with compassion and dignity. Although harm reduction services such as needle and syringe programmes (NSP) or opioid agonist treatment (OAT) are essential interventions in reaching HIV and hepatitis C prevention and treatment goals, the COVID-19 pandemic also demonstrated that harm reduction services are essential public health services.

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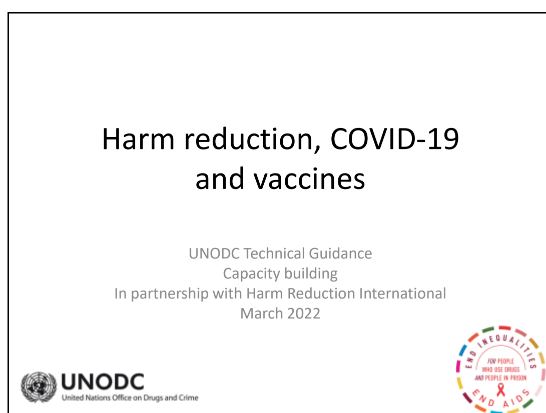
END INEQUALITIES
FOR PEOPLE WHO USE DRUGS AND PEOPLE IN PRISON
END AIDS

CAPACITY BUILDING OUTLINE

Topic	Approach	Time
1. Harm reduction services rising to the challenge		Total 25 min
Intro piece ▪ Disruptions around the world ▪ Key data on harm reduction service disruption ▪ Harm reduction services adaptable and dynamic – demonstrated their value	PPT Fac guide	5-10
Small groups or plenary – ▪ How has your service/organisation/network adapted to COVID-19? ▪ What has been your service/organisation/network experience on service disruption?	Fac guide	15
2. Maintaining good practice in the implementation of COVID-19 safety measures		Total 25 min
▪ Specific vulnerability of people who use and inject drugs ▪ Common barriers and feedback from PWUD Example from practice - video (3-5 min) ▪ COVID-19 and harm reduction services	PPT Fac guide Video	5-10
Small groups – ▪ What has worked well in your city in terms of rolling out COVID-19 safety measures? ▪ Where have major challenges arisen? ▪ Score your progress against the key action points (section 2 of the TG)	Fac guide	15
Plan for 10 min break		
3. Vaccines and harm reduction services		Total 70 min
Vaccinations ▪ Why integrate vaccines into harm reduction services?	PPT	30 min

▪ Planning (steps recommended, situational assessment, estimating the number of clients for vaccination) ▪ Establish links with public health authorities ▪ Advocacy for vaccines for people who use drugs ▪ Introduction to the three pathways ▪ 3 examples from practice for each path video (3, 5, 5 min)	Fac guide Videos	
Small groups and plenary ▪ Which pathway makes most sense in your city? Are there aspects of other pathways that could be adopted? ▪ Identify current challenges, advocacy targets [support development of plan for moving towards pathway] ▪ Group discussion 15-20min ▪ Report back in plenary and plenary discussion 15-20min	 Fac guide	30-40 min

SLIDE 1



Talking points:

- Facilitator can use power point presentation's title page and the slide with the headings and timing of the capacity building to introduce themselves and briefly summarise the topic and aims of the capacity building

SLIDE 2

Contents

1. Harm reduction services rising to the challenge (25mins)
2. Maintaining good practice in the implementation of COVID-19 safety measures (25mins)

10 minutes break

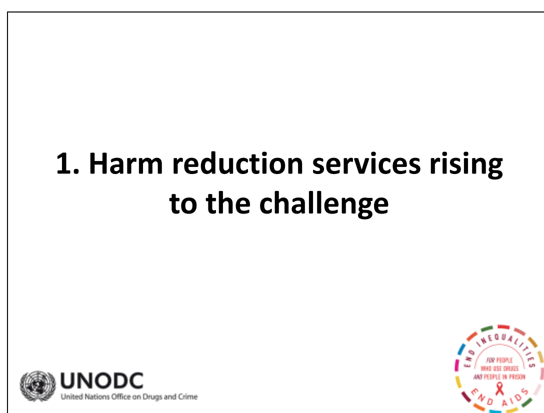
3. Vaccines and harm reduction services (70min)

Talking points:

- Facilitator can use this point to introduce themselves and briefly summarise the topic and aims of the capacity building.

1.HARM REDUCTION SERVICES RISING TO THE CHALLENGE

SLIDE 3



Talking points:

- This section is a summary of the consequences of the COVID-19 pandemic on harm reduction service delivery during the pandemic, focusing on service disruption during the beginning of the pandemic as the period in which adaptations and innovative measures were introduced. The section is based on the Background chapter of the technical guidance.

SLIDE 4

COVID-19 and harm reduction

The pandemic has highlighted:

- Civil society organisations and peer networks are pivotal in providing access to information and services
- Harm reduction services are key in linking key populations to other social and health care services
- Networks of people who use drugs are:
  - contributing to service delivery (e.g. secondary needle distr)
  - providing input for other harm reduction service providers
  - disseminating crucial information among the community of people who use drugs

Talking points:

- The pandemic highlighted the strengths and benefits of harm reduction services and community involvement in terms of public health. The points above are all inherent characteristics of harm reduction programmes and peer networks – the pandemic just made them more pronounced.

