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Applied Policy Project Final Report

The Impacts of COVID-19 on Harm Reduction Service Provision: A Comparative Analysis

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EXECUTIVE SUMMARY

Uninterrupted provision of harm reduction programs is vital for maintaining the human security of the communities of people who consume drugs. However, the global outbreak of the novel Coronavirus (Covid-19) has put effective delivery of the harm reduction services at stake. People who use drugs, hence, became vulnerable towards the public *force majeure* and uncertainty streamed from the Covid-19. Moreover, considering the lack of coherent international framework ensuring the sustainable operation of the harm reduction programs at the level of nations, legitimate concerns arose regarding the preventive capacities of the particular harm reduction sites to eliminate the probability of the virus spread and consistently provide the running services in place.

This report explores the extent to which the Coronavirus health emergency endangered adequate provision of the harm reduction services in three different policy and institutional settings of Georgia, Portugal, and the United States of America (USA), depicted through the thorough analysis of circumstances around harm reduction delivery in Pennsylvania. The selection of the three contexts is framed by the differences observed in the legislative status of narcotic substances and harm reduction in each country. Portugal's pioneering drug decriminalization process is often perceived as an example of good practices among scholars and health practitioners. Although drug policy in Georgia is still subject to critics and contentious points, the local provision of harm reduction programs evidences progressist practices while analyzing through the lenses of the current regional trends. Finally, example of the United States illustrates a scenario where national regulation poses a further challenge to the activity of organizations working to mitigate risks associated with the consumption of psychoactive substances.

The research is built upon qualitative, semi-structured, in-depth interviews with frontline harm reduction workers, harm reduction management and international harm reduction Non-Governmental Organization (NGO) representatives from the respective three local contexts and beyond. The report offers detailed study of the international effort before and after Covid-19 to mitigate harms of drug consumption. After capturing the global trends, the report presents the influence of the Coronavirus outbreak on the harm reduction provision in

Georgia, Portugal and Pennsylvania. Lastly, the central findings and recommendations are outlined for further operation of the harm reduction programs in the chosen national and sub-national settings amid the Covid-19. The report highlights that the ability to anticipate potential scenarios and challenges derived from the pandemic will play an important role in the future of harm reduction policies. This is a good opportunity to advocate for structural, systemic change, as the situation has exposed the weaknesses of approaches to drug policy in all of the case study contexts. While Portugal's model has been widely celebrated, issues around marginalized populations' access to care and safe supply of drugs have come to the surface. Georgia and several cities in Pennsylvania, including Philadelphia, have decriminalized the possession of small amounts of marijuana, which only contributed to legislators and the population at large overlooking the bigger issues around substance use. Overall, the case studies bring important lessons in all levels. The COVID-19 crisis has depicted that harm reduction services need to be flexible and adaptable to truly serve the needs of the population and meet people where they are at. The quick response of NGOs shows that the service providers know the communities they serve, are aware of the steps that need to be taken and have the capacity to adapt and make services more effective, when given the autonomy to do so.

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Author's Declaration

This report contains no material which has been accepted as part of the requirements of any other academic degree or non-degree program, in English or in any other language. This is a true copy of the report including final revisions.

Ethics declaration:

This research was completed with the belief in a people-centered approach to tackling the global drug problem and holds the stance that full-spectrum harm reduction involving interagency solutions is fundamental. This report sought to provide a space for harm reduction service providers to communicate their lived experiences of working in the field. The voices of state agencies and other actors involved in the formulation of drug policy were included in some parts of this study, but remain underrepresented, as they were unavailable for comment at the time and/or for the purposes of this report.

INTRODUCTION

Harm reduction policies, guidelines, and practices are designed to mitigate physical harms related to drug use, protect the rights of people who use drugs, and promote a public health approach in dealing with drug problems (WHO, 2012).Examples of harm reduction programs include, but are not limited to, clean needle and syringe programs, opioid substitution therapy (OST), safe drug consumption rooms, take-home Naloxone and peer support program. Needle exchange projects were implemented as a part of harm reduction programs that aimed to reduce the widespread of HIV infections among the people who injected drugs in Nepal in 1991 and other Asian countries around 1995 (Thomson, 2013).The World Health Organization (WHO) declaration of commitment on HIV/AIDS in 2001, specifically illustrated that harm reduction was extremely effective in preventing and combating human immunodeficiency viruses (HIV), particularly among PWUD (WHO, 2001). The UNODC and WHO guidance on the "International Standards for Treatment of Drug Use Disorders" 2016, established the importance of the availability of treatment services for drug dependencies, implementation of evidence-based treatment approaches, and the necessity of harm reduction for the well-being of people with drug disorders. UNAIDS has also demonstrated that harm reduction programs such as Needle-Syringe programs, opioid substitution therapy, and treatment services are effective in preventing HIV among PWUD and other harms related to drug use (UNAIDS, 2016).

Providing adequate access to harm reduction services for people who use drugs should be considered a part of ensuring the right to health. It is the right that any individual, regardless of race, gender, and age, is entitled to enjoy equally. According to Article 25 of the Universal Declaration of Human Rights, everyone is equally entitled to adequate health care and essential services for the well-being of himself or his family (United Nations, 2015). The WHO constitution (WHO, 1946, p.1) stated that "{t}he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

In the context of drug policy and harm reduction, the right to health means providing HIV prevention, treatment, health care, and essential services for PWUD. The international guidelines on rights and drug policy published by UNODC, UNAIDS, and WHO endorsed that the right to the highest attainable standard of health is fundamental and it should be applied equally in drug laws, policies, and practices in harm reduction and drug dependence treatment programs (WHO, 2019).Furthermore, the joint statement against the compulsory drug detention and rehabilitation centers by UN agencies- as such ILO, UNHR, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UNWOMEN, WFP, WHO, and UNAIDS strongly demonstrated the necessity of rights-based approach on all aspects of drug treatments programs (UNODC, 2012). Also, the Sustainable Development Goal 3 – which is aimed to achieve by 2030, focuses on the good health and well-being of the people aims to end epidemics of AIDS and to promote prevention and treatment of substance abuse by making sure that no one is left behind in accessing health care services (WHO).

The United Nations agencies, international organizations- which focus on advocating for drug policy reform and promoting harm reduction services, and drug policy advocates continuously affirm the need for countries to promote the right to health approach by decriminalizing their drug policies. As of 2019, 87 countries around the world are implementing the needles and syringes program (NSP) as a part of harm reduction service in supporting the right to health for PWUD, according to International Harm Reduction (HRI, 2019). Adopting the right to health approach and decriminalizing drug use usually expands treatment and harm reduction programs of the implementing countries. The decriminalizing of the consumption of all illicit drugs in Portugal in 2001 demonstrated a decrease in the death rate among people who use drugs, increase the number of people who receive treatments, and the incidence of HIV/AIDS infection decreased (Drug Policy Alliance, 2019). The proved evidence points strongly to the effectiveness of harm reduction programs in reducing HIV infection rates, physical harms for PWUD, and the societal harms. However, there is a strong need to redefine and adjust the scope of harm reduction approaches differently according to the country context, availability of drugs and the patterns of drug use.

Despite the UN's strong position on promoting harm reduction services for people who use drugs and calling for its member states to implement drug policies with a decriminalization approach, many countries around the world maintain punitive policy approaches that ignore the well-being of PWUD. Criminalization of drug use and possession for personal use increases the stigma associated with drug use, encourages discrimination against people who use drugs, discourage people who use drugs from seeking help for their health and security, reduces government incentives to invest in appropriate health care services for PWUD and oftentimes encourages the police harassment of PWUD including when promotion in the police is based on high arrest rate. In Asia, there are still countries that have "Zero Tolerance" policies that penalize PWUD, instead of helping them access health care services they require. In these countries, needles and syringes program (NSP) can be unlawful, offensive, or prohibited (Thomson, 2013).There is no drug consumption room and no NSP program in prisons in Asia and only India and Afghanistan implement take-home naloxone programs (HRI, 2019).

In addition, international agencies such as Harm Reduction International (HRI), International Drug Policy Consortium, and International Network of People who Use Drugs (INPUD) have been advocating and working with UN agencies (UNODC, UNAIDS), INCB, CND, UNGA, and ECOSOC) to promote harm reduction services that based on the right to health approach but lack formal communication channels. In 2018, the UN system's new common position on drugs was the first systematic effort by the UN System Chief Executives Board for Coordination (CEB) in supporting the collaboration between the United Nations and the international agencies to achieve the drug policies that ensure no one is left behind. Yet, no effective practical programming and implementation have come out from the common position so far.

In this context of the lack of stable legal and financial guarantees for the sustainability of harm reduction programs on the global level, significant differences can be observed in how programs operate in different context, which includes their resilience to outside shocks, such as the COVID-19 pandemic. This research thus brings the international and

local contexts together to identify problems brought on by the crisis that link to fundamental issues with the realization of the harm reduction approach as a whole.

METHODOLOGY

The research combines global and national level analysis to illustrate the dynamics of service provision and guidance and best practice formulation. The research selected three countries as case studies for analysis – Portugal, Georgia, and the United States of America. The selection of the three contexts is framed by the differences observed in the legislative status of drugs / harm reduction of each country. The qualitative methodology applied in the research consisted of semi-structured and in-depth interviews with workers involved in different fronts of harm reduction services in each of these contexts. A total of 23 interviews was realized – 10 in Portugal, 3 in Georgia, 10 in the US (6 in the State of Pennsylvania). Due to the exceptional conditions posed by the COVID-19 pandemic, interviews were held online, through video call platforms. With the participant's authorization, the talks were recorded, transcribed, and further analyzed by the authors. It is important to note that the interviews were conducted in the local language of each country – Portuguese, Georgian, and English – as an effort to collect high quality and detailed material. Interviews lasted an average of 1hour and 30mins. Lastly, to ensure security to this study's contributors, participants' identity was anonymized in the cases where confidentiality was asked for.

For the global level overview, four main methods were applied to analyze the impacts of COVID-19 on harm reduction services for people who use drugs globally. The four methods included monitoring media, following influential individuals on social media, participating in the video conference, and interviewing a key informant at the international level. First, we mainly monitored seven important websites of the organizations that focused on. Advocating for the people right to health, providing harm reduction, and advocating for global drug policy reforms. The seven organizations/institutions are the United Nations, United Nations Office on Drugs and Crimes, the World Health Organization, International Network of People Who Use Drug, Harm Reduction International, and International Drug Policy Consortium. We also followed some influential individuals who are advocating for drug policy reform and health-based harm reduction

programs. Next, we participated in two webinars on the "COVID-19 and Harm Reduction Programme Implementation: Sharing Experience in Practices". Both webinars were jointly organized by the UNODC, WHO, INPUD, and HRI. Last, we conducted one in-depth interview with Judy Chang, Executive Director of INPUD, as a key informant.

AN OVERVIEW OF THE GLOBAL RESPONSE

The COVID-19 Panorama

The novel coronavirus was found in Wuhan, Hubei province in China on 31st December 2019 (WHO, 2019).Despite the lockdown measures applied by the Chinese government in Wuhan to stop the spread of the virus, it has gradually spread throughout the world within one to two months. The World Health Organization declared the novel coronavirus (COVID-19) outbreak a global pandemic on March 11, 2020 (WHO, 2020). People with underlying medical conditions and people over 65 are more vulnerable to the infection and have a higher mortality rate. As of May 31, there are more than 6 million confirmed cases and more than 371,166 deaths in 216 national territories (WHO, 2020). Staying home, self-isolating, and avoiding crowded places was recommended by the WHO to reduce to risks of COVID-19 infections (WHO, 2020). To contain the pandemic, countries around the world are enforcing national lockdowns, travel restrictions by closing airports and borders, curfews on people's movement within the country, and closures of non-essential services (Aljazeera, 2020). As of May, 91% of the world population are living in countries with restrictions (Aljazeera, 2020).

COVID-19's impacts on the people who use drug and harm reduction

COVID-19 affects everyone regardless of their race, gender, age, and religion. However, while the disease does not discriminate, people who use drugs are more exposed to the risk of infection because of the stigma and discrimination toward PWUD; a criminalization approach that disables access to harm reduction; lack of government's capacities and efforts to provide equal health care for marginalized populations and the common underlying health issues among PWUD such as the prevalence of chronic obstructive pulmonary diseases (COPD) and asthma.

First, according to the 2019 World Drug Report, there are 271 million people who use drugs, around the world which is 5.5% of the global population.Among those,there are 53.4 million opioid users and 11.3 million people who inject drugs (World Drug Report, 2019). One in eight PWID are living with HIV, which makes them more vulnerable to other infectious diseases like COVID-19. Besides, among those users, 35 million are living with drug use disorders, and only one out of seven receive treatment (World Drug Report, 2019). According to UNODC, one-third of PWUD are youth, and 21%of them have experienced homelessness and unstable housing, and thus are among the most vulnerable population during COVID-19 (World Drug Report, 2019).

Second, the illicit drug trade, like any other business, has experienced a challenge to its operations due to border closures and national lockdowns, resulting in delivery delays, temporary supply shortages and fluctuations in price (Reuters, 2020).While most popular drugs such as marijuana, amphetamine, and cannabis remain accessible, some countries have experienced shifts in supply, which creates uncertainties and apotentially higher demand for harm reduction services. Judy Chang expressed that "with the interruption of illicit supply, more people than ever are going to need access to methadone and buprenorphine," referring to fears of shortages or contamination in the supply of opiates that might incentivize more people who use opioids to seek out enrollment to substitution programs to ensure their access to safe supply.

