

Editorial

From risk environments to safe havens: understanding context in the development of harm reduction interventions for drug users

This special issue of the *International Journal of Drug Policy* highlights key papers presented at the annual meeting of the International Harm Reduction Association, which was held in New Delhi, India, in April 2001. This conference marked the first time the meeting had been held in Asia, a continent that has witnessed rapid diffusion of both injection drug use and HIV infection in recent years. The theme of the conference, 'Community Development for Harm Reduction', embodies the spirit of this issue, which focuses on elements of the social environment that can contribute to both risk taking and risk reduction.

We have chosen to dedicate this issue to two front-line harm reduction workers in Asia, Mr. Keith Kanga (Society to End Urban Poverty, New Delhi, India) and Ms. Manisha Singh Lifegiving and Life Saving Society (LALS), Nepal whose untimely deaths in 2000 were met with a profound sense of grief and loss. In their life's work, both Keith and Manisha tirelessly strove to create a safe haven for drug users and truly contributed to community development in their respective environments. They are gone, but will never be forgotten.

The concept of the 'risk environment' is elegantly laid out in a commentary by Tim Rhodes (Rhodes, 2002). In this paper, Rhodes argues that in shifting focus towards the 'risk environment' as a unit of analysis, the limits of individualism which characterise most HIV prevention interventions can be duly overcome. Additionally, understanding a drug users' environment can lead to a more tangible appreciation of how drug-related harms inter-connect with health and vulnerability. In turn, such a framework elevates the importance of structural interventions for harm reduction that can improve the health of drug users and the communities they live in.

The well-documented outbreak of HIV infection among IDUs in Vancouver is a case in point of the need for ongoing evaluation of proven interventions. Wood et al. (2002) investigated reasons why nearly one quarter of IDUs in Vancouver reported having difficulty accessing sterile syringes, despite the

availability of a large, high volume needle exchange program (NEP) that had been in operation for many years. Despite continuous attempts to improve the coverage and effectiveness of NEPs, Vancouver's IDUs still face difficulties in obtaining sterile syringes in given circumstances, and those reporting problems with syringe access were more than three times as likely to share needles. Difficulties with sterile syringe access were associated with both intrinsic characteristics of drug consumption habits (cocaine injection and bingeing), but also with programmatic constraints related to the operation of NEPs themselves. Additionally, there was evidence of prejudice against IDUs who were refused syringe purchase in pharmacies. These data highlight the need to focus interventions on structural barriers that prevent consistent use of sterile syringes, and provide insights into why individual-level interventions to reduce needle sharing behaviours may have been insufficient.

From a complementary point of view, Heimer, Bray, Burris, Khoshnood & Blankenship (2002) describe a framework for operationalizing structural interventions to reduce drug related harms, which is based on the premise that health is a product of social structures and processes which can be promoted by changing the political, legal, or cultural context. Structural interventions would therefore include those that change laws, standards, or administrative procedures, all of which can indirectly affect human behaviours and health. In their application to opiate maintenance interventions, Heimer et al. point to myriad constraints posed by unfavourable norms and regulations on such programs, which are often structural in nature. In turn, they propose that there are at least three types of structural interventions that can be implemented to optimize opiate maintenance. These include expanding the range of treatment options and associated services, improving the funding and regulation of maintenance programs, and altering the public perception and treatment of drug users in and out of treatment. In this sense, social reform and structural interventions can have a pivotal role not

only in the conceptual framework of prevention initiatives but can also function to influence the availability, affordability and cost-effectiveness of different treatment options. Heimer's and Wood's papers clearly show that barriers situated in the crossroad of the health system and the broad social environment can seriously jeopardize attempts to reduce drug related harms among IDUs.

Several papers in this issue paint a stark picture of the risk environment in both developed and developing countries. Social factors relating to transitions to injection were the focus of a paper by Sherman and colleagues, (Sherman, Smith, Laney & Strathdee, 2002) who report upon a qualitative study of new initiates to injection in Baltimore, Maryland, USA. In exploring the context related to transition from non-injection to injection drug use, Sherman et al. noted that the spheres of influence relied heavily on elements of an individual's network: family, friends and sexual partners. Interestingly, in the view of these young drug users, injection was considered to be a cheaper alternative to sniffing heroin prior to their initiation of injection, but this view quickly changed once they realized that injection drug use compounded their dependency, which eventually led to more injection.

In describing the sociodemographic and behavioral profile of drug users in Quetta, Zafar and ul Hasan (2002) highlight the extent to which Pakistan's proximity to Afghanistan as well as local and international pressures on heroin trafficking in the region have had an impact on transitions from non-injection to injection drug use. The aftermath of the September 11 terrorist attack on the United States and the subsequent war on Afghanistan will undoubtedly contribute to more vulnerability, poverty and an unpredictable flow of heroin in the region, all of which can foster transitions to injection drug use. Added to this mix has been an influx of two million Afghan refugees into border towns in Pakistan. Quetta and other cities in the region will require major humanitarian assistance, education, support and culturally appropriate interventions to quell what Zafar and ul Hasan predict will be an inevitable epidemic of injection drug use, amidst a setting where HIV awareness is low and both sexual and drug related risk taking is high.

Reid and colleagues (Reid, Beyer, Higgs & Crofts, 2002) describe factors contributing to vulnerability among Vietnamese drug users in Australia. Issues such as unemployment, poor English proficiency, social and economic difficulties, inter-generational conflicts and acculturation, racism and denial are believed to contribute to a climate that fosters involvement in drug use and drug trafficking. A point of interest is the observation that patterns of drug use among Viet-

namese Australians appear to differ from their Anglo-Australian counterparts. For example, the former are more likely to engage in heroin smoking before transitioning to injection, which is less common among other drug users. Such observations have important implications for primary prevention programs to discourage transitions to injection, as a strategy to reduce a number of drug related harms. Surprisingly, little emphasis has been placed on prevention of injection drug use itself as an intervention, which is clearly warranted.

The paper by Bastos and colleagues (Bastos, Fatima de Pina & Szarcwald, 2002) describes challenges in the face of the ongoing spread of HIV in the southern region of Brazil. Despite universal access to antiretroviral therapies and progressive implementation of various harm reduction strategies, these initiatives have only partially reversed the negative impact of social inequalities and other barriers and delays to the implementation of well-funded and well-staffed preventive programmes targeting IDU populations. The continuous spread of HIV/AIDS among IDUs, their partners, and offspring in southern Brazil functions as a call to expand existing interventions, keeping in sight the need to face persistent gaps, and the ongoing need to monitor the ever-changing dynamics of drug scenes and drug trafficking routes.

Collectively, these papers generate a resounding theme. In identifying the social and environmental barriers and the levels that they operate, it will be possible to design structural interventions that can help reduce a number of social and medical harms among drug users, which can create a safe haven for us all.

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