SLIDE 5

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Disruptions in service delivery

- Early 2020: COVID-19 measures (lockdown, physical distancing, etc) seriously disrupted harm reduction service delivery across the globe
- In 2020, harm reduction services were:
  - Completely disrupted in 30% of countries
  - Partially disrupted in 35% of countries
- End of 2021:
  Some level of disruption in half of the countries

Talking points:

- For details see Background chapter of the technical guidance.
- For details on disruptions in harm reduction service delivery across the globe see Global State of Harm Reduction 2020, COVID-19 chapter. For example:

  "Harm reduction service delivery has been disrupted by the pandemic. In Asia, accessing services due to quarantine and travel restrictions was a challenge, including receiving opioid agonist therapy (OAT) medications and HIV-related services. Access to OAT during the period of travel restrictions was also challenging in sub-Saharan Africa, where OAT is rarely available on a take-home basis. The closure of international borders caused disruptions to the supply of OAT medication in Eurasia and the COVID-related restructuring of government resources negatively impacted harm reduction programmes in countries in the Eurasian region. Funding for harm reduction services in Latin America and the Caribbean was also negatively impacted, with reports highlighting that outreach programmes were especially hindered by the limitation of movement and the introduction of physical distancing rules. Harm reduction services in most countries in the Middle East and North Africa faced similar problems. People who use drugs faced difficulties accessing services because of lockdown measures, while service providers had to reduce the number of working days or close entirely. Although the pandemic seriously affected service delivery and the coverage of harm reduction services in North America, Oceania and

Western Europe, the impact was less severe compared to other regions. For example, the majority of European Union countries reported a slight decrease or no change in availability of harm reduction services.

- For an example from practice on service adaptations at the beginning of the pandemic, the facilitator can use “Example of early adaptation and implementation of COVID-19 safety measures – AHRN, Myanmar” section of the technical guidance.

Suggested additional reading

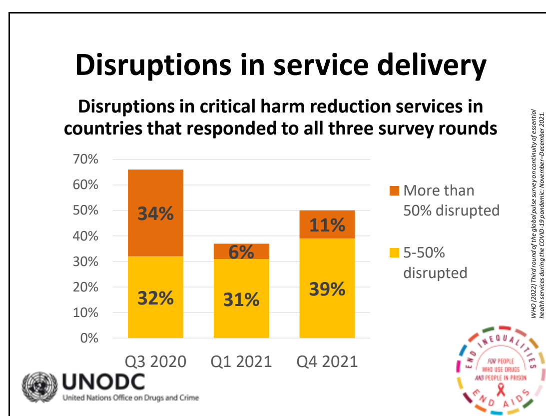
- WHO’s Pulse survey can be also a good additional source on service disruptions during COVID-19:

  WHO. Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report [Internet]. Geneva: World Health Organization; 2020. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1

  WHO. Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January-March 2021 [Internet]. Geneva: World Health Organization; 2021. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS-continuity-survey-2021.1

  WHO. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021 [Internet]. Geneva: World Health Organization; 2022. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1

SLIDE 6



Talking points

- There were serious disruptions in harm reduction services across the globe.
- Two thirds of the reporting countries experienced disruptions.
- One third of reporting countries experienced vital problems (more than 50% of services in the country disrupted)
- The issue still remains; though there was some improvement in Q1 2021, at the end of 2021 half of the reporting countries were still experiencing problems. However, there are fewer countries with serious disruptions.
- Disruptions are not distributed equally across regions, low- and middle-income countries are more heavily affected.
- See WHO report p11 for more details on differences between countries: "Some variation was seen in the percentage of services reported as disrupted by countries across regions and income groups. Overall, countries in the WHO Region of the Americas reported the highest average percentage of services disrupted in each country (55% in 27 countries versus 28% in 23 countries in the European region), although these findings should be interpreted with caution, given the varied response rates across regions. Regarding disruptions across any of the 66 tracer services, there was considerable variation by and within country income groups, with high-income countries generally reporting fewer services disrupted compared to lower-income countries (see Figure 2, below). 32 high-income countries reported an

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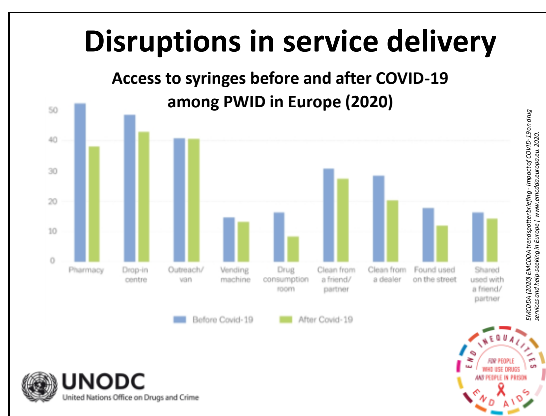
average of 34% of service disrupted, while 31 upper middle-income countries reported an average of 55% of services disrupted in country."

- Check WHO report for more details about the chart included. In the report, critical harm reduction services are defined by examples as "for example, needle exchange programmes, outreach services".

Data source

WHO. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November–December 2021. Geneva: World Health Organization; 2022. Available from: https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1

SLIDE 7



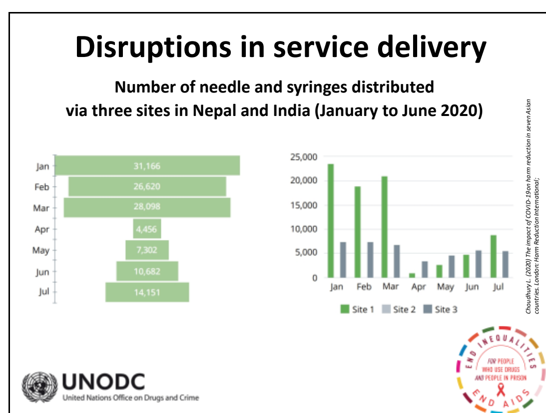
Talking points:

- The above chart is an illustration to show the extent of disruptions. Disruptions have been different in different regions.
- Access to syringes at drop-in centres and outreach settings were not hugely affected.
- There were disruptions, but in the majority of EU countries experienced only slight decrease or no change in the availability and provision of harm reduction services.
- See EMCDDA Trendspotter briefing for more details, especially: p3-5, p11-12

Data source

EMCDDA. EMCDDA trendspotter briefing - Impact of COVID-19 on drug services and help-seeking in Europe | www.emcdda.europa.eu. 2020. Available from: https://www.emcdda.europa.eu/publications/ad-hoc/impact-of-covid-19-on-drug-services-and-help-seeking-in-europe_en

SLIDE 8



Talking points:

- The above charts show the extent of disruptions in Nepal and India.
- Number of distributed syringes dropped significantly when the pandemic started, and physical distancing measures were introduced.
- See HRI report on the impact of COVID-19 on harm reduction in seven Asian countries for more details (especially p9-11).