Third,the lockdown measures and temporaryshortages in the supply contribute to shifting consumption behaviors toward more harmful drugs among some PWUD and an increase in equipment sharing (UNODC, 2020).The rise of drug injection and the use of more harmful drugs intensify the harms and increase the risk of HIV and hepatitis C disease infection. According to the key informant interview with Judy Chang- executive director of the International Network of People who Use Drugs, overdose deaths in North America have increased at the early stages of the pandemic, and health ambulance and first-aid workers in some countries were not responding todrug overdose incidents during COVID-19.

> "We see rise increase in overdose deaths in North America and we're also hearing reports that ambulance and first responders are not responding to overdose cases because of COVID" (Judy Chang, INPUD)

Finally, social distancing and national lockdown strategies resulted in extreme difficulties for harm reduction service providers, especially the outreach programs, to perform and even to keep the services going in some countries (IDPC, 2020). In most places, the operation of OST programs relies heavily on participants visiting the clinics daily to take their medication under supervision, which poses challenges with stay-at-home orders and the scaling back of public transportation services, for example. Also, homeless PWUD are even more vulnerable during COVID-19 because it makes it difficult for the harm reduction service providers to reach them. More importantly, limited financial resources for local harm reduction organizations and legal restrictions in countries that practice harsh drug policies are creating an additional burden to provide necessary harm reduction services for PWUD.

Additionally**,** in the context of criminalization, people who use drugs are facing an additional burden to access health care services because of the punitive legal barrier and social stigma (Harm Reduction Coalition, 2020).Even among the countries that have decriminalized personal drug consumption, harm reduction approaches in healthcare are not fully normalized and/or flexible,which increases health risk for PWUD under lockdown. This can negatively impact not only the well-being of PWUD but also the efforts to contain the pandemic.

COVID-19 RESPONSES

The Response of the United Nations

The UNODC adopted the "suggestions about treatment, care and rehabilitation of people with drug use disorder in the context of the COVID-19 pandemic" in March to ensure that people who use drugs, those living with drug use disorders, and PWUD living with HIV have access tothe health care and harm reduction services they need (UNODC, 2020). The suggestion calls on the member states to "address continued access to the services, address the safety of the staff and the patients at the services, make sure the premises of the services are clean and hygienic, provide people with information on and means to protect themselves at every possible occasion, continuity of low-threshold services, and continuity of therapies" (UNODC, 2020). Most importantly, the document strongly stated that "*under no condition should a person be denied access to health care based on the fact that they use drugs*" (UNODC, 2020). Besides, it also published tremendous guidelines on prevention and control among people living in prison, and HIV prevention, treatment, care, and support for people who use drugs (UNODC, 2020). These guidelines were picked up by international harm reduction organizations around the world and translated into different languages (nine languages as of May 18) (Harm Reduction Coalition, 2020).

On April 16, the UN experts published a statement calling for national authorities to protect the right of people who use drugs to access public health services during the pandemic (OHCHR, 2020). The statement reaffirms the importance of providing harm reduction programs to protect PWUD, implementing gender-sensitive harm reduction services to protect women who use drugs, supporting the homeless, considering early release of prisoners, and enabling equal health care during health-emergency (OHCHR, 2020). In May, WHO, UNAIDS, and OHCHR together with UNODC jointly called for the countries to continue treatments and harm prevention services for people living with drug use disorder and/or HIV in the prison system (UNAIDS, 2020). Lastly, the UN has called on all its members to protect the mental health of vulnerable populations including PWUD and people living with HIV during and after the pandemic (United Nations,

2020).Regardless of what UN agencies recommend, the UN regional offices have carried out different strategies. UNODC in Nigeria launched "DrugHelpNet" to provide over-the-phone assistance for PWUD in time of pandemic by working together with 80 health workers and professionals (UNODC, 2020). This program is only implemented in one region and has not expanded to others.

International harm reduction organizations responses

Many international organizations that focus on drug policies and harm reduction responded to the crisis differently based on their capacities and positions. The International Network of People Who Use Drugs (INPUD), International Drug Policy Consortium (IDPC) and Harm Reduction International (HRI) together called on the international communities and UN agencies to ensure countries respect the rights of PWUD and to implement UN's guidelines on providing health care services for everyone (HRI, 2020). *Judy Chang* voiced the importance of adapting the UN guidelines in the relevant context for people to understand and enable people who do not have access to the internet. As a part of harm reduction effort during the pandemic, INPUD has also developed harm reduction advice, to drug dealers (INPUD, 2020), drug buyers (INPUD, 2020), heroin/opioid users (INPUD, 2020), and for people who use drugs (INPUD, 2020). Recently, a joint statement was published by the INPUD and HRI that called for donors,in particular the Global Fund, to keep and increase the funding for harm reduction programs; and for nations to invest in the harm reduction services (HRI, 2020).

Cooperation

Cooperation is predominantly vital at all levels. As the vulnerabilities of the PWUD are at risk during COVID-19, the network of PWUD around the world is coming together on a virtual platform, voicing their concerns, sharing their experiences and challenges, and trying to keep each other safe, like never before.

> "More than ever it's very important for us to be vocal about PWUD because what will inevitably happen with some of the funding for HIV shifting to COVID-19 [response], we may fall off." (Interview with Judy Chang, 2020)

Beside PWUD's voices, cooperating among the UN agencies across international and national levels are also very critical. The UN has already acknowledged the need for cooperation among its agencies, international organizations, and the communities in achieving drug policy reform and harm reduction advocacy (Vienna NGO Committee on Drugs, 2019). In times of health crisis like COVID, it has again become important for the UN agencies to push their member statesto implement country-level systemic changes.

> "We are trying to get UNAIDS to stay strong globally in pressuring their country offices to work with key populations at the national level so when there are violations there could be ways to address those. In South Africa, recently a lot of homeless PWUD were put in the camps outside, and Medicines sans Frontiers weren't allowed to go in and give out methadone, and the UN country office didn't help in that. It opens your eyes to how important it is for the UN country offices to be on board and present and have relationships with networks on the ground. (Interview with Judy Chang, 2020)

Not only the network of PWUD but also international communities and organizations have joined hands in trying to share information and reach out to the PWUD communities in different parts of the world. For example, UN agencies, international organizations, and communities are cooperatively organizing webinars to share experiences from different countries. As the nature of advocacies during COVID has shifted to virtual platforms, it makes it easier to cooperate.

> "This crisis has definitely brought us (those who work on drug policies and harm reduction) together more, especially in this phase where there's traditionally been a real lack of funding, there has always been that element of competitiveness of needing to compete for funds. But the moment of crisis brings people together, in realizing the importance of sharing information, to be working together. That's a positive that can lead to more collaboration, more information-sharing, but I

> wonder what it will mean for advocacy for PWUD, sex workers, and LGBTQI."(Interview with Judy Chang, 2020)

Judy Chang believed that while the COVID-19 has made it possible for international organizations to come together, the uncertainty of how the cooperation would benefit the overall advocacy for the human rights-based drug policy reforms remains.

Community-driven Responses

While the UN's guidelines might provide countries and international organizations to adapt to the situation, the political will of the government and financial resources play very critical roles. According to the webinar'COVID-19 and Harm Reduction Programme Implementation: Sharing Experience in Practice' organized by INPUD, HRI, UNODC and WHO in May, thirty countries have already been redirecting the guidelines of the Ministries of Health to change the practices in the context of COVID-19 (Medecins du Monde, 2020).The changes included adjusting the legal framework to enable take-home doses for participants of OST programs during lockdown, including in Nepal, Ukraine, New York, and India. The OST program, which operated under daily supervision before, is experiencing an incredible change which made it possible for the patients to access to increases take-home dose for a week or two for the first time. Naomi Burke Shyne-Executive Director of HRI said on the webinar, "this is very exciting because it's something we've been advocating for a few years and has been unable to achieve" (Medecins du Monde, 2020).The shifting willingness and approach in providing methadone in these countries is a positive outcome that came out of COVID-19.

> "That is a key message from COVID that we want to push, that harm reduction services should be adapting, and easy, and flexible, and match people's needs and lifestyles, rather than this very rigid, punishing system which it always has been." (Interview with Judy Chang, 2020)

However, whether or not this change will continue after the pandemic remains a big concern. But there is a hope that countries that adopted the new protocols of enabling take-home doses will comprehend the effectiveness of the change and make it sustained.

> "I think there's definitely a possibility that they could be kept. A lot of the time the whole take-home doses thing is just based on a lot of unfounded fear, that's in the media. Australia has a very strict take-home policy because 20 years ago a child in Melbourne died because they accessed their parents' methadone, and ever since then it's been very sick. So, I think it's also based on a lot of negative media, unfounded fears of what it means, and also in a lot of countries methadone is quite new, buprenorphine is quite new, so they're scared to do it. Once they put it in place and realize that it actually makes everything a lot easier on multiple fronts, there's a good chance that things could change in treatment at least."(Interview with Judy Chang, 2020)Apart from the change in the methadone program, local harm reduction service providers in some countries are also developing a better relationship with the government, in particular with the Ministry of Health. According to the interview with Judy Chang, harm reduction organizations in India and Nepal, for example, are working with the government in times of health crisis which could potentially strengthen the relationship.

It is very crucial to pay attention to different countries' harm reduction services responses for PWUD in this pandemic. The experiences, adjustments, and lessons learned from countries with different drug policies, harm reduction practices, and stigma around drug use during COVID have a significant potential to contribute to drug policy and harm reduction reforms both at the global level and the countries that are practicing the harsh-punishment approaches.

> "I guess the perfect model is a cycle or circle type thing, so global guidance, principles established on the global level, and then they need to be communicated to the national grassroots level and implemented at the national-local level. But then what happens on the ground, any lessons learned during implementations that need to be brought to the global level – so the global level doesn't exist in a vacuum." (Interview with Judy Chang, 2020)

To deepen the understandings of COVID-19's impacts on the PWUD and harm reduction responses in time of health crisis in different counties, the following section will present the case studies of Georgia, Portugal and the State of Pennsylvania.

CASE STUDIES

To illustrate the dynamics of global, national, and local-level guidance and decision-making, the research selected three countries as case studies for analysis – Portugal, Georgia, and the United States of America. The selection of the three contexts is framed by the differences observed in the legislative status of drugs / harm reduction of each country. Portugal's pioneering drug decriminalization process is often perceived as an example of good practices among scholars and health practitioners. Although drug policy in Georgia is still subject to critics and contentious points, the local provision of harm reduction programs evidences progressist practices when analyzed in comparison to regional trends. Finally, the example of the United States was included to illustrate a scenario where national regulation poses a further challenge to the activity of organizations working to mitigate risks associated with the consumption of psychoactive substances. In such a scenario, the relative autonomy held by local (state level if US) administration might be important for finding alternative solutions and partnerships with civil society for the provision of harm reduction efforts and the promotion of public health. Having in mind the federative division of public competences, the researchers selected the specific case of the state of Pennsylvania for further analysis.

PORTUGAL

Nearly 20 years since its decriminalization process, Portugal is a pioneering case in the field of drug policy. Being the most long-lasting example for the observation of progressive reforms' outcomes, the country is often looked at for best practices in studies of harm reduction and substance consumption behaviors. After years afflicted by injectable psychoactive crisis[1], in 2001 Portugal adopted a paradigm shift regarding the legislation ruling drug use, removing the issue from criminal competence and framing it as a public health concern. Currently, the acquisition, possession, and use of small quantities of all psychoactive substances is decriminalized (Laqueur, 2015). The change allowed for the creation of a robust system for data collection and measuring indicators, which ultimately guide the design, implementation and evaluation of harm reduction services in the country. Today, the Portuguese drug policy is aimed at addressing the drug consumption phenomenon through a network management, with interventions focused on prevention, treatment, harm reduction, social reinsertion and consumption dissuasion (SICAD, 2020).

Legal background:

The Portuguese decriminalization process was implemented in response to a health and social crisis.With the new legislation, the shift in the debate terms came to changehow drug consumers are perceived by the law. Rather than offenders subject to criminal sanctions, people who use drugsare individuals in need of healthcare and treatment (Soares, Carvalho, Valbom, Rodrigues, 2017). Ultimately, the new regime is based in providing health access

[1] The 2001 Decriminalization Act was introduced after the country saw an exponential increase in drug market and consumption during the 1990s, particularly connected to heroin intravenous use. During those years, Portugal saw its hospitalization numbers for drug overdoses rise fivefold (SPTT, 1999), while drug-related offences vaulted from 3,586 in 1990 to 14,276 in 2000. (EMCDDA, 2004). The crisis brought also consequences to public health, with infectious diseases quickly spreading. In 1999, Portugal had the highest rate of drug-related AIDS cases in the European Union and the second highest prevalence of HIV among injecting drug users (EMCDDA 2000).

to people who use drugs, offering them the necessary treatment to overcome substance dependence.[2]

Although not framed as a criminal offense, drug consumption remains an administrative infraction according to the Portuguese legislation. Thus, police force continues to serve as the primary source of detection and referral, responsible for bringing individuals found using or in possession of drugs - below the legal threshold - before one of the district-level Commissions for the Dissuasion of Drug Addiction (CDTs) (SICAD, 2020). However, more than a body charged with the responsibility of security provision, police force becomes an important actor for the promotion of public health. Bringing individuals framed for drug possession before the CDTs, law enforcement operators become quasi-health agents, acting as the point of entry to the health care system, and increasing access to public services.

The CDTs are responsible for analyzing each case individually, in order to assess the most appropriated measure to be taken. In this sense, processes can be either charged with noncriminal sanctions – such as a warning, monetary fines or, in most extreme cases, the loss of the driver's license – or adequate medical treatment – subject to the individuals' consent. Indeed, one important feature of the Portuguese model is the perception of the drug consumption phenomenon as a multifaced issue, which calls for the need of adopting a pluralistic response. With this in mind, all cases are analyzed considering a set of different factors, such as economic, psychological and social conditions. In addition to that, support services and programs are offered to provide assistance in a multitude of areas.

Lastly, it is important to note that although decriminalization made drug consumption an administrative rather than a criminal offence, drug cultivation remains criminally

[2] It is important to note that criminal penalties are still a possibility in cases where the amount of substance possessed exceeds the thresholds defining "one's own consumption" - a quantity representing the "average individual consumption during a period of 10 days" (Law 30/2000 of 29 November 2000, Art 2.2). In those cases, individuals can be criminally charged for drug-trafficking. The specific criminal penalties are those set out in the older Decree Law 15/1993, and depend on several factors that can potentially work as case aggravators.

prohibited, even in cases for personal consumption purposes[3]. This predisposition brings important implications, as it ultimately imposes that drug consumers must rely on the illicit market to purchase substances (Laqueur, 2015).

Drug consumption facts and figures:

The scenario of drug consumption in Portugal saw important improvements since decriminalization. Currently, the country performs with one of the lowest numbers of drug-induced mortality rates and new HIV diagnoses attributed to injecting drug use in the European region[4].

The latest data available on substance use in the country reveals cannabis to be most frequently consumed drug, followed by MDMA/Ecstasy and cocaine.[5] Concerning high-risk opioids use, it is estimated that Portugal has about 33,290 users, from which 13,160 are injecting consumers (SICAD, 2017). Although the number performs among the highest of the European Union, it is important to note that it comes accompanied by also high rates of available treatment and harm reduction services.

Harm reduction programs:

The Portuguese National Strategy to Fight Against Drugs, designed in 1999, guides harm reduction services in the country based on principles of humanism and pragmatism. Governance and implementation of such programs happen within the framework of the Operational Plan for Integrated Responses (PORI), managed by the General-Directorate for

[3] The statute states: "Article 40, save with regard to cultivation, and Article 41 of Decree- Law no. 15/93, of 22 January, are hereby repealed" (Decree-Law 30/2000, November 29, 2000).

[4] While in 1999 drug-induced deaths accounted for more than 350 cases, in 2017 the numbers substantially dropped to a total of 38 overdoses. Newly diagnosed HIV cases among people who inject drugs dropped from 1,482 in 2000 to only 18 new cases in 2017 (EMCDDA, 2019).

[5] The use of illicit substances is more common among young adults (aged 15-34 years old), with problematic use and subsequent search for treatment mainly driven by the male population. Importantly, the male population also account for most drug-induced mortality rates, with men between 45 and 49 years old representing the parcel at higher risk (EMCDDA, 2019).

Intervention on Addictive Behaviours and Dependencies (SICAD, in Portuguese) – a branch of the Health Ministry. The plan is a leading instrument, instructing interventions for drug consumption and dependence with evidence-based approaches. Implementing such interventions, a national network of services was consolidated, aimed at addressing the needs of individuals with problematic patterns of drug consumption.

The Risk Reduction and Harm Minimization policies were legally reinforced in 2001, with the approval of regulation supporting the creation of socio-health teams, support offices, opiate replacement programs with low threshold requirements, reception centers and shelters, as well as the inclusion of outreach teams and information points (CDT, 2001). In this sense, harm reduction services have become an integrated part of the Portuguese public health system, with NGOs being the main providers of such services (EMCDDA, 2017).

Since 2013, Harm Reduction programs deal with a broader scope of addictive behavior beyond those concerning illicit substance use[6], which implied the involvement of new partners, as well as new action strategies (PNRCAD, 2012). The current National Plan for the Reduction of Additive Behaviors and Dependencies is foreseen until 2020, when it shall be replaced by a new plan designed to address the latest diagnosed demands in the national context.

Who provides Harm Reduction Services?

Harm reduction programs in Portugal are the result of a joint effort. Currently, the SICAD is the central body responsible for providing normative and technical assistance to frontline harm reduction services operators. It is important to note that the SICAD is not directly involved in the implementation process of such programs, with local organizations autonomous to take decisions on how services will be coordinated and delivered.

How are Harm Reduction Services designed?

[6] Such as alcohol, medicine, gaming, gambling and internet use.

The National Plan represents the guidelines defining the goals and approaches to harm reduction programs in the country. Rather than a centralized top-down decision, the plan is the outcome of an investigative process made possible only through the collaborative work of data collection and evaluation institutes, health authorities, local networks, NGOs and grassroots movements. After receiving and considering the results, challenges and demands brought by these stakeholders, a diagnosis is made, which will ultimately guide the focus and course of future policies.

Where does the funding come from?

The national plan determines the areas of action which harm reduction programs will be targeting, as well as the funding allocation for service providers. In this sense, organizations submit their projects to SICAD, who analyzes and selects which ones will receive government funding. Currently, public financing of harm reduction programs in Portugal has no fixed budget. Funding is divided on an individual basis, with projects submitting their proposals and needs to SICAD every two years. Financingwas intended to cover 80% of a projects' cost, with organizations entitled to seek for complementary financial support from regional and local public administrations. Recent reforms in the funding system changed public support to cover 100% of projects' costs.

Which Harm Reduction services are offered?

Portugal currently offers a broad range of harm reduction services. The programs are dispersed all over the country, including its islands – although a higher concentration and variety of them are observed in the main urban centers. With a management model focusing on networked operations, harm reduction services are provided by a multitude of stakeholders, englobing a varied set of issues, aiming to contribute to widening the scope of interventions, and cost-effectively using the available resources (SICAD, 2020). The table in the next page brings a summary of the services provided.

Program	Program Description
Support offices for PWUD without a social-family background	Screening, support and socio-therapeutic referral offices, operating 24 hours a day, 7 days a week. They can operate in mobile of fixed unites and provide basic health care, minimum hygiene and food care, nursing care, medical and psychiatric support, exchange of syringes according to the law, screening for infectious diseases, psychosocial support that allows an effective approach to treatment structures and provide access to low threshold methadone replacement programs under legal terms.
Reception centers	Temporary residential spaces, operating 24 hours a day, 7 days a week, designed to contribute to the removal of environments conducive to consumption, as well as for social and therapeutic referral of consumers in socio-familiar exclusion. They provide users with accommodation, guarantee minimum hygiene and food, provide psychological and social support and nursing care, track infectious diseases, provide condoms, as well as medical and psychiatric assistance, and can run replacement programs with low threshold requirements according to the law.
Shelters	They are overnight spaces, operating 7 days a week, intended to contribute to the improvement of the sleeping conditions of consumers without a social and family context. They provide facilities for hygiene, food, screening for and treatment of infectious diseases, psychological and social support, nursing care, condoms, low threshold opioid replacement and needle exchange, according to the law.
Points of contact and information	Fixed or mobile units designed to prevent or mitigate the use of drugs and their risks and to inform and listen to the population about the risks and effects of drug consumption, as well as other topics that may contribute to prevention efforts. Some of these points are starting to be equipped to provide drug testing services
Drug testing	On an experimental basis, this service is being provided by info and contact points. The exceptional authorization for the program is subject to annual renewal. The purpose of the program is to test the composition and effects of drugs.
Opioids substitution programs at low threshold requirements	These Programs are intended to promote the reduction of heroin consumption through its replacement with methadone. In an effort to accessibility, abstinence is not required. Socio-health teams are available in the facilities, providing assistance to those consumers interested in such. The administration of methadone is made in person, by a health technician with dosage and periodicity established by medical prescription. Opening hours are previously fixed and adapted to the target population.
Needle exchange program	This program can operate in fixed or mobile installations, meeting the socio-sanitary needs of customers. The goals is to prevent the transmission of infectious diseases by intravenous route, promoting accessibility to the exchange of syringes and needles, as well as filters, wipes, water distilled, citric acid and other suitable materials. These utensils are distributed manually and on request and, whenever indicated, accompanied by written information about the damage and the reduction of risks associated with the consumption of psychoactive substances.
Outreach teams	Designed to promote risk reduction in the public space where the consumption of psychoactive substances is experienced as a social problem, they develop actions to disseminate tools and risk reduction programs, information provision, promotion of the appropriate referral of people in situations and risk, intervention in first aid in the face of emergency or negligence situations, and replacement of syringes – all in accordance with the law. The geographical area of intervention must correspond to places associated with drug consumption and trafficking.
Programs for supervised consumption	The programs for supervised consumption aim to increase asepsis in intravenous consumption and the consequent reduction of risks inherent to this form of consumption, as well as to promote proximity with consumers, according to the respective socio-cultural context, with a view to raising awareness and referrals through the creation of places of consumption.
Mobile spaces for the prevention of infectious diseases	Socio-sanitary structures operating in mobile installations placed in proximity to areas associated with the consumption of psychoactive substances and sex working. This program is designed to screen and treat the most frequent infectious diseases among consumers, to vaccinate the population at risk and to contribute to the reduction of intravenous or smoked heroin consumption on the street, through substitution with methadone, to be dispensed in facilities related to the projects, according to the law.

Current harm reduction status:

Although the Portuguese model represents a good and stable development of harm reduction programs, innovation does happen at a cautious pace. The 20 years of successful policies reporting positive results might have contributed to a sense of security among political elites, which ends up reinforcing a preference for a "business as usual" approach. Such a trend is illustrated in the implementation of assisted consumption rooms. While Portugal was one of the pioneers of drug policy decriminalization in Europe, the opening of such facilities happened later than most of other countries in the region. Even though supported by the law since 2001(Decree-law 183/2001), Portugal's first consumption room started to operate only in 2019 in the city of Lisbon. The facility is a mobile unit, that places itself in critical areas according to the local demand. Other two facilities are planned to be launched in 2020, although the impacts brought by the COVID-19 pandemic might pose additional delays to the policy.

The COVID-19 crisis in Portugal

The first cases of coronavirus in Portugal were confirmed in the beginning of March 2020. Despite the geographic proximity to Spain – one of the most impacted countries in the region – Portugal is a remarkable example of good practices and crisis management[7]. The performance can be attributed to how fast public administration adopted preventive measures to respond to the pandemic. Portugal declared State of emergency in March 18th(Presidential Decree 14-A/2020 of March 18th, 2020). All airports were shut down, terrestrial borders were closedand citizens were asked to remain confined in their councils of residence. Social gatherings of more than 5 people were prohibited, non-essential businesses were closed, and pedestrian transit in public spaces were limited. The provision was revaluated and renewed every 15 days.

[7] Until June 20th, Spain had reported a rate of 6,259 infections and 606 deaths per 1 million of the population, while Portugal's rates accounted for 3,809 infections and 150 deaths per 1 million of the population (Johns Hopkins CSSE, 2020).

The adoption of lockdown measures from a very early stage prevented the virus spread and allowed the Portuguese public health system to address the cases in need of hospitalization without running over capacity. The government's quick measures allowed also for the adoption of extraordinary legislative adjustments aimed at addressing health authorities demands more easily. Public spending was increased to attend critical needs in health, economic and social security areas. Remarkably, the country has one of the highest rates of COVID-19 testing in Europe, applying 57,111 tests per 1 million people[8].

The impacts of COVID-19 on harm reduction services:

The pandemic was also felt in harm reduction services. With limitations imposed by lockdown measures, and the contagion risks associated to personal activities, new guidelines had to be issued for the continuity of harm reduction operations in the country. However, differently than the overall national response to the crisis, orchestrated instructions deriving from the central administration took longer time to be formulated.

Definitive guidelines issued by the SICAD were sent to frontline organizations two weeks after state of emergency was declared. In the meantime, organizations reported some challenges for the continuity of their operations. While public offices and health authorities' bureaus closed doors and moved entirely to online regimes, frontline workers delivering harm reduction services remained in the streets. According to a frontline worker in Porto,

> "For the first weeks we were operating in the dark. Most of the people stayed at home, while we continued going out in the streets, delivering the programs. And SICAD recognizes it. We are often praised as the heroes in the situation – the core of harm reduction services in the country - but the truth is that we had not much of a choice neither guidance when the outbreak came." (Portugal: Interviewee 6, 2020)

[8] Numbers according to the online platform Worldometer, with data reflecting the statistics released on June 9th, 2020.

In such a context, organizations had to quickly adapt to respond to the crisis. While disruption in their activities could bring severe impacts for their participants, business as usual could also bring risks to field workers' health, and, consequently, to the wellbeing of those accessing these services. In the absence of central administration's guidelines, organizations relied on lay knowledge exchanged among the national and international harm reduction communities. An interviewed agent working for an NGO with operations in Porto and Lisbon commented:

> "We are in close contact with agents working with harm reduction in Italy and Spain, to keep updated about infections trends and possible changes in the drug market and individuals' consumption patterns. This helps us to anticipate possible scenarios here and prepare the programs accordingly" (Portugal: Interviewee 2, 2020)

The situation also underscored the importance of local governance for the provision of harm reduction services. In face of a delayed response from central administration, local authorities from the most impacted regions of the country adopted remarkable initiatives aiming tofill the temporary management gap. The example of Lisbon's municipal administration illustrates the case. Having the highest number of COVID-19 infections of Portugal, city authorities started to work with harm reduction providers at early stages of the pandemic. The close relationship between public administration and NGOs agents was crucial for understanding the challenges brought by the crisis to the sector and developing alternatives to respond to their needs. According to a public official working for the municipal chamber:

> "The city hall has prioritized communication with harm reduction organizations, especially those working in the frontline. Our goal is to make sure agents have the necessary resources for safely delivering programs. We have been also working to deliver alterative responses with different actors in society. For example, we are in contact with hotels and hostels around the city, to get basic

> hygiene supplies donations, so we can put up preventive care kits to be distributed to people experiencing homeliness". (Portugal: Interviewee 4, 2020)

Although issued at a later stage, the central administration's response focusing on the harm reduction sector was a pivotal contributor to Portugal's successful management of the crisis. In its response to COVID-19, SICAD promoted closer interaction with all levels of the harm reduction service provision network, scheduling remote meetings aimed at listening to fieldworkers needs and challenges. The new dynamic allowed for quick and comprehensive analysis of the national picture, which was ultimately brought to the central government and used to endorse the requirement of further financial support. At the end, an increase of 15% in public expenditure was allowedin the first month following the coronavirus outbreak. The measure aimedto quickly attendto the needs of harm reduction workers.