Data source:

Choudhury L. The impact of COVID-19 on harm reduction in seven Asian countries. London: Harm Reduction International; 2020 Nov. Available from: https://www.hri.global/files/2020/12/07/HRI-COVID-Report.pdf

SLIDE 9

Adaptation to the pandemic reality 1/2

- Harm reduction services proved resilient, adapted quickly and effectively
- Adopted COVID-19 prevention measures, adjusted service delivery and methods to maintain service coverage
- Integrated innovative modes of service provision, for example:
  - mailing harm reduction equipment/commodities to clients
  - offering online, phone or video consultations
  - increased outreach activities

Talking points

- For details see Background chapter of the technical guidance.
- Facilitator could add local good practices from the ground on innovative service adaptations during COVID-19.
- Alternatively add examples from around the world. For example, on innovative practices at harm reduction services during COVID-19 see:

  Putri D, Shirley-Beavan S, Bridge J. Innovation and resilience in times of crisis (Part 2) the response from harm reduction services [Internet]. London: IDPC, HRI; 2021 Jul. Available from: https://idpc.net/publications/2021/07/innovation-and-resilience-in-times-of-crisis-part-2-the-response-to-covid-19-from-harm-reduction-services

  EHRA. Harm reduction service delivery to people who use drugs during a public health emergency: Examples from the COVID-19 pandemic in selected countries [Internet]. Vilnius: Eurasian Harm Reduction Association; 2020. Available from: https://harmreductioneurasia.org/covid-19-practices-english/

  HRI. Global State of Harm Reduction 2020 [Internet]. London: Harm Reduction International; 2020. Available from: https://www.hri.global/global-state-of-harm-reduction-2020

SLIDE 10

Adaptation to the pandemic reality 2/2

- Opioid agonist treatment regulations were eased in many countries
  - expanded take-home periods
  - home delivery of OAT or distribution in outreach settings
  - reduced waiting periods and initiation

Talking points

- For details see Background chapter of the technical guidance.
- Facilitator could add local good practices from the ground on innovative service adaptations during COVID-19.
- Alternatively add examples from around the world. For example, on innovative practices at harm reduction services during COVID-19 see:

  Putri D, Shirley-Beavan S, Bridge J. Innovation and resilience in times of crisis (Part 2) the response from harm reduction services [Internet]. London: IDPC, HRI; 2021 Jul. Available from: https://idpc.net/publications/2021/07/innovation-and-resilience-in-times-of-crisis-part-2-the-response-to-covid-19-from-harm-reduction-services

  EHRA. Harm reduction service delivery to people who use drugs during a public health emergency: Examples from the COVID-19 pandemic in selected countries [Internet]. Vilnius: Eurasian Harm Reduction Association; 2020. Available from: https://harmreductioneurasia.org/covid-19-practices-english/

  HRI. Global State of Harm Reduction 2020 [Internet]. London: Harm Reduction International; 2020. Available from: https://www.hri.global/global-state-of-harm-reduction-2020

SLIDE 11

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Discussion

- How has your service/organisation/network adapted to COVID-19?
- What has been your service/organisation/network experience on service disruption?

Interactive discussion guidance

- This can be done in small groups or in the plenary.
- The aim is to get the discussion going and give every participant a chance to speak (encourage active participation)
- Questions to help the discussion:

  - How has your service/organisation/network adapted to COVID-19?
  - What were the first weeks like? How were decisions made on adaptation? What were the main sources of information? What worked and what did not? (share practical examples)

    What has your service/organisation/network experience been regarding service disruption?

    Where does your region/city stand with respect to the severity of disruption? What types of services were disrupted the most? (e.g. needle exchange programmes, opioid agonist treatment, outreach services, mobile programmes, etc). Have you arrived to the point where your service coverage was before the pandemic?

2. MAINTAINING GOOD PRACTICE IN THE IMPLEMENTATION OF COVID-19 SAFETY MEASURES

SLIDE 12

2. Maintaining good practice in the implementation of COVID-19 safety measures

SLIDE 13

Vulnerability of PWUD and PWID

- Consequences of the pandemic disproportionally impacted the most marginalised and criminalised communities
- PWUD, PWID are more likely to experience social and economic disadvantage, stigma and discrimination
- PWID can have underlying medical conditions that enhance vulnerability, for example:
  HIV, viral hepatitis C, TB

Talking points

- For details see Background section of the technical guidance.
- Important to note here that people who use drugs (PWUD) are not vulnerable because of their actions, but because of structural factors, like stigma, discrimination and criminalisation are all increasing the risks that PWUD face. Moreover, PWUD often experience mistreatment and judgmental communication in healthcare settings, which forces them away from using those services. These structural forces together result in worse health outcomes and higher health risks for PWUD. The facilitator's framing and wording should reflect this.

Suggested additional reading

- The concept of risk environment could be useful to keep in mind.
  See for example:
  Rhodes T. The 'risk environment': a framework for understanding and reducing drug-related harm. International Journal of Drug Policy. 2002 Jun 1;13(2):85–94
  https://www.academia.edu/13894183/The_risk_environment_a_framework_for_understanding_and_reducing_drug_related_harm)

- On health inequalities and COVID-19 see the second chapter of this book (open access, link below):
  Bambra C, Lynch J, Smith KE, Pickett K. Pale rider: pandemic inequalities. In: The Unequal Pandemic. 1st ed. Bristol University Press; 2021. p. 13–34. (COVID-19 and Health Inequalities). Available from: http://www.jstor.org/stable/j.ctv1qp9gnf.9

- On special vulnerabilities of people who smoke crack cocaine, see:
  Harris M. An urgent impetus for action: safe inhalation interventions to reduce COVID-19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom. Int J Drug Policy. 2020 Jun 22; Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7306748/

SLIDE 14

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Vulnerability of PWUD and PWID

- People who smoke or inject drugs: higher risks and vulnerabilities of COVID-19
  - smoking or inhaling increases COVID-19 related risks
  - long history of opiate or stimulant use can lead to compromised immune sys.
- The COVID-19 measures and restrictions introduced (eg. physical distancing, isolation, stay at home, travel restrictions) also negatively affected people who use drugs.