Lessons Learned and Best Practices:

Overall, Portugal's response to the COVID-19 brings important lessons at all levels. The following section will briefly describe the most critical impacts felt in each level of the harm reduction network, and the measures adopted to respond to the challenges while ensuring staff and users safety and wellbeing.

Central administration communication with network fringes:

From the perspective of central administration and local authorities, close interactions with the stakeholders operating in the harm reduction network helped to ensure a cautious and yet assertive set of measures for the management of the pandemic. The novelty of the crisis caught policymakers and program agents unprepared to immediately respond to the context, but the adoption of an analytical and observant approach allowed central administration to understand the magnitude of the challenge, properly mobilize

communication and efficiently distribute resources. The cautious approach is justified in the interview with a SICAD representative:

> "Harm reduction policies are almost always the response to a social phenomenon. It is hard to predict context outcomes, which limits our strategies to a responsive approach. Before implementing any changes, we need evidences. Thus, data and indicators support and guide our measures."(Portugal: Interviewee 10, 2020)

Importantly, communication channels and periodicity were adapted to properly respond to agents' needs. After the first two weeks of uncertainty, the contact among network workers was quickly readjusted, with meetings happening once a week, via online tools. In those conferences, representatives of organizations were responsible for bringing critical points, demands and findings towards SICAD, which would evaluate the scenarios in order to wisely reallocate available resources and request additional financing from the central government. According to a frontline worker in Porto,

> "COVID-19 came to breakdown the unnecessary bureaucracies ultimately undermining the networks' capacity to quickly respond to social demands […]. I have the contact of SICAD's chairman in my WhatsApp now, which allows me to quickly address urgent matters with central authorities". (Portugal: Interviewee 7, 2020)

Network resilience and communication:

Organizations and agents working on the frontline did justice to the long-lasting tradition of resilience and adaptability of harm reduction services. In order to continue operations while being mindful of workers and users' health, the working schedules were reduced and organized to allow alternating shifts. Activities in which remote regime was possible moved to online operations, such as counselling, psychological support and information provision.

Although access to preventive gear such as masks, gloves and liquid sanitizer was mentioned as one of the main difficulties, outreach teams continued to operate in streets. Attempting to overcome resource shortages, NGOs sought to establish different partnerships, for example reaching out to hotels to provide supplies for the confection of hygiene kits to be distributed to people experiencing homelessness and public shelters. With social distancing and lockdown, the teams started to focus less on preventive sex gear distribution and prioritize the sharing of hygiene kits and injecting supplies for safer drug use.

In the lack of clear guidelines deriving from central administration, NGOs sought international support. The interaction with harm reduction agents working in countries hit first by the crisis, such as Italy, allowed Portuguese organizations observe and learn from their best practices. New practices were adopted in the field, especially regarding hygiene protocol for outreach teams and mobile units offering opioids substitution services.

New risks, new harm reduction strategies:

The addition of new preventive tools to the scope of services provided was also an important step. The distribution of safe smoking kits, despite NGO's efforts to get public support for its provision, was traditionally left outside of the national risk mitigation strategy. COVID-19 added new hazards to the consumption of substances, particularly for users sharing smoking equipment. With the virus spreading through droplets, a new range of substances had to be included to the list with potentially dangerous use. Ultimately, the novel crisis changed the determinants within the harm reduction agenda, adding new needs and problems to the field, which contributed to the achievement of consensus in previously hindered issues.

That was also the case regarding the long-lasting debate concerning guidelines for opioid substitution programs. With the pandemic, important adaptations were introduced to these services. For the low threshold program, mobile and street facilities continued to operate on alternate schedules. Access to services remained open to the public, including

foreigners irrespective of their legal situation in the country. It is important to note that abstinence is not a criterion for entering any of the treatments, and although social and psychological counseling are advised and available on site, they are not mandatory. Regarding the high threshold program, scheduled pick up times were set for the collection of methadone doses. In cases of consumers belonging to a population at risk, doses were delivered to their places of residence.

Although opioid substitution services in Portugal are recognized as comprehensive and receptive, availability and access to naloxone has been a sensitive disagreement point among health practitioners, social workers and public authorities. With the pandemic, low and high threshold programs increased the amount of methadone doses provided per visit – respecting the limits established by the law - in an attempt to reduce social exposure to a minimum. Such an increase was considered to contribute to overdose risk, which called for the need of adopting additional preventive measures. Ultimately, the change in the context brought the necessary urgency for promoting agreement among network members.

PWUD experiencing homelessness and harm reduction programs:

COVID-19 impacted the harm reduction sector as a whole, but programs such as shelters and reception centers were the most severely hit. In a context of lockdown and self-quarantine, PWUD experiencing homelessness became a critical population at risk. The pandemic disrupted most of the formal and informal activities responsible for generating income for these individuals, at the same time it shut down public facilities offering food and basic hygiene necessary for contagion prevention. The need for adopting new safety measures for protecting staff and users from the risks associated with the spread of the coronavirus could undermine access to the services. Nevertheless, business as usual could contribute to the creation of focal points for the infection, ultimately threatening workers and users, and potentially leading to stigmatization of the group.

Different measures were adopted in shelters spread by the country, but the case of Lisbon offers valuable lessons. The city has four operative shelters and it was the most

impacted region by the pandemic. In order to deal with quarantine needs, one of the shelters was specifically designed to accommodate people who use drugs. These facilities allowed the entrance of alcohol, as well as offered assisted injecting consumption rooms, opioids substitution programs and socio and psychological support for those interested in such services.

Importantly, for those choosing to leave these spaces, NGO's, in partnership with local administration, provided second-hand mobile phones. The distribution of the devices aimed at ensuring contact between agents and individuals outside of shelter and at-risk situation, in order to deliver reliable information, guarantee socio and psychological support, and provide aid in case of emergencies.

The pandemic disrupted the developments in the opening of new assisted consumption rooms in the city. It is probable that the crisis will bring further delays in operations, although public authorities guaranteed those will start to take place in 2020. The mobile unit continue to operate with a new set of hygiene and guiding protocols. However, it is important to note that the focus remains on injecting consumption of any substance, leaving smoking substance users outside of the program's scope.

Nevertheless, COVID-19 also contributed for quickly advancing other programs in the local administration agenda, as in the case of the project "Housing first" offered by the Lisbon's city hall. The policy offers free houses to people experiencing homelessness, with local administration paying for the rent of vacant properties. The program started in 2019 providing 100 houses. With the pandemic emphasizing the vulnerability experienced by the population in the streets, the scope of the project was enlarged to encompass 400 houses by the end of 2020. Among the targeted beneficiaries, people who use drugs are an important group.

Reshaping old programs: smart use of resources

Interestingly, the pandemic also revived older programs with decreasing access rates. The SICAD helpline (1414) used to be an important source for reliable information on

harm reduction services and for safe substance consumption. However, with the internet's increasing popularity, the number of calls to the line was declining consistently. The COVID-19 outbreak spiked the demand for the program, mainly driven by coronavirus related questions. In this context, the helpline gained importance, because "it offers advice to people regularly consuming substances that suddenly found themselves in solo lockdown. It was also pivotal for informing family members of PWUD, as well as harm reduction frontline workers, police force and lawyers" (Portugal: Interviewee 10). Responding to the rise in demand, the SICAD increased personnel and functioning hours of the helpline.

Harm reduction as a holistic policy:

In a moment where most life interactions moved to online regimes, a valuable feature of harm reduction services was endangered – the building of personal relationships. The Portuguese harm reduction model is heavily based upon on an individual subjective approach, focusing on constructing an apparatus equipped for providing individuals adequate case-by-case responses. Thus, the socio-economic and psychological aspects of intervention measures are essential components for achieving successful outcomes. Recognizing the possible impacts such areas might bring to individuals' drug consumption patterns, organizations have been working to develop alternative programs, targeting issues beyond conventional harm reduction approaches.

From the provision of alternative communication channels to crowdfunding initiatives for informal workers unable to continue their activities, the COVID-19 outbreak has pushed the Portuguese model to focus even more on building a resilient and personal harm reduction network. For such, the work of different ministries, civil society organizations and public administration levels come together to achieve a comprehensive and interconnected set of policies. Several interviewees, for example, mentioned the creation of crowdfunding initiatives for sex workers, in order to guarantee their financial stability and allow them to self-isolate.

Long-term scenario planning:

Lastly, the ability to anticipate future scenarios and challenges derived from the pandemic will play an important role on the outcome of harm reduction policies. Important imbalances are expected to be observed in the illicit substances market while social distancing and lockdown is likely to bring deep changes in people's drug consumption patterns. According to a worker from an NGO providing drug testing services

> "[t]he pandemic disrupted important drug routes supplying the European market. In Portugal we were observing a relatively stable trend in the substances we were testing, with low levels of adulteration. With the barriers for accessing supplying stocks, we are expecting this context will suffer important changes. Most likely dealers will start to cut substances with novel chemicals, and the results these might bring to public health are yet to be seen". (Portugal: Interviewee 3, 2020)

In order to respond to these new challenges, evaluation tools and indicators have a pivotal importance. Periodic scenario assessments are being made by all organizations involved – directly and indirectly - in the provision of harm reduction services. These diagnoses will be an important instrument for assisting decision-making of policymakers and frontline agents. Programs such as drug-testing will assume a crucial role for monitoring the trends in the market and preparing harm reduction practitioners to promptly respond to the health risks brought by novel substances. An interview with a SICAD member reinforces this hypothesis:

> "We are aware of the possible long-terms consequences this pandemic will bring to the harm reduction sector in Portugal. We are now working to fulfill the critical and urgent demands arising in the country, but we have also started to discuss the strategies to be adopted to mitigate the future risks. For example, we believe the helpline will become an important preventive tool in the context of social distancing, and we are planning to increase funding for drug testing

> programs, which can help us to understand the new trends we will be dealing with". (Portugal: Interviewee 10, 2020)

Ultimately, COVID-19 can be used as a window of opportunity to address traditionally contentious topics, allowing for the adoption of long-needed innovative approaches. The following quote illustrates a common feeling expressed by several interviewees regarding the monotone nature of the Portuguese drug policy in the last years.

> "The Portuguese model is well-succeeded, that is a fact. But maybe years of positive indicators have contributed to conceal deeper issues in society, precluding debates for innovative approaches. There is this reluctance in changing the status-quo, because it appears to be working perfectly. The truth is that there is still room for improvement, but maybe not enough political will to address it."(Portugal: Interviewee 9, 2020)

The pandemic is a stress test for the 20 years of consolidated drug policy in the country. However, instead of bringing down the Portuguese model's pillars, the crisis is providing the necessary material needed for building a new chapter in the country's history. The observation of the stakeholders' responses during the outbreak evidences their ability to positively seize these opportunities, which is expected to renew the international relevance of the model for the harm reduction field in the years to come.

GEORGIA

Georgia has one of the harshest state regulations on drug circulation in the Eurasian region. Nonetheless, since the early 2000s, the country has developed progressive harm reduction policies that have successfully approached problematic drug use as a health issue and have mitigated health risks of people who use drugs,which stem fromthe illicit drug supply and punitive drug policing. Georgia's policy of drug penalization finds its fundamental basis at the counterproductive, nationwide Zero Tolerance policy against all types of crimes, including misdemeanors and drug-related offenses. Notably, the regulative landscape has gradually moved away from encouraging such inhumane treatment practices. The latter shift occurred through the lenses of the historical decisions of the Georgian constitutional court on practical legalization of cannabis consumption, alongside the resonant, albeit futile, grassroots movement requesting the comprehensive drug policy reform.

Legal Framework

The "Law of Georgia on Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Assistance" defines state policy for illegal circulation of narcotic drugs, psychotropic substances and precursors and serves as a legal basis for drug policy in the country. The law determines narcotic drugs strictly limited and limited for circulation, establishes the minimum quantities of narcotic drugs classified as administrative offenses, and defines the instances of small, large, and particularly large amounts of narcotic drugs' possession, considered as criminal offense. If the law does not define the amount of dosage that falls under the special control, possession of any quantity of the substance is regarded as a criminal act, leading to at least six years of captivity. Significantly, the law does not specify the minimum criminalized thresholds in case of three fourth of the enlisted substances (Parliament of Georgia 2012).

Committing drug-related crimes is automatically associated with the deprivation of the individual rights ranging from suspension of driving license to the right to practice the law in Georgia (Parliament of Georgia 2007). Moreover, the Decree of the Ministry of Internal Affairs sets the basis for the medical examination for detecting the fact of drugs consumption (EMC 2019, 17). The legal grounds for medical examination include the record of "operative information" about the person being under the influence of substances, obtained through the secret investigative activities, or received through direct communication of the third party with the law enforcement officer. The last record creates space for bias and encourages police impunity during the execution of the drug control within Georgia (Minitry of internal Affiars of Georgia 2015).

The recent decisions of the Georgian constitutional court significantly contributed to the liberalization of the existing drug policy. On July 30, 2018, the constitutional court ruled that the prohibition of consumption of cannabis was unconstitutional, which resulted in practical legalization of marijuana possession in private spaces. Before the court ruling, in 2017, the Georgian "National Drug Policy Platform," advocacy network of 41 non-partisan, community-based NGOs, in partnership with the five Members of Parliament from Georgia's governing coalition, proposed the first comprehensive drug policy reform to the National parliament. Unfortunately, the reform process has been suspended without the further notice, and the Georgian drug policy legal framework has remained unchanged (Human Rights Watch 2018).

Harm Reduction for PWIDs in Georgia

Harm Reduction in Georgia, coordinated at the state level and targeted at People Who Inject Drugs (PWIDs), comprises the following services:

1. Opioid Substitution Treatment (OST) (Methadone/ Buprenorphine, and Naloxone (Suboxone);
2. Distributing injecting pieces of equipment, condoms, and information materials.
3. Prevention of drug overdoses through distributing Naloxone.
4. Case management of PWIDs (legal, psychological, individual counseling);

5. Voluntary counseling and testing (VCT) of HIV/AIDS, HVB, HVC, and Syphilis;
6. Screening and referral of Tuberculosis (TB);
7. Peer-driven outreach to PWIDs;
8. Counseling and individual assistance to sex partners of the PWIDs (GHRN 2015).

In the context of Georgia, the given report overviews the challenges amidst the COVID-19 pandemic faced by the low threshold (all the aforementioned HR typologies except OST) Harm Reduction (HR) service providers. Therefore, the provided part of the study specifically focuses on the Georgian Harm Reduction Network (GHRN), an umbrella organization unifying 26 community-based NGOs, responsible for delivering low threshold harm reduction within the country. GHRN services, provided through 14 stationary and nine mobile harm reduction centers in 11 cities, reach the entire populated sites of Georgia.

This part of the report rests on three semi-structured in-depth interviews conducted with the executive director of the GHRN alongside the GHRN's two sub-contractor NGO managers, running the harm reduction stationary sites in six cities of Georgia (Tbilisi, Kutaisi, Samtredia, Gori, Borjomi, Telavi) and covering a more comprehensive range of surrounding areas with four mobile harm reduction centers. The selected sample of harm reduction centers delivers its services to one-third of Georgia's low-threshold HR beneficiaries.

Novel Coronavirus and the State Response

Georgia detected the first Coronavirus-infected patient on February 26. On March 16, Georgia announced stringent measures to fight the pandemic, including banning entrance to the country for foreign nationals, nighttime curfew, and the complete lockdown of the local areas with surging Coronavirus cases. The government decree shut down all workplaces but the pharmacies, hospitals, food delivery services, grocery stores and essential state agencies. Moreover, the decree suspended public transportation during the special order and banned the private transportation for 10 days between 17th and 27th of April. As for June 21, the country has 906 detected Coronavirus cases in total, with 755 recoveries and 14 fatal cases (Government of Georgia 2020).

Perilous Journey to Self-Adjustment

Following the spread of the Covid-19 epidemic within Georgia, the harm reduction providers at the GHRN primarily attempted to ensure continuous, steady delivery of the services in place. As explained, the first constraint for the low-threshold harm reduction spaces was the substantial rearrangement of the existing programs, requiring physical interactions between the beneficiaries and personnel, to make them compatible with the highly contagious disease.

According to the Executive Director of the GHRN, even though the GHRN has generally been accountable towards the National Center for Disease Control (NCDC) of Georgia, the initial stage of the health force majeure lacked timely coordination between the harm reduction service providers and the state apparatus.

> "Yes, the state entities possessed the information on how to coordinate, but no one had time for us. According to the current hierarchical structure, the GHRN subordinates to the NCDC. However, amidst the epidemic, we alone became responsible for adjusting our services to the new reality." (Georgia: Interviewee 1, 2020)

The reason for such miscoordination was that the NCDC became an epidemiological secretariat to fight the Covid-19 epidemic nationwide at the initial stage of the virus outbreak. Thus, the situation led the low-threshold harm reduction services in Georgia to the structural, albeit perilous, "self-adjustment" process.

Through the latter lens, the research participants identified the primary challenge as being related to the state's legal classification of harm reduction centers. The current legislative framework of Georgia does not recognize low-threshold harm reduction centers, stationary or mobile, as licensed healthcare institutions. Consequently, within the special order in the country, provision of low-threshold harm reduction services conflicted with the "Governmental Decree about the Special Order." The decree enlisted the private and public services available during the lockdown measures but automatically excluded the low-threshold harm reduction from its core constituents. Executive Director of the GHRN noted that even though he attempted personal communication with the NCDC administration to

request official permission for operating under the special order, the state agency could not provide such documentation.

> "...I printed our contract with the NCDC and distributed it on the harm reduction sites so that if the police came, we had proof, and they could not fine us. Whether such challenging times return, we will need to be legally recognized as healthcare institutions."-He explained (Georgia: Interviewee 1, 2020).

Amongst the provided services, participants highlighted the program of Voluntary Counseling and Testing (VCT) for HIV, HBV, HCV, and Syphilis alongside the screening of Tuberculosis to be of utmost vulnerability, as these practices require the greatest extent of human-to-human interaction and thus include enhanced risk of spreading the Novel Coronavirus. Hence, before the launch of the self-adjustment process, GHRN's management promptly decided on suspending the VCT program for a week to decrease the probability of infection transmission from the program beneficiaries to the personnel or vice versa. In the meantime, the GHRN targeted its centralized administrative effort to stock sufficient amounts of masks, isolation gowns, suits, medical gloves, and sanitizers. Particular harm reduction sites began to produce cloth facemasks to distribute them within the known communities of PWIDs. However, the participants outlined that the quantities of the received protective types of equipment have been restricted. Therefore, the management still faces an obstacle to providing the harm reduction staff with an adequate extent of protection from the infection. One of the interviewees explained that the country, in general, does not have enough of the protective types of equipment, and even though the GHRN endeavors to equip its personnel, the sufficient stocks of protective facilities are continually lacking.

Succeeding a week of preparations, Harm Reduction centers that integrate the state program of HCV elimination relaunched the VCTs. Nevertheless, participants of the given research demonstrate that the daily number of the tested beneficiaries at the stationary centers significantly decreased as the stringent lockdown measures of Georgia banned public transportation throughout the country. While the stationary centers captured the diminishing trend of the number of PWIDs tested daily, the mobile hospitals turned out to

be inflexible places for testing, considering the inability of social distancing within such tight areas.

Due to the remote working patterns of the employed social workers, GHRN stationary sites suspended the case management and peer-driven outreach services. Nonetheless, the organizations used their existing capacities to increase the amount of injecting equipment provided through the framework of the Needle and Syringe Program (NSP). Mobile harm reduction was utilized to distribute a weekly amount of safe injecting kits and reasonable doses of Naloxone for self-administration to PWIDs. The latter has been an exceptional precedent in the country, where, due to the draconian drug legislation, PWIDs could only access daily amounts of injecting and overdose prevention tools before the Covid-19 pandemic. One of the interviewees outlined the motivation behind the new internal policy regarding the distribution of weekly equipment stocks:

> "Before the Coronavirus outbreak, GHRN had the limits to the daily distributable amounts of clean injecting pieces of equipment and Naloxone; however, we decided to exceed these limits as we did not possess any other measures to prevent the flow of the beneficiaries into our Harm Reduction stationary centers. When we changed the distributing tactic, we notified the NCDC and Country Coordinating Mechanism (CCM), and they encouraged our strategy. " (Georgia: Interviewee 2, 2020).

This is where the interviewees bolstered the rationale behind the decision-making at the level of state and beyond, at the level of the Country Coordinating Mechanism (CCM) of the Global Fund, the major international donor of the low-threshold harm reduction services in Georgia. Covid-19 substantially expanded the fiscal and administrative autonomy of the GHRN and its sub-contractor NGOs. The latter was demonstrated through granting the GHRN and its subordinate entities the possibility to revise their fixed budgets, access the savings, and take the lead to manage the programs according to the ever-changing and unforeseeable crisis circumstances.

Nonetheless, as the research participants observed, the applied measures targeted the short-term impediments, whereas sustainable and long-term vision of the future

developments has been missing. The employed effort focused on providing uninterrupted delivery of the low-threshold harm reduction services in Georgia, but it could not anticipate the risks associated with the potential of spreading the virus within the communities of the PWIDs. "You know, drug injection is a collective ritual organized at the level of groups of 8 to 10 consumers," the harm reduction provider highlighted, "but I still cannot predict how we will deal with the situation when even one of such group members gets infected." (Georgia: Interviewee 2, 2020)

Newcomers and the Disappeared

Uncertainty at the early stages of the pandemic outbreak encouraged people globally to reach their families and secure destinations. The latter tendency, therefore, enhanced the number of private or state-funded international flights across the countries. Georgia was not an exception to the rule. According to the official information of the Ministry of Foreign Affairs (MFA), as for April 20, around 7000 Georgians have been brought home from the different Coronavirus-hit areas worldwide (Agenda.ge 2020).

As the study participants highlight, such a pattern of behavior significantly affected the numbers of registered beneficiaries in the low-threshold harm reduction centers. The Georgian injecting drug consumer migrants returned mainly from Europe, restarted, or began to utilize the GHRN's service shortly after entering the country. One of the harm reduction site managers denoted that, following the Coronavirus outbreak, she encountered a large number of novel or forgotten faces at their stationary centers. Nonetheless, even though the low-threshold harm reduction centers were able to supply the new intakes, in particular instances, they encountered significant administrative problems related to registering the newcomers into the national harm reduction system.

> "We had a case when the returned person tested positive for HIV and wanted to register in our system, but he did not have an Identity Document. When the Justice Hall does not work, you cannot get the ID card, and the person had to wait, albeit his waiting had a price."(Georgia: Interviewee 3, 2020)

As a result, the Coronavirus-driven bureaucratic hurdles increased the vulnerability of the PWIDs, especially the vulnerability of the migrant PWIDs. Through the same lens, GHRN almost canceled the individual counseling and case management services to the PWIDs, even though the beneficiaries needed for the bare necessities such as an Identity Document for registering in the harm reduction system.

In contrast to the migrant PWIDs, Coronavirus negatively affected the social workers' level of communication with some of the traditional, albeit exceptionally marginalized groups of the low-threshold harm reduction service recipients. Women who inject drugs or female intimate partners of PWIDs represent one clear demonstration of such lost personal ties. The research participants emphasize that the female beneficiaries of the low-threshold harm reduction services have remained as the most marginalized community. Thus, considering the extent to which the epidemic added to the constraints of reaching the low-threshold harm reduction beneficiaries in Georgia, the female beneficiaries disappeared.

Human Element of the Harm Reduction is Lost

The respondents outlined that besides the female beneficiaries, compared to the pre-Coronavirus period, lately, the numbers of harm reduction recipients show a diminishing trend, which is visible in the context of Voluntary Counseling and Testing (VCT) program. Although the GHRN administration relaunched provision of the VCT program shortly after its suspension, it still has not received a stable number of daily beneficiaries. The latter partially relates to the applied measures of the special order within the country. However, the participants highlight that putting the lockdown impacts aside, the low-threshold harm reduction has obtained specific, typical nature for the Georgian beneficiaries. As implementation of the provided services requires a considerable extent of face-to-face interaction, they have been associated with the human element, which explains their popularity among PWUDs. Hence, the Coronavirus-related preventive and security measures, including wearing the protective equipment, encouragement to self-isolation, and physical distancing, decreased the value of such human elements of the GHRN's programs.

Uninterrupted provision of the low-threshold harm reduction services does not define their ultimate effectiveness to reach and reduce harms within the communities of people who inject drugs, the interviewees denoted. What makes the difference, alternatively, adding to the quality provision of the programs in place, is daily human interaction between the social workers, harm reduction personnel, and their beneficiaries. While referring to PWUDs living in the social shelters in the capital of Georgia, Tbilisi, one of the harm reduction NGO managers outlined that even though the community lives far from the harm reduction site, it intentionally avoids utilizing the mobile service of testing and equipment delivery. As the participant highlighted, the PWIDs, usually socially insecure and stigmatized from the society, seek human element when receiving the daily harm reduction:

> "Our organization is located near the Tbilisi Concert Hall while the social shelter is in Lilo, in 40 minutes driving distance from our place. Consumers from the social shelter used to commute daily to receive our services. I think this was more about the friendly attitudes and relationships that we offer them. They used to come here, talk to us, laugh and complain."(Georgia: interviewee 2, 2020)

The latter explains why these specific recipients refused to benefit from the so-called "Sigma" services, the harm reduction vending machines across Tbilisi, providing clean needles, syringes, and Naloxone when accessed with the individual plastic cards.

Adding to the eliminated human interaction, the research participants argue that in particular instances, the isolation measures decreased PWID's access to food. When reaching the harm reduction centers, besides interacting with the administration, the beneficiaries were fed, whereas, during the Coronavirus outbreak, such practices no longer occur. The executive director of the GHRN estimated that due to the existing gap in daily communication with PWUDs, post-Coronavirus sustainability plan would have to increase the budget for the individual case management services, considering the current basic needs of the people who use drugs.

Lastly, and mostly, the interviewees highlighted that the social workers at the low-threshold harm reduction centers tracked the potentially increasing trend of overdoses in the communities of the PWIDs. In parallel to the low-threshold harm reduction, the Opioid

Substitution Treatment (OST) programs in Georgia also distribute increased amounts of substitution substances within the PWID communities. As the latter practice is innovative for Georgia, the substance usage behavior has changed as the PWIDs began to consume the provided quantities of opioid substitutes in higher amounts, which led to a surge in the cases of overdoses, resulting in doubling the demand on Naloxone to prevent the overdoses.