Talking points

- For details see Background section of the technical guidance.
- Important to note here that PWUD are not vulnerable because of their actions, but because of structural factors, like stigma, discrimination and criminalisation that are all increasing the risks that PWUD face. Moreover, PWUD often experience mistreatment and judgmental communication in healthcare settings, which force them away from using those services. These structural forces together result in worse health outcomes and higher health risks for PWUD. The facilitator's framing and wording should reflect this.

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SLIDE 15

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Vulnerability of PWUD and PWID

- Restrictions disrupted access to services, and increased adverse mental health impacts
- These circumstances can also lead to an increased risk of drug use and overdose
- PWUD experiencing unstable housing may be less able to maintain self-isolation or adhere to physical distancing rules

Talking points

- For details see Background section.
- Regarding the circumstances leading to an increased risk of drug use and overdose mention:
  - increased drug use in riskier settings (using alone or stockpiling)
  - insufficient availability of harm reduction resources or OAT
- On PWUD being less able to maintain self-isolation or adhere to physical distancing rules, highlight, for example, that PWUD:
  - must access OAT or ART
  - need to buy drugs to avoid withdrawal

Suggested additional reading

- A good resource on COVID-19 and increased risks of drug use:
  Nguyen T, Buxton JA. Pathways between COVID-19 public health responses and increasing overdose risks: A rapid review and conceptual framework. International Journal of Drug Policy. 2021 Jul 1;93:103236.

SLIDE 16

Vulnerability of PWUD and PWID

- Practical examples from peers from Indonesia

Video

- Play the video “Practical examples from peers, Womxn's Voice, Indonesia” (3:25) where Maya talks about her experiences in the beginning of the COVID-19 pandemic.
- There is an option to add another video here “Practical examples from peers, AKSI, Indonesia” (2:39) which showcases more service provider focused experiences at the beginning of the pandemic.

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SLIDE 17

COVID-19 and harm reduction

Recommended steps for integrating COVID-19 measures:

- Carry out situational analysis for COVID-19 safety measures (local laws and policies, data sources, stakeholder analysis, programme resources)
- Implement service adaptations (integrate COVID-19 measures)
- Develop information materials (to ensure the availability of clear, accessible, evidence-based information)
- Train the harm reduction workers
- Ensure community involvement throughout

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Talking points

- For details see second chapter of the technical guidance “2. Planning for the implementation of the COVID-19 safety measures”.
- Acknowledge here that harm reduction service providers have worked hard since the outbreak of the pandemic to adapt their services. Working on the ground can be different from theory, and there might be circumstances where a full situational assessment is not feasible before a decision must be taken due to the rapidly changing extant environment. Throughout the COVID-19 pandemic, frontline harm reduction workers have demonstrated their ability to quickly adapt, often by learning through practice and responding to challenges as they emerged.
- The aim here is to reflect and see how service adaptations can be made and what the suggested steps would have been (a systematic, step-by-step guide which could be generalised and used for future service adaptations).

SLIDE 18

Situational analysis for COVID-19 measures

- Assessment of local law and policy environment, restrictions
- Identify national and local public health data sources that can be used to assess the pandemic risks and overall COVID-19 situation
- Identify relevant national and local public health actors
- Assessment of programme resources

Talking points

- For details see section “2.1. Situational analysis for COVID-19 safety measures”.
- Start with highlighting the importance of involving peers throughout, and especially at the situational analysis phase, as the community has invaluable and lived experience which is an essential input for the process.
  For example:
  - Involving peer networks and the community at the assessment phase is essential. Harm reduction services can adapt in different ways, and the community must be included in decision-making processes when choosing the most appropriate modality of service delivery in the specific context.
- For the “Identify relevant national and local public health actors” point highlight that harm reduction programmes might have already established most connections through their daily work.
- For the “Assessment of programme resources” point the facilitator might want to talk about the different types of programme resources that are relevant here, including: characteristics of the premises (physical characteristics, number of rooms available, etc.); knowledge base and skillset of the harm reduction workers; and online spaces of the programme.

SLIDE 19

Service adaptations

Essential measures to integrate:

- Face masks (+other PPE appropriate/accessible to the service)
- Physical distancing
- Strict hand hygiene, use of alcohol-based rubs or soap and water
- Regular cleaning and disinfecting (especially frequently touched surfaces)
- Limit the number of people in closed spaces to avoid crowded indoor settings
- Appropriate ventilation of indoor spaces

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Talking points

- For details see section “2.2. Service adaptations”
- As participant likely to already have these in place, it might be enough to quickly go through the list.

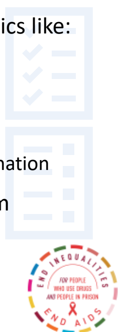
Interactive discussion guidance

- Might be an opportunity to have a brief interactive section. Ask participants what their experiences were and whether it was possible to integrate everything from the list. Is there anything missing? Is there another measure that should be included?
- Another option is to talk about the “Potential negative effects” box in the technical guidance.
- Service adaptations like physical distancing, masks and other personal protective equipment can have a negative effect on interactions with clients. Is it true? What were the participants’ experiences? How did they mitigate the negative effects of COVID-19 measures? Does this highlight the importance of strong communication with clients?

SLIDE 20

Develop information materials

- Information materials could include topics like:
  - COVID-19 prevention
  - Proper use of PPEs
  - Extent of travel bans, levels of lockdown, curfew times, etc
  - Information on vaccines and access to vaccination
- Promote/disseminate materials on harm reduction strategies for PWUD



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Talking points

- For details see section "2.3. Develop information materials"
- Highlight why it is important to have information, education and communication (IEC) materials at the harm reduction service.
- Facilitator can use the first paragraph of the section:
  "It is strategic for HIV harm reduction programmes providing services to disadvantaged, marginalised communities like people experiencing homelessness, indigenous peoples and undocumented migrants to focus on ensuring effective dissemination of clear, accessible, evidence-based information. Highly marginalised groups may have more limited access to reliable information on the pandemic and how it unfolds."
- About promoting/disseminating materials on harm reduction strategies for PWUD, facilitator can mention the following topics:
  - COVID-19 and other comorbidities for PWUD, PWID
  - Changes in OAT provision
  - Harm reduction advice for PWUD (mention that there are ready-to-use information materials on INPUD's website)
- When talking about harm reduction advice for PWUD, it is important to highlight the role of the community – a good example is the quick development of IEC materials by INPUD (these were available in the first weeks of the pandemic, around March 2020).

Suggested additional reading

- INPUD's COVID-19 resources website:
  https://inpud.net/covid-19-crisis-harm-reduction-resources-for-people-who-use-drugs/
  Scroll down for shareable leaflets:
  Harm Reduction Tips for Drug Users to Avoid COVID-19
  Harm Reduction Advice for Heroin/Opioid Users on Avoiding COVID-19
  Harm Reduction Tips for Avoiding COVID-19 while Drug Dealing
  Harm Reduction Tips for Avoiding COVID-19 when Buying Drugs

Interactive discussion guidance

- Participants might have already developed IEC materials over the past years, so this is a good opportunity for another discussion:
  - Were there good IEC materials available at the beginning of the pandemic?
  - Have you developed IEC materials? What worked? What was missing?

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SLIDE 21

Discussion

- What has worked well in your city in terms of rolling out COVID-19 safety measures?
- Where have the major challenges arisen?

Interactive discussion guidance

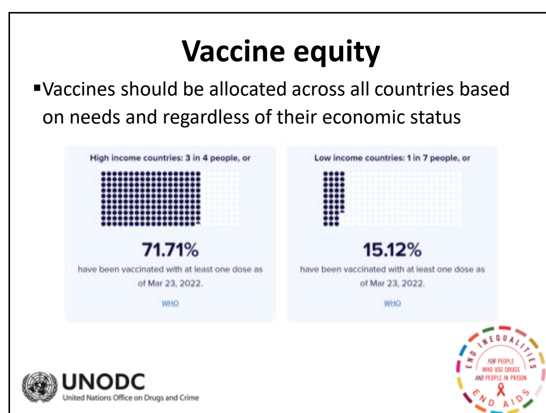
- Create small groups to discuss the question above.
- Allow 15 minutes for group discussion.
- If there is time left, it might be good to do a quick report back in plenary.
- Use the section titled "Summary of questions - checking your readiness for…" (at the end of chapter 2. Planning for the implementation of the COVID-19 safety measures) to facilitate discussion.
- Another option is to ask participants to score their progress against the key action points (section 2 of the Technical Guidance)
- Facilitator can add all questions to the slide above and leave it there during the group discussion, or print it out as a handout.

3. VACCINES AND HARM REDUCTION SERVICES

SLIDE 22

3. Vaccines and harm reduction services

SLIDE 23



Talking points

- Start the introduction to vaccine integration with acknowledging vaccine inequities.
- Main talking point:
  Globally, inequitable distribution of vaccines represents an overwhelming barrier to access. As of the beginning of March 2022, in high income countries more than two thirds of the population have been vaccinated with at least one dose, while just 15% of people in low-income countries have received one dose of the COVID-19 vaccine.
- See WHO data for more details: https://data.undp.org/vaccine-equity/

Suggestions

The figure is a screenshot, facilitator might want to replace it with most recent data: https://data.undp.org/vaccine-equity/accessibility/

SLIDE 24

Why integrate vaccines into harm reduction?

Two studies on COVID-19 vaccine hesitancy among PWID

- Melbourne, Australia (Dietze et al 2022):
  PWID: 58% would be vaccinated,
  20% undecided, 22% would not
- San Diego-Tijuana border region (Strathdee et al 2021)
  32,3% of PWID were hesitant
  to receive COVID-19 vaccine

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Talking points

- A brief introduction to vaccines integration, addressing why is it important to integrate COVID-19 vaccines into harm reduction services.
- Please refer to the introduction of the 3rd chapter (COVID-19 Vaccination Programme Planning) of the technical guidance.
- Add examples from local context on COVID-19 vaccine hesitancy in the general population. For example, anti-vaccine social media groups, demonstrations, political parties utilising anti-vaccine sentiments, etc.
- On PWUD experiencing discrimination and mistreatment in healthcare settings highlight that being repeatedly humiliated or treated poorly creates an offending environment, forcing PWUD away from these settings.

Suggested additional reading

- Examples on PWID mistreatment and stigmatisation in healthcare settings: Muncan, B., Walters, S. M., Ezell, J., & Ompad, D. C. (2020). "They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City. Harm reduction journal, 17(1), 53. https://doi.org/10.1186/s12954-020-00399-8

Graham R, Masters-Awatere B. Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. Australian and New Zealand Journal of Public Health 2020;44(3):193–200. https://onlinelibrary.wiley.com/share/GCF7GGPKHNENV4B6QXXM?target=10.1111/1753-6405.12971

Biancarelli DL, Biello KB, Childs E, Drainoni M, Salhaney P, Edeza A, et al. Strategies used by people who inject drugs to avoid stigma in healthcare settings. Drug Alcohol Depend. 2019 May 1;198:80–6.