Conclusion and Key Findings

The coronavirus outbreak in Georgia has brought substantial obstacles to the low-threshold harm reduction centers of the Georgian Harm Reduction Network (GHRN). Nonetheless, due to the enhanced responsibility of the state's National Center for Disease Control (NCDC) to manage epidemiological trends within the country, GHRN faced the need for self-reshuffling or self-adjusting to the new, crisis reality. Through the latter lens, in the short and medium terms, GHRN's adjustment strategy has centered on the uninterrupted and robust provision of the services in place, while the sustainable vision for the future development, based on risk assessment, has been lacking. The study participants outlined that such sustainable-oriented tactics are missing considering the unforeseeable potential financing schemes of the Global Fund and the NCDC. The GHRN participates in the public procurements of the NCDC to receive the permission to provide the low-threshold harm reduction in Georgia; hence, sustainable delivery of the low-threshold harm reduction services, especially amidst the pandemic, is conditional on guaranteed financial recourses that will retain the current design and scope of the programs in place.

Concurrently to the process of self-adjustment, according to the interviewees, pandemic-related force majeure notably added to the fiscal and administrative autonomy of the GHRN and its sub-contractor NGOs. Individual decision-making of the organization regarding increased delivery of the injecting equipment, more flexible access to the savings and fixed budget of the programs in place represent practical manifestations of such autonomy. This increased the effectiveness of the organization and contributed to the timely response of the GHRN to the public health emergency. Despite the greater autonomy, GHRN faced challenges when it came to operating under the special order

within Georgia. As low-threshold harm reduction services in the country are not included in the state's classification of healthcare institutions, "Governmental Decree about the Special Order" unintentionally excluded the operation of the low-threshold harm reduction centers from its core constituents. The last barrier created another hurdle when the special order measures banned transportation within the country. Respondents argue that it took a meaningful amount of time until the government licensed the low-threshold harm reduction personnel and mobile centers to drive in the course of the transportation restriction. Thus, it is of utmost significance that the low-threshold harm reduction services are recognized as the healthcare institutions or benefit from the equal administrative rights as such institutions do during the special order.

At the level of program recipients, the public health crisis in Georgia incentivized migrant communities of PWUDs mainly from Europe to seek secured stay in their family places. As mentioned above, the tendency to increase the beneficiaries of the low-threshold harm reduction centers in the country added a burden to the management of the GHRN's programs. Disregarding the surging demand, the harm reduction providers well handled the novel streams of the program recipients. Nevertheless, considering the stringent lockdown measures applied in Georgia, GHRN almost suspended its case management services. This elevated the vulnerabilities of the particular beneficiaries such as those who did not possess documentation to register in the programs alongside the recipients that accessed food at the service centers or visited the harm reduction sites conditional on the distributed packages (female IDUs, female intimate partners of the PWIDs).

Moreover, the new, Coronavirus-adjusted design of the low-threshold harm reduction programs was counterproductive in two parallel dimensions. Primarily, greater emphasis on the home-delivery of the harm reduction facilities eliminated the human element of the low-threshold harm reduction services, while the latter, as the interviewees' highlight, represented one of the core success determinants of such programs. On the other hand, encouragement towards self-administration of injecting, preventive harm reduction facilities, and the opioid substitution substances, affected drug-consuming habits of the PWIDs, which increased the demand on Naloxone to address the surging overdoses cases.

To conclude, two different sides of the low-threshold harm reduction administration amidst the health emergency has been demonstrated. Lacking the coordination with the state apparatus substantially challenged the GHRN; however, alternatively, it brought a high autonomy in the management of the programs in place and increased promptness and efficiency of navigating through the crisis-driven unpredictable circumstances. Consequently, while the effective administration of the low-threshold harm reduction resulted in the steady and uninterrupted promotion of the existing programs, it overlooked the larger dimension of sustainability. Hence, the latter resulted in the disappearance of the human-to-human interactions from the harm reduction services and an increase in overdoses. However, when the global management systems collapse, steady and continual delivery of the local harm reduction services in Georgia should be objectively regarded as a tremendous success.

PENNSYLVANIA

Drug policy remains a contingency point in the context of the United States. It is highly intertwined with major social issues that are heated now, while governance remains fragmented between the federal, state and local level, leading to discrepancies that further inequalities.In this sense, the selection of the specific case of Pennsylvania brings important insights. Today, Pennsylvania has one of the highest death rates from opioid overdoses in the United States.In such a context, harm reduction programs become an essential service. The COVID-19 pandemic brought important aggravators to an already challenging picture, forcing the state to battle two epidemics at the same time. The responses adopted by harm reduction agents in light to the crisis evidence a valuable set of best practices for workers operating in adverse frameworks. This section builds on interviews conducted between March and May 2020, with Clayton Ruley, Director of Community Engagement and Volunteer Services, Prevention Point Philadelphia; Devin Reaves, Executive Director, Philadelphia Harm Reduction Coalition;[9] Julia Hilbert, Intern, Prevention Point Pittsburgh; and Jake Agliata, Policy and Communications Officer, INPUD.

Local, state and nationwide drug laws

Drug laws in the state of Pennsylvania follow the DEA's scheduling of substances, and penalties are outlined as two misdemeanors and three felonies. Possession of any scheduled substance or drug paraphernalia (such as needles and syringes) is a misdemeanor punishable by up to one year in prison, or a fine up to $5000. On the other hand, possession with intent of trafficking, possession with intent to deliver, and unlawful manufacturing are framed as criminal felonies. Such practices can be punished on a sliding scale based on the schedule of the substance, quantity and other factors. In general, sentences for felony drug

[9] Devin Reaves has resigned from his position as Executive Director of the Philadelphia Harm Reduction Coalition on June 26th, 2020. All opinions are his own.

offences can be up to 15 years in prison, or up to $250,000 per count in fines. Conviction on any of these charges also entails a minimum of six months' suspension of the individual's drivers' license, which doubles with any subsequent conviction.[10]The District Attorney may choose to federalize cases, leading to their prosecution in federal court. The impacts of such decision add important outcomes to cases, as federal drug crimes in the US may result in sentences up to life in prison without parole. (Criminal Law Practice of Price Benowitz, 2020)

On the local level, in Pennsylvania Single County Authorities (SCAs) are responsible for organizing drug and alcohol prevention and treatment services. They are responsible for distributing federal and state funds essentially setting drug and alcohol policy in that county. In a similar fashion, criminal justice policy on the state and local level is directed by Criminal Justice Advisory Boards (CJAs), responsible for coordinating the local police, sheriffs, the prison system and county commissioners. This affects drug and alcohol policy both through enforcement, and through the drug courts and diversionary programs, as their structure is set by the CJA – this determines, for instance, if naloxone or OST is available in county jails and prisons. Several cities in Pennsylvania have local ordinances in place that have decriminalized the possession of up to an ounce (28.5 grams) of marijuana, including Philadelphia and Pittsburgh. In these cities, possession is punished by fines of up to $500.

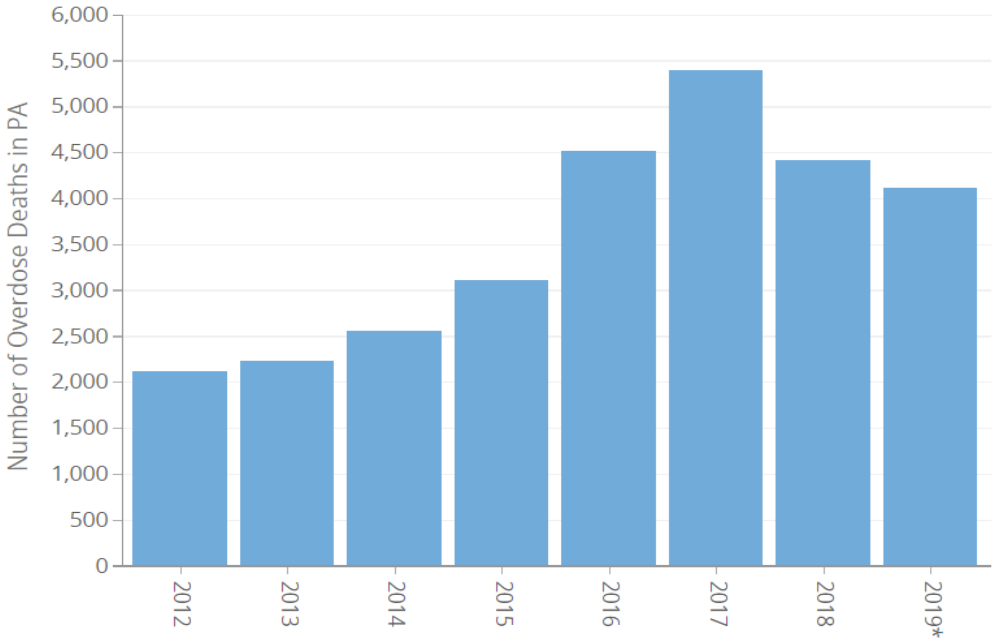
The opioid crisis in Pennsylvania

> "The opioid epidemic affects every walk of life. Rich, poor, black, white, young, or old — the opioid crisis is unprejudiced in its reach and devastation. At least 10 Pennsylvanians die every day from a drug overdose, with more than 5,300 overdose deaths in Pennsylvania in 2017 alone." (Government of Pennsylvania, 2020)

[10] It is important to note drivers' licenses are the main form of identification document in the US.

Pennsylvania has one of the highest death rates from opioid overdoses in the United States. The city of Philadelphia, the capital of Pennsylvania, has designated the opioid use and overdose epidemic as the greatest public health crisis of the century. 4,642 drug-related overdose deaths were reported in 2016 in PA, opioids were found as the cause of death in 85% (25% of which were prescribed). Increase in drug-related overdose deaths between 2015 and 2016 larger in rural counties (42%) compared to urban counties (34%). The drug-related overdose rate in PA was 36.5 per 100,000 people, compared to the national average 16.3 per 100,000, and 78 percent of PA counties had overdose death rates higher than the national average (DEA Drug Overdose Report, 2016).

Graph: Estimated Accidental and Undetermined Drug Overdose Deaths 2012-2018

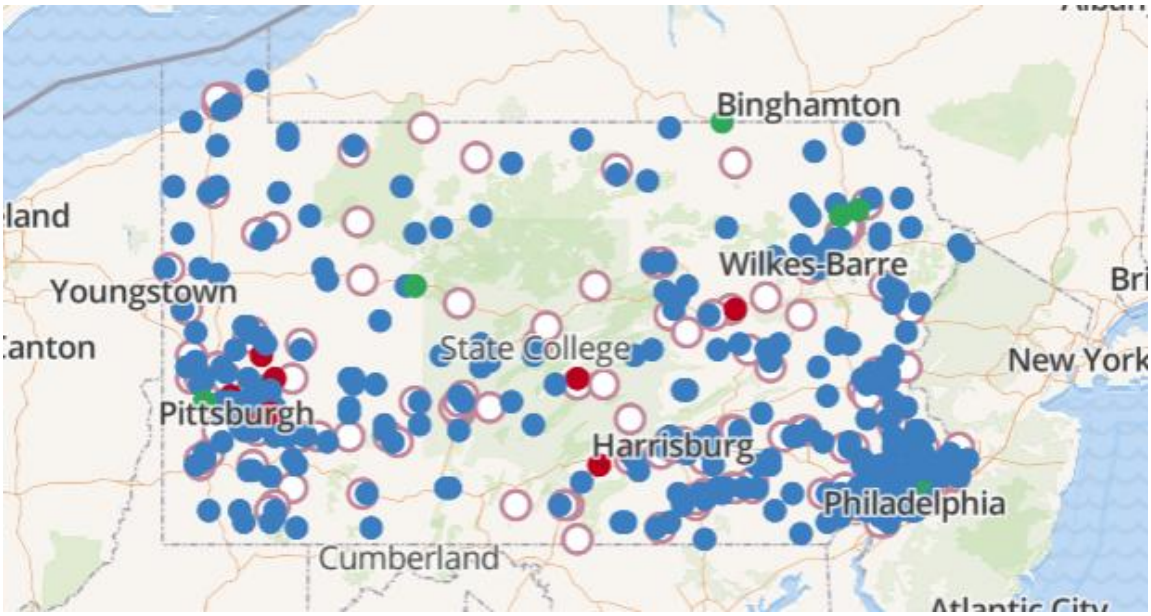


Source: Government of Pennsylvania. Available at: https://data.pa.gov/stories/s/9q45-nckt/

Between January 1st, 2018, and May 23rd, 2020, more than 24.000 Emergency Room visits related to opioid overdose were recorded (Government of Pennsylvania, 2020). In 2018, 70% of all drug overdose deaths in Pennsylvania involved fentanyl, and around 35%

involved heroin (Overdose Free PA, 2020), though the drug categories are not mutually exclusive, and deaths may have involved more than one substance. However, this data stands in line with the observations of community member and frontline workers that the prevalence of fentanyl has partially replaced heroin in the illicit supply, in addition to the fentanyl available by subscription.

Graph: Dispersion of Pennsylvania Drug and Alcohol Treatment facilities



Source: Government of Pennsylvania. Available at: https://data.pa.gov/stories/s/Treatment/fvkx-eumb

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency with the U.S. Department of Health and Human Services (HHS) responsible for "providing leadership and resources – programs, policies, information and data, funding, and personnel - [to] advance mental and substance use disorder prevention, treatment, and recovery services in order to improve individual, community, and public health" on the federal level (SAMHSA, 2020).

Clinics providing Medication Assisted Treatment have to be approved by the SAMHSA through a lengthy application process. Federal legislation allows for the provision of MAT

in residential, behavioral and outpatient programs, as well as in hospitals and jails and prisons. The Food and Drug Administration (FDA) approves the use of methadone, buprenorphine and naltrexone as medication for use in detoxification or maintenance treatment of opioid use disorder (OUD), and MATs are also allowed to suboxone and naloxone as it is also allowed on the federal level by the FDA (Holt et al. 2019).