El-Bassel, N., Strathdee, S. A., & El Sadr, W. M. (2013). HIV and people who use drugs in central Asia: confronting the perfect storm. Drug and alcohol dependence, 132 Suppl 1(0 1), S2–S6. https://doi.org/10.1016/j.drugalcdep.2013.07.020

Terlikbayeva, A., Zhussupov, B., Primbetova, S., Gilbert, L., Atabekov, N., Giyasova, G., Ruziev, M., Soliev, A., Saliev, D., & El-Bassel, N. (2013). Access to HIV counseling and testing among people who inject drugs in Central Asia: strategies for improving access and linkages to treatment and care. Drug and alcohol dependence, 132 Suppl 1(0 1), S61–S64. https://doi.org/10.1016/j.drugalcdep.2013.07.007

SLIDE 25

Why integrate vaccines into harm reduction?

Two studies on COVID-19 vaccine hesitancy among PWID

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  PWID: 58% would be vaccinated,
  20% undecided, 22% would not
- San Diego-Tijuana border region (Strathdee et al 2021)
  32,3% of PWID were hesitant
  to receive COVID-19 vaccine

Talking points

- When talking about the first study (Melbourne, Australia), add that in the general population of 79% would be vaccinated, and highlight that PWID most often cited safety concerns as a reason for vaccine hesitancy.
- Add about the second study (San Diego-Tijuana border region) that vaccine sceptics were generally younger, had higher education, homeless, had COVID-19, and used social media as their primary source of COVID-19 information.

Commented [UNODC HAS14]: It contradicts other listed factors in this sentence

Commented [RC15R14]: That was the result of the study: Of the 393 participants, 266 (67.7%) were willing to receive COVID-19 vaccines and 127 (32.3%) were hesitant (23.4% unwilling and 8.9% unsure). Compared to those who were willing to be vaccinated against COVID-19 (Table 2), vaccine-hesitant participants were younger (mean age: 40.5 vs. 43.3 years, p=.009) and had higher education (mean years of schooling completed: 10.1 vs. 9.0, p<.001). Higher proportions of vaccine-hesitant participants were born in the U.S. (57.5% vs. 33.5%, p<.001), currently resided in San Diego (57.5% vs. 44.4%, p=.01), and were homeless (51.2% vs. 37.2%, p=.009). Compared to other participants, those who felt that they had already had COVID-19 were more likely to be vaccine-hesitant (16.5% vs. 6%, p<0.001). See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8690110/

Interactive discussion guidance

- After briefly summarising the results of the studies ask participants about their experiences on the ground:
  - Have they experienced vaccine hesitancy among clients? How prevalent is vaccine hesitancy among their clients?What did they do when clients expressed vaccine-hesitant sentiments? Is there a practice that worked? (5 mins)

Suggested additional reading

- Studies on COVID-19 vaccine hesitancy among PWUD:
  Strathdee SA, Abramovitz D, Harvey-Vera A, Vera CF, Rangel G, Artamonova I, et al. Correlates of COVID-19 Vaccine Hesitancy among People who Inject Drugs in the San Diego-Tijuana Border Region. Clin Infect Dis. 2021 Nov 22;ciab975.

  Dietze PM, Hall C, Price O, Stewart AC, Crawford S, Peacock A, et al. COVID-19 vaccine acceptability among people in Australia who inject drugs: Implications for vaccine rollout. Drug and Alcohol Review. 2022;41(2):484–7.

SLIDE 26

Steps recommended

- Full situational assessment
- Estimate the number of clients that will require vaccination
- Establish links with public health authorities and other partners involved in the COVID-19 vaccination
- Identifying suitable pathways to integrate COVID-19 vaccines
- Identify the COVID-19 vaccination provider, and develop a vaccination plan
- Advocacy for vaccines for people who use drugs
- Develop a COVID-19 vaccine outreach plan and information materials
- Train harm reduction workers

Talking points

- It is important to acknowledge that harm reduction services have been quick to adapt and integrate innovative measures, and they most likely have integrated new programme elements in the past, so they are experienced and proficient in this topic.
- Furthermore, situations like the COVID-19 pandemic often require quick actions, where following each step by the book is not realistic. From this perspective, these recommendations could seem too theoretical and far from practice.
- This could be a good point to address this issue and acknowledge that the real world is not so clear-cut, though these are all steps that can contribute to well-founded, effective programme implementation.

SLIDE 27

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Full situational assessment

Aim: identify an appropriate and feasible way to integrate COVID-19 vaccination to harm reduction services

- **Meaningfully involve the community**
- Policies, laws and regulations
  - What are the rules relating to vaccine administration and storage?
  - Is it possible outside formal healthcare settings?
  - Are there barriers related to the eligibility?

Talking points

- For details on each step in the situational assessment see: 3.1. Full situational assessment
- Highlight why it is necessary to involve the community throughout the process.
- In addition to analysing vaccine-related regulations and policies, it is important to explore the needs of the community of PWUD to ensure that the intervention will address the most urgent issues in the target population. It is essential to meaningfully involve the community in the **assessment, design, and implementation** of plans for improving access to vaccines. PWUD have **invaluable knowledge about the lifestyle and everyday practices** of people for whom the harm reduction programme is there to serve. Peer-informed programme design and implementation will ensure that connections to vaccination programmes will be **accessible and appropriate to the needs of the community**, while at the same time it will **increase the credibility of and trust in the service.**

Additional talking points

- There are contexts in which openly admitting drug use is not possible because of the criminalisation of drug use or the stigmatisation of PWUD. In these contexts, involving peers in services can be challenging. It should be recognised by the

facilitator, however, that simple, feasible means of involving the community can be discussed here. For example: asking clients' opinions on your service development plans, discussing what to include in IEC ~~nformation, education and communication~~ materials, developing a short questionnaire for clients, or involving people with lived experience who are not using drugs anymore.

Interactive discussion guidance

- Question to the participants:
  What have your experiences been on peer involvement during the COVID-19 pandemic?

SLIDE 28

Full situational assessment

- Vaccines
  - A comprehensive list of available vaccines
  - Requirements regarding each vaccine

- Stakeholder analysis
  - Relevant national and local public health actors
  - Local social/health services responsible for coordinating vaccinations
  - Possible partners in advocacy or implementation

Talking points

- For details on each step in the situational assessment: See: 3.1. Full situational assessment.

SLIDE 29

Full situational assessment

- Programme resources
  - Financial resources
  - Physical environment of the programme
  - Characteristics of the building or office
  - Opening hours
  - Number of harm reduction workers available
  - Knowledge and skillset of harm reduction workers
  - Volunteers

Talking points

- For details on each step in the situational assessment: See: 3.1. Full situational assessment

SLIDE 30

Estimating the number of clients for vaccination

- Aim is to get most people vaccinated, though priority groups are defined in the general population, same can be done among the clients of the harm reduction programmes
- Possible data sources:
  - national PWID/PWUD estimates
  - national/local HIV, HepC, TB prevalence est. among PWID
  - service data
  - involve peers
  - ad-hoc survey, qualitative research at the programme (if feasible)

Talking points

- For further details see: 3.2 Identifying and estimating the number of clients that will require vaccination.
- The aim is to show participants that this is an exercise they can do, as they have the knowledge and means necessary. Harm reduction service providers will know the number of clients they have; this, combined with the age distribution of their clients, would produce an estimate of the different priority groups – the number of clients above 70 years old, 69-60, 59-50, under 50 (using the same categories as the national/local vaccination plan). If national or local estimates on the prevalence of HIV, hepatitis C or TB among PWUD/PWID are available, these can be used to add another layer to the estimates (add these to the first age group on the priority list).

SLIDE 31

Establish links with public health authorities and other partners involved

- Established contacts at public health authorities or health care institutions can help identify the actors responsible for COVID-19 vaccination
- Involve relevant actors and partners early during the planning
  - help in finding a suitable pathway to integrate COVID-19 vacc.
  - they will have relevant inputs and practical knowledge
  - this can ensure that all relevant aspects are considered

Talking points

- For details see: 3.3. Establish links with public health authorities and other partners involved in the COVID-19 vaccination.

SLIDE 32

Advocacy for vaccines for PWUD

- Vaccines should be made available in an environment that is safe, confidential, without discrimination and tailored to community needs
- Peer involvement throughout advocacy planning and processes
- Specify in the advocacy plan:
  - each target audience
  - the message
  - modes of communication and influence
- Consider cooperation with other advocates
- This is a good opportunity to highlight that harm reduction services are essential public health services

Talking points

- For details see: 3.6. Advocacy for vaccines for people who use drugs.
- Highlight why advocacy is necessary:
  - PWUD have multiple vulnerabilities to COVID-19 (see Background section of the technical guidance);
  - PWUD often experience stigma and discrimination in health care settings, which create significant barriers to access it.
- Therefore, it is crucial to increase access to COVID-19 vaccines for PWUD.
- The stakeholder analysis is a good starting point to identify the target audience for advocacy-related to access to vaccines.

Additional talking points

Why harm reduction services are essential public health services:

- Entry points for HIV and viral hepatitis prevention interventions, testing for blood borne diseases;
- Referrals and linking communities with multiple vulnerabilities to the healthcare system.
- Providing health services in settings where traditional health institutions are not fit for purpose.

- Cost-effectiveness of harm reduction services: See, for example, Harm Reduction International (2020), Making the investment case: Cost-effectiveness evidence for harm reduction. London. Available from https://www.hri.global/contents/2027
- Reducing the transmission of infectious diseases among PWID

Suggested additional reading

- UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID (2017) Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions https://inpud.net/iduit-implementing-comprehensive-hiv-and-hcv-programmes-with-people-who-inject-drugs/
- WHO (2016) Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs: consolidated guidelines https://apps.who.int/iris/handle/10665/204484
- WHO (2019) Consolidated strategic information guidelines for viral hepatitis: Planning and tracking progress towards elimination https://www.who.int/publications/i/item/consolidated-strategic-information-guidelines-for-viral-hepatitis-planning-978-92-4-151519-1

SLIDE 33

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Pathways to integrate COVID-19 vaccines into harm reduction programmes

- Harm reduction programmes can support PWUD access to vaccines because they are:
  - trusted source of health-related information
  - provider of counselling (e.g. HIV and HepC)
  - accessible without stigma and discrimination
- Some critical components supporting vaccination programmes already available at many harm reduction programmes

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.
- Facilitators could reiterate and start with: "Based on the full situational assessment, considering the needs of the community, laws and regulations, and the possibilities in the harm reduction services, harm reduction service providers can plan for the integration of COVID-19 vaccines."
- An introduction to the pathways concept.
  Aim is to highlight that harm reduction programmes are optimal for offering health services to the community, as key populations often forced away from traditional healthcare settings because of stigma and discrimination, and highlight that harm reduction programmes are already providing services that can be easily used in supporting COVID-19 vaccination (acknowledge the work harm reduction services are already doing, and empower service providers to integrate COVID-19 vaccine support, as they are already doing very similar things).
- Examples to mention on components supporting vaccination programmes already available at many harm reduction programmes:
  - referrals, connecting PWUD to the health care system;
  - disseminating information;
  - motivating people to practice harm reduction (or get vaccinated).

Additional talking points

- Full integration of vaccination into harm reduction programmes is implementing health care service in low threshold/community settings. There are other health care interventions that can be provided at harm reduction programmes – for example HIV and viral hepatitis C testing (see for example: EMCDDA's Manual: increasing access to hepatitis C testing and care for PWID , available here: https://www.emcdda.europa.eu/publications/manuals/manual-increasing-access-hepatitis-c-testing-and-care-people-who-inject-drugs_en) – and COVID-19 vaccines can be later used to integrate other health services too (such as hepatitis B vaccination and HIV or hepatitis C treatment).