The number of physicians legally allowed to treat OUD by prescribing the appropriate medications to patients is restricted. Buprenorphine prescription are entitled only to doctors who first obtained special license from the Drug Enforcement Administration. The requirement was created by the federal Drug Addiction Treatment Act in 2000 (DATA 2000). The X-waiver requires additional training, administrative hurdles, and puts a cap on the number of patients a doctor can prescribe buprenorphine to per year. The baseline is 30 patients per year, but according to the SUPPORT Act of 2018, "qualifying other practitioners" can treat 100 patients in their first year, after which they can request an increase to 275 patients (American Society of Addiction Medicine, 2020). According to a 2019 estimate, less than 1 percent of doctors in emergency care units and less than 4 percent of all licensed doctors in the U.S. have an X-waiver. This also means that nearly half of the counties in the U.S. have no licensed providers (Stein et al., 2015) and less than 40% of Americans living with an OUD receive MAT treatment (Haffajee et. al., 2018). The limitations bring important obstacles to efforts to address the opioid crisis, as a licensed doctor tends to fill up the patient thresholds in short amounts of time. Ultimately, the limitations mean not enough available services for individuals in need of health treatment (Hanson, 2019).

In the state of Pennsylvania, as of 2019, MAT is available at 46 Centers of Excellence (The Wright Center, 2019) and 5 Pennsylvania Coordinated Medication-Assisted Treatment centers (Government of Pennsylvania, 2018). For a state with a population of close to 13 million people, and in the context of the opioid crisis, this number is quite low. The geography of Pennsylvania is also quite diverse, ranging from urban areas to rural and very rural, mountainous areas, and coverage is not equally nor adequately dispersed based on the needs of the community. "Rural providers, hospitals, clinics, and treatment professionals

are often dispersed across large geographic areas, making access difficult, especially for patients who lack transportation" (Holt et al., 2019)

A common way to determine adequate access to medical care and treatment in the U.S. is assessing whether health services are available within a 30-minute driving distance - in Pennsylvania, urban areas surrounding major cities have treatment centers fulfilling this conditions, but in rural areas this is very limited, posing a major challenge to care and long-term treatment of OUD, especially MAT. (Holt et al., 2019)

Harm reduction services in Pennsylvania under COVID-19

> "What government is not good at is nuanced response. Nowhere in there do you have someone that's taking a broad focus, wide-view, macro drug policy lens. You have an overreactive state responding too quickly, a drug and alcohol system that doesn't understand public health, a criminal justice system that doesn't understand public health – and you've got a recipe for disaster."(Interview with Devin Reaves, 2020)

The current Governor of Pennsylvania, Tom Wolf, entered office in 2015, declaring tackling the heroin and opioid epidemic in the state his top priority. (Wolf, 2018) Since he's been in office, some important policies have been implemented, such as a statewide standing order for naloxone issued in 2015 – a prescription written for the general public, signed by the acting Secretary of Health of Pennsylvania, which allows individuals to access this medications without having to visit a physician. (Pennsylvania Department of Health, 2019).However, they still have to pay for it, and it is not included in most insurance schemes. (Government of Pennsylvania, 2020).In 2018, the Governor issued Pennsylvania's Opioid Disaster Declaration, and launched 13 statewide initiatives focused on solving the problem, including an Opioid Operational Command Center staffed by 13 different state agencies and launching Centers of Excellence focused on getting people into treatment and engaged in the continuum of care longer, with a "focus […] on treating the whole person, whether it's underlying pain, a mental health issue or addiction."

(Government of Pennsylvania, 2018).The policies also recognize the importance of full-spectrum harm reduction, including providing support services like housing and education as "wraparound services" (Government of Pennsylvania, 2018).

However, actual implementation of these policies on the ground has been less than ideal. Some success has been achieved since 2017 in reducing the number of opioid-related overdose deaths in the state, but the extensive and almost exclusive focus on treatment and recovery and the "warm hand-off policy, where people who end up in the emergency room from overdoses or encounter first responders or law enforcement have the option to enter treatment" (Government of Pennsylvania, 2018),still entails extensive involvement of the criminal justice system in drug policy, and does not foster a true harm reduction approach.

Implementation problems are partially due to Pennsylvania having a very weak public health infrastructure – only 9 out of the 67 counties in the state have public health departments. This significantly contributes to local authorities being unable to respond to emergencies, as has been seen through the opioid epidemic and the COVID-19 pandemic - most of the time, non-public health people are making decisions about drug policy (as outlined above, SCAs and CJAs significantly shape drug and alcohol policy in the state, mostly through the criminal justice system). (Interview with Devin Reaves, 2020)

Drug supply and conditions on the ground during the pandemic

Changes in the drug supply can't be definitively identified as of now, but people's level of concern about their supply has been high, including accounting for scenarios of their dealer getting sick (Interview with Julia Hilbert, 2020). There were fears that getting fentanyl and heroin supply to the East Coast markets due to the limiting of traffic across the US-Mexico border, but so far it seems that the flow of illicit drugs has not visibly slowed down – instead, there could be a case of "street dealers buying the hype and cutting their product out of fear [of shortage]." (Stewart in Moraff, 2020) In Kensington, people who use heroin/fentanyl and cocaine have reported recent declines in quality. (Moraff, 2020) Concern was also raised over the closure of Wonderland, a notorious tobacco shop/convenience store in Kensington, where dealers usually buy vitamin C to cut their

drugs with. Now that it's closed due to the lockdown, it becomes a question of what they are using to cut the drugs with now. (Interview with Devin Reaves, 2020)

The announcement that non-violent low-level offenders will not be arrested at this time, has been followed by reports of increase of petty theft on subways and trains, as the most marginalized have lost their income sources – panhandling, casual work, sex work are all non-existent or highly dangerous right now, and they had to find opportunities. (Moraff, 2020)

There has also been a significant uptick in violence – Philadelphia's homicide rate is up by over 10% compared to this time last year, while the tendency worldwide has been a dramatic fall in reported crime rates since the lockdown. In Kensington's drug using circles, the uptick of violence is attributed to fear and anxiety related to not just the pandemic situation, but fears of decline of substance purity, as well as dealers fearing losing their clientele – conflicts have occurred because people passed by dealers without purchasing from them. (Moraff, 2020)

Low-threshold harm reduction services

As possession of drug paraphernalia is a punishable offense under state legislation, needle and syringe exchange services are essentially illegal. The exceptions are two organizations, Prevention Point Philadelphia, and Prevention Point Pittsburgh. The Philadelphia site operates legally under operate under executive order by the mayor, issued in 1992. As opposed to a city ordinance (that the Pittsburgh site received in 2008), the executive order can be reversed at any time by the decision of the mayor. Though, given "the fact that the city continues to be a hotbed for opiate use, a number of overdoses, and the prevalence of fentanyl in the drug supply over the last couple of years – and the fact that the program is effective -, that doesn't seem to be a threat anytime soon." (Interview with Clayton Ruley, 2020)

Prevention Point Philadelphia operates in the city's Kensington neighborhood, which is home to the largest open drug using scene in Philadelphia, and the heart of the city's

overdose crisis. The service operates out of a central building as well as 15 mobile locations all over the city. The basic services, also available at the mobile sites, are needle and syringe exchange services, and overdose prevention, including education on administering and distributing Naloxone. In their central building, PPP offers case management services for a host of concerns, including medical, housing, accessing public benefits, health insurance, obtaining food stamps, legal services, ID assistance, shelter referral, food and clothing distribution, and a mail service for about 1500 people. They operate a drop-in center in the building where participant can "hang out, chill, get a coffee, and access these services." (Interview with Clayton Ruley, 2020) They also operate specialized clinics for HIV and Hep C, wound care clinics, and an acute medical clinic that is staffed by students of medical universities. They also manage a police-assisted diversion program, and a re-entry program for folks getting out of prison.

Due to the COVID-19 pandemic, they had to scale back their services by about 80%, so that only the absolutely essentials remain – medication assisted recovery services (MARS), syringe distribution, overdose prevention and Naloxone distribution, HIV and Hep C care, and very limited case management, such as the mail service. They offer general assistance to participants to navigate the system of resources available and necessary now, like accessing benefits. Primary, wound care, and acute medical care stopped mainly because they've relied heavily on outside providers, such as nurses, who are not able to come to the site because of the high demand on medical facilities due to COVID-19. The drop-in center has closed, the weekly Ladies' Night is put on a hiatus, and diversion programs have stopped. 7 mobile sites have remained active throughout the pandemic, offering syringe service and Naloxone distribution.

Since around 70% of the people PPP works with are street homeless or lacking stable housing, a significant issue has been their difficulty of abiding by social distancing norms and social isolation orders. In the first few weeks of the lockdown, the city police were aggressively enforcing social distancing, which affected this population. This practice has since been stopped as reports were released that showcased that this manner of enforcement was unrealistic and very hostile. Further, the District Attorney has issued a moratorium for

police commissioners are the Prosecutor to put arrests and prosecutions on hold for low-level offences, including drug possession and selling, and sex work. These measure were welcomed by the community, though PPP noted that their participants were not disproportionately targeted by law enforcement before, due to the current DA's approach of "wanting to have concrete evidence on folks, [and understanding] the nature of the drug dealing business – you take one person down from a corner and another come along."(Interview with Clayton Ruley, 2020)

PPP has not seen a significant decrease during COVID-19 in terms of the people accessing their services, though the mobile services have been noticeably less frequented. According to testimonies by participants, locations around the city became difficult to access due to the cut of public transportation during the lockdown. SEPTA, the transportation network serving Philadelphia has cut their services and schedules down by almost 90% as a part of the strategy to slow down the spread of the virus, operating a very limited "Sunday schedule." This has not only made it difficult for folks to access services, but many people without a home had used the city's 24-hour transportation system as a last resort shelter before, including sleeping on trains or at stations. (Rosenberg, 2020) SEPTA also enforces limits on the numbers of passengers on board at a given time and utilizes transit police to verify that people have a legitimate reason to travel. This has barred homeless people from seeking shelter on trains, and they've also been banished from stations due to infection concerns. Following reports, SEPTA has adopted a policy of "restricting access and getting outreach support from Project HOME and the city's Office of Homeless Services." (Madej& Laughlin, 2020)

Because of the uncertainty around whether participants will be able to access services on a sustainable basis due to concerns like this, as well as to limit the number of contacts, PPP is giving out more days' of supply of equipment and hygiene kits at their mobile and building locations as they normally do.

Treatment providers

In the context of COVID-19 and the resulting lockdowns, on March 16 (updated on March 19) the SAMHSA issued guidance of OST providers that increased flexibility and allowed for state to "request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder" and "up to 14 days of Take-Home medication for those patients who are less stable but who the OTP believes can safely handle this level of Take-Home medication." (SAMHSA, 2020) With this guidance, SAMHSA has essentially passed down responsibility to the states in deciding on a maximum allowed dose and placed the ultimate responsibility of deciding on distribution criteria to the individual treatment providers, leading to largely inconsistent provision of services. In Pennsylvania, the state allows a maximum of one-week dose for take-home provision, which most clinics have provided to all their participants, but new intakes are basically stopped due to lack of capacity at most places. (Reeves, 2020; and Moraff, 2020)

This is despite a temporary relaxation on new intakes. Federal law requires a complete in-person physical evaluation before admission to an OTP - for the duration of the national emergency declared in response to the COVID-19 pandemic, SAMHSA has temporarily allowed using telehealth for enrolling new patients to be treated with buprenorphine, removing the requirement to see an X-waivered physician at least once before having the option to receive prescriptions by telemedicine. In light of this relaxation, some OST providers, including CleanSlate Outpatient Addiction Medicine in Philadelphia, have sent care coordinators to the streets with a phone in hand to directly reach out to PWUD and offer them the opportunity to get on the phone with a doctor and get enrolled in the program. The exemption does not include those to be treated with methadone, due to the more complicated dosing regime used until a patient reaches therapeutic levels. (SAMHSA, 2020)

As the access to OST has remained limited and fears of an adulterated or dried up illicit supply loomed, the focus on distribution opioid overdose reversal medicines like naloxone. A statewide effort was exerted through the Pennsylvania Harm Reduction Coalition

(PAHRC) to ship extra supplies of Naloxone to prisons, and to organizations that serve people who recently got out of prison. As PA county jails started rapid decarceration to slow the spread of the virus – and people getting out of jail, without IDs, without connections to enroll in OSTs are in general more vulnerable to overdose death, and the risk has been exacerbated during the pandemic. Until the beginning of May, PAHRC has sent over 2000 Naloxone kits to 27 county prisons – only two of the county's prisons had Naloxone to distribute before. "We refuse to let that go [after the COVID], we're going to work with those people, stopping is not an option," is the perception of sustaining this service in the long-term. (Interview with Devin Reaves, 2020)

Safe injection site

Philadelphia-based nonprofit SafeHouse has been working for the last couple of years on establishing the nation's first supervised injection facility in the city to prevent overdose deaths. They have faced great pushback, both from the local community and local authorities. The U.S. Attorney for the Eastern District of Pennsylvania filed a civil lawsuit to the federal court to declare that supervised consumption sites are illegal under 21 U.S.C. §856(a), know as the "Crack House" Statute. In late 2019, the court ruled in favor of SafeHouse, asserting that "the ultimate goal of Safehouse's proposed operation is to reduce drug use, not facilitate it, and accordingly, §856(a) does not prohibit Safehouse's proposed conduct." (SafeHouse, 2020)

COVID-19 has come at an interesting time for the SafeHouse project – they have overcome the final legal hurdle and entered a phase where they have to focus on other issues that were sidelined as attention was rightfully drawn to legal problems. Details that still need to be figured out are major, as it includes the location of the site, exploring its accessibility, ensuring staffing – and addressing community concerns. Kensington, the neighborhood that's been a top spot for people who inject drugs for 30-40 years (Interview with Clayton Ruley, 2020), was the first choice of location, logically, but was ruled out because it is difficult to access from other parts of the city by public transport. On the other hand, the idea of placing the site in other neighborhoods has been faced with huge backlash

from the non-drug using community of Philadelphia, precisely because they fear their neighborhood turning into Kensington. "The community's perception comes from Kensington, the scene there is what they associate with drug use – a particular population of people that they wouldn't like to move to their neighborhood if this is built." (Interview with Jake Agliata, 2020)

Because of the legal hurdles, these concerns were not addressed by SafeHouse, who were planning a series of forums and community dialogue for this spring, that didn't occur due to COVID-19. If these concerns are not addressed properly, they run the risk of people interfering with the opening, people harassing people trying to access the site, anger, protest – which would all lead to people not using the site. "The COVID-19 situation could be a time to take advantage of to make people understand that nothing about their life is going to change [from the opening of the safe injection site], there's just going to be less open use, […] and less people will die, [and then] they'll become a lot more comfortable with the idea."(Interview with Jake Agliata, 2020)

Conclusion

The case study of Pennsylvania shows that harm reduction services fulfill many other social functions that governments fail to deliver and fill in the gaps in the public health system that perpetuate inequalities for already marginalized populations such as PWUD, people experiencing homelessness, communities of color, sex workers, LGBTQI+. The pandemic highlighted the enormous demand on and need for harm reduction services, especially from those populations that are underserved by and/or experience discrimination in formal healthcare institutions. The present moment when the intersection of social issues and health that is contributing to the several epidemics that have been happening in the United States for years has come to the forefront of public discussion, embedded also in the reignition of the Black Lives Matter movement, provides a window of opportunity to exert higher level and intensity, coordinated, and more focused demands for policy change.