SLIDE 34

Pathways to integrate COVID-19 vaccines into harm reduction programmes

- Three pathways:
  - **Path 1 – Information and motivation**
  - **Path 2 – Cooperation**
  - **Path 3 – Fully integrated vaccination service**
- These pathways are general approaches to integration (not comprehensive but illustrative)
- Service providers can start in one and build up to another Timely implementation is key: start with the easiest, prepare for greater integration

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.

SLIDE 35

Path 1 – Information and motivation

- When:
  - vaccine related laws and regulations do not permit vaccination at harm reduction site
  - harm reduction services do not have adequate resources to implement
- Aim:
  - address misinformation and misconceptions about vaccines
  - information about how to get vaccinated

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.
- Examples on information about how to get vaccinated:
  - what to expect when PWUD receive the vaccine;
  - support clients in registering for the vaccine;
  - display location and opening hours of vaccination sites, availability of boosters etc.

SLIDE 36

Path 1 – Information and motivation

Key programme elements:

- Information and advice on COVID-19 vaccines
- Information about vaccination sites
- Information on community friendly vaccination sites
- Developing community-led information materials on vaccines and sites
- Training peer navigators or peer counsellors about COVID-19 vaccines
- Collecting testimonials from vaccinated PWUD and harm reduction staff
- Support clients to register for vaccines
- Support clients to acquire or store vaccination certificates
- Post vaccine support information
- Organising events about COVID-19 vaccines

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.

SLIDE 37

Path 1 – Information and motivation

- Practical examples from peers: KeNPUD, Kenya

VIdeo

- For details see: Case study KeNPUD, Kenya (included in the technical guidance)
- Play the video “Practical examples from peers, KeNPUD, Kenya” (3:12)

SLIDE 38

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Path 2 – Cooperation

- When:
  - harm reduction programmes have adequate resources (e.g. space, qualified staff)
  - closer cooperation with COVID-19 vaccination programmes is possible
- Aim:
  - decrease barriers to accessing COVID-19 vaccines
  - co-locate the vaccination programmes or build close cooperation
  - support clients navigate the healthcare system

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.

SLIDE 39

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Path 2 – Cooperation

Key programme elements (in addition to path 1)

- COVID-19 vaccination programme co-located at, or positioned close to, harm reduction premises , or regular access to a mobile COVID-19 vaccination programmes
- Peer or harm reduction worker support at COVID-19 vaccination sites
- Accompanying clients to vaccination sites
- Involve vaccination partners in events and trainings about COVID-19 vaccines
- Providing post-vaccine support

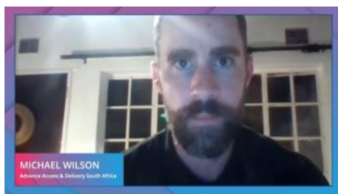
Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes

SLIDE 40

Path 2 – Cooperation

- Practical examples:
  Bellhaven Harm Reduction Centre, South Africa



Video

- For details see: Case study Bellhaven Harm Reduction Centre, South Africa (included in the technical guidance)
- Play the video “Practical examples, Bellhaven Harm Reduction Centre, South Africa” (5:18)

SLIDE 41

Path 3 – Fully integrated vaccination service

- When:
  -Where it is appropriate and feasible (e.g. laws and regulations allow, harm reduction staff qualified, etc.)

- Aim:
  - COVID-19 vaccinations are available at a harm reduction service
  - Administered by staff members known and trusted by the community
  - According to client needs vaccines can be organised as a drop-in service or available at specified intervals

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes.

SLIDE 42

Path 3 – Fully integrated vaccination service

Key programme elements (in addition to path 1 and 2):

- Drop-in COVID-19 vaccination at the service during opening hours
- COVID-19 vaccination days/hours
- Harm reduction services collect data and provide the required data to national/local public health system on vaccination (including receipt of proof of vaccination, QR code, etc.)

Talking points

- For details see: 3.4 Identifying suitable pathways to integrate COVID-19 vaccines into harm reduction programmes

SLIDE 43

Path 3 – Fully integrated vaccination service

- Practical examples from peers: NUAA, Australia

Video

- For details see: Case study NUAA, Australia (included in the technical guidance)
- Play the video “Practical examples from peers, NUAA, Australia” (5:04)

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SLIDE 44

Discussion

- Which pathway – 1, 2 or 3 - makes most sense in your city?
  Are there aspects of other pathways that could be adopted? Or hybrid approaches?
  Are there programme elements already implemented at your service?
- What are the most important barriers in integrating COVID-19 vaccines to harm reduction in your city? What are the most urgent/central issue? Identify advocacy targets!

Interactive discussion guidance

- Create small groups to discuss the questions above.
- 15-20 minutes for group discussion, and ask for report back in plenary.
- 15-20 minutes for plenary discussion.

- The aim of the discussion exercise is to support the development of plans for moving towards one of the pathways, identifying current challenges and advocacy targets.
- The facilitator can help the discussion along by highlighting that harm reduction services might already have implemented programme elements, and have resources they can build upon.
- Identifying advocacy targets can be facilitated with more concrete questions (facilitator can ask for an answer to each):
  -What is the issue? What would be the objective?
  -What is the message? (Why is it important? Why would it be better? e.g. from a public health perspective);
  -Who is the target audience? Who can facilitate the change?
  -Who can be your allies/partners in advocacy?

Equipment: flipcharts or similar to take notes, markers.

SLIDE 45

Summary and conclusions

Talking points

- Facilitator might want to add a brief summary of the discussion here, highlighting the main advocacy points and possible advocacy actions that emerged.
- Close the session.