This includes several issues that are rather specific to the U.S. context, such as the need for recognition of racism and other forms of discrimination against marginalized populations as a public health issue. A significant obstacle to day-to-day operations is the lack of inclusion and recognition of harm reduction services as being part of the public health system, co-occurring with the rigidity of the formal health care system that makes the implementation of flexible, low-threshold harm reduction services difficult, often even legally challenging. This is both the symptom and the cause of discrepancies in governance, where advocating for and/or achieving change on the local level can stand in contrast with national guidelines.

LESSONS LEARNED AND BEST PRACTICES

Overall, the case studies bring important lessons at all levels. The COVID-19 crisis has highlighted that harm reduction services need to be flexible and adaptable to truly serve the needs of the population and meet people where they are at. The quick response of NGOs shows that service providers know the communities they serve, know the steps that need to be taken, and have the capacity to adapt and make services more effective, when given the autonomy to do so. The following section will briefly describe the most critical impacts felt in each level of harm reduction network, and the measures adopted by agents to respond to the challenges and guarantee services provision while ensuring staff and clients' safety and wellbeing.

Operating without central administration guidance

- Effective provision of harm reduction services amidst the public health emergency brought an immediate need for enhancing the autonomy and operative independence of the local harm reduction providers. As highlighted in the cases of Portugal and Georgia, the crisis quickened the communication between the central and local harm reduction administrations, added to the trust between them and resulted in better navigation through the Covid-19 uncertainty.

Legal guarantees are nevertheless important

- At the same time, researches on Georgia and Philadelphia demonstrated the extent to which punitive drug frameworks might hinder uninterrupted provision of harm reduction services throughout the episodes of pandemic. Forbidding the harm reduction organizations from recognizing their work as a matter of health legally, puts the sustainability of harm reduction services, lives and wellbeing of people engaged in providing or receiving the treatment at stake.

Network resilience and communication diversification

- Adjustment to Covid-19 emergency circumstances outlined significance of knowledge sharing practices both at the national and international level. Within Georgia and Pennsylvania retaining resilience of the harm reduction networks was ensured more on piecemeal basis and through local capacity building projects. Alternatively, besides utilizing best of the local resources, Portugal promptly attempted to learn foreign practices as a tool to mitigate the negative impacts of the health crisis.

Overlooked methods can become crucial

- The public health crisis motivated considerable rearrangement and reshuffling of harm reduction services. In the cases of Georgia and Portugal, the research revealed the harm reduction administrations were flexible to cut down or boost programs amid the *force majeure*. Revival of the SICAD helpline and suspension of the individual case management by GHRN depict such instances. Thus, it was readiness for novel and pliable responses at the program delivery level that reasonably contributed to relative success of the employed strategies of navigation by Portugal and Georgia during the Covid-19.

Controversial models and methods put to the test

- In all the taken cases, the harm reduction organizations permitted higher daily doses of Opioid Substitution Treatment (OST) substances. Primarily, the latter was emphasized as an achievement especially in the contexts of Georgia and Pennsylvania where the daily amounts alongside the structure of provision of the substitutive substances have been a matter of conflict and controversy. Moreover, as greater availability of self-administration increased the overdoses cases, higher demand on Naloxone became apparent in Portugal. This added to clarity regarding

significance of access to preventive treatment services, especially access to Naloxone.

Harm reduction is more than syringes

- Uninterrupted provision of the low-threshold harm reduction services does not define their ultimate effectiveness to reach and reduce harms within the injecting drug user communities, the interviewees from Georgia denoted. In a moment where the majority of life interactions moved to online regimes, a valuable feature of harm reduction services was endangered in Georgia – human element of building personal relationships between staff and participants. Alternatively, Covid-19 give birth to significant crowd funding initiatives in Portugal, as those targeted at providing safe places for isolating for sex workers who use drugs. Such progressive approaches added to efficiency of strategies that the harm reduction administrations employed to respond to the health emergency.

Diverse needs, diverse services

- The case studies highlighted the need to adjust the harm reduction services to the diverse needs of the program beneficiaries; however, the tactics to reduce novel risks streamed from Coronavirus outbreak have been dissimilar. Portugal provided special isolation space, the operative shelter, accommodating the PWUD. These spaces were designed in a way that envisaged needs of the consumers such as alcohol usage and injection necessities. Contrary to the Portuguese instance, both Georgia and Pennsylvania has faced the challenge of enrolling new patients to OSTs under a lockdown period, although in different ways. Georgian harm reduction sites received surging number of new recipients, Georgian PWID migrants to the EU, returned to the homeland to find secured stay. Differently, Pennsylvanian OST programs enrolled new beneficiaries on a surge of demand that stemmed froma fear of interruptions to the illicit supply, including the quality and purity of the

substances. Nevertheless, disregarding enhanced demands, the harm reduction programs well managed to cope with the new recipient streams.

Planning for the long-term

- Visions for long term planning have been diverse in the selected three case studies. In the U.S. context, it has been argued that scaling back services that were increased or modified for the emergency conditions would actually be more costly than keeping them. Take-home doses, for example, reduce the frequency of visits to a clinic, thus reducing the burden on staff, or reducing the size of staff needed altogether. In Georgia, however, sustainable organization of the harm reduction programs amidst the pandemic was lacking considering the instability of the financing schemes of the low-threshold harm reduction programs. Lastly, in Portugal the pandemic did not endanger delivery of the harm reduction services but the unintended consequences of Covid-19 has been at odds with long-term progress and development plan of the central and local harm reduction administrations.

RECOMMENDATIONS

The ability to anticipate future scenarios and challenges derived from the pandemic will play an important role in the future of harm reduction policies. This is a good opportunity to advocate for structural, systemic change, as the situation has exposed the weaknesses of approaches to drug policy in all of the case study contexts. While Portugal's model has been widely celebrated, issues around marginalized populations' access to care and safe supply of drugs have come to the surface. Georgia and several cities in Pennsylvania, including Philadelphia, have decriminalized the possession of small amounts of marijuana, which only contributed to legislators and the population at large overlooking the bigger issues around substance use.

Full-spectrum harm reduction and intersectional policy approach is needed

Harm reduction needs to be recognized as a public health and social service.The fact that harm reduction services were deemed essential, life-saving services during the pandemic - despite some of them having questionable legal status or being a stigmatized service - should be used to demonstrate how providing healthcare services for PWUD is anfundamental component of public health. Low-threshold harm reduction service providers should be more integrated into the healthcare system, including being recognized as healthcare institutions to gain more administrative rights and secure funding to ensure sustainability of operations.

Moreover, the emergency has highlighted how harm reduction services providers are often the most important entry point for marginalized populations to the health and social services system. A comprehensive set of policies is needed which focuses on harm reduction beyond substance use and encompass factors that can impact drug consumption patterns and social insecurities.

Harm reduction is about meeting people where they are at, knowing their needs and providing them with exactly what they need at that moment – be it syringes, pipes, hand

sanitizer, a phone charger, a referral to a clinic – or referral for housing. It needs to be highlighted how intertwined problematic and/or unsafe drug use is with social insecurities, inequalities, and vulnerabilities - which can only be solved by comprehensive, structural changes in policies. Issues stemming from this lack of integration include barring access to homeless or domestic violence shelters for PWUD, inability to afford treatment due to economic insecurity co-occurring with workplace discrimination because of drug use and lack of gender-sensitive and inclusive services. Low-threshold harm reduction services that also provide housing and job assistance have been performing well as methods of intervention.

Prioritize advocating for safe supply

Important imbalances are expected to be observed in the illicit substances market at the same time that social distancing and lockdown is likely to bring deep changes in people's drug consumption patterns. While it is too early to assess the impacts on the supply and keeping in mind that the illicit drug market is very resilient and adaptable, this situation has once again highlighted the importance of safe supply. It is important to note, especially from Portugal's case, that decriminalization does not significantly reduce the risk of health-related harms from substance use, as monitoring the illicit drug supply for quality is difficult for agencies and impossible for individuals.

Drug checking or testing programs are key to provide evidence and data to support future measures and inform agents and public authorities about new trends in the supply and the challenges they could pose. They should, however, be more broadly available, including at harm reduction service sites to regularly check and monitor the local supply, and be able to keep participants from consuming adulterated substances.

Opioid substitution therapies can also be a form of safe supply, as they can keep patients from purchasing their drugs on the illicit market. For this to be effective, however, availability of OSTs need to be broadened and made more flexible. This includesmaking the programs more accessible byloweringthe thresholds for enrollment in the program and increasing the number of authorized treatment providers. Further, stigmatizing,

dehumanizing, and inflexible regulations need to be removed, including limitations and checks regarding abstinence andhaving to consume the medication at the clinics under supervision.

The model of allowing take-home doses implemented during the pandemic needs to be monitored and documented closely by harm reduction providers with clients enrolled on OST. Indicators such as overdoses or diversion to the illicit market are important for decisionmakers, and if the new regulations show improved quality services, these can be key to the permanent adoption of these policies.

At the same time, Naloxone and other opioid overdose reversal medications should be made broadly available, funded and supported as a resource for harm reduction providers for on-site administration and distribution to participants. This should include people in jails and prisons. Naloxone should also be available for anyone who wishes to obtain it.

Diversify networks

The COVID-19 crisis has highlighted the delays of central and national administrations inquickly providing nuanced guidance. It has also evidenced how harm reduction service providers were able to adapt fast and efficiently to the changed circumstances because of the close relationships they foster with their communities, understanding their needs. Higherlevel regulations might not be in correspondence with the reality on the ground, and therefore it is unequipped to provide proper support on its own.

Service providers thus should not rely entirely on central administration guidance and should diversify their networks of agents of change. Lobbying and advocating for country-level policy change is important, but as the crisis has also shown, local administrations are significantly more receptive to supporting harm reduction services by accounting for their actual needs.

Embeddedness in the local community is crucial on multiple fronts - residents of areas where harm reduction services are located, for example, should be well-informed about the public health importance of the availability of these services to help reduce the stigma and

further decrease the potential risk of violence against the site or its participants. Further, local residents can be important allies in pitching issues and advocating for change at the level of the local administration.

Communication between harm reduction services at multiple locations is key for information sharing and joint advocacy efforts at higher levels of the national administration. Harm reduction services can also benefit from diversifying their networks by establishing deeper connections with other service providers, across state or country borders. This is a gateway to the share of experiences and best practices, policy learning, potential avenue for diversifying funding sources, and the route to advocacy at an international level. Local experiences should inform national policymaking to influence international guidance, and international guidance should in turn support national and local initiatives.

CONCLUSION

This report sought to open a space for harm reduction service providers to communicate the challenges lived in the field in a moment of pandemic crisis. Combining global and national level analysis, the report aims to illustrate the dynamics of service provision and guidance as well as the best practices formulated in the harm reduction field.Using a qualitative methodology, the research selected three countries as case studies for analysis – Portugal, Georgia, and the United States of America. The selection of the three contexts is framed by the differences observed in the legislative status of drugs / harm reduction of each country. The voices of state agencies and other actors involved in the formulation of drug policy were included in some parts of this study, but remain underrepresented, as they were unavailable for comment at the time and/or for the purposes of this report.

The study comes to stress the importance of local actors for the provision of public health in a context of crisis. In face of the delays and adversity in higher regulation and coordination, the interviews collected in this research emphasize the ability to adapt and the resilience of the agents working in the field. Shedding a light into the cooperative network, it also reveals the limitations and opportunities a better engagement with such actors might bring. The study concludes drawing a set of recommendations applicable in general contexts, with lessons learned from the observation of the case studies and international organizations in the drug policy system. Importantly, it reveals the potential impacts brought by the COVID-19 pandemic to the drug supply market. In a moment of uncertainties and imbalances, harm reduction becomes, more than ever, an essential mean for the provision of public health.

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