Commentary

Analysis of harm minimisation as a public health policy: a Brazil and Australia case study

Abstract

Background: Harm is not only a physical damage. Harm is a set of multifactor problems that encompasses individual, community and society levels. This study aims in identifying drivers and barriers involved during the development of public policies on Harm Minimisation for injected drug users in two distinctive countries and cities (Sydney, Australia and Santos, Brazil). It also draws lessons and policy historical experiences with both successful and failure outcomes.

Methods: Based on the historical analysis of open-ended review of published data.

Results: Findings strongly suggested that political support and the judiciary cannot be detached from health policy and its successful outcomes demands also further community support and ownership.

Conclusion: the paper was able to shed light on the role of political engagement and the community in the development of sustainable public health policy.

Keywords: minimisation, multifactor, humanitarian, economic, consequences, malnutrition

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Introduction

"Drugs has always been part of society, eradication is impossible and the multiple attempts to eradicate it may result in more damage than benefits".[1] Following this rationale, harm minimization is a humanitarian public health perspective that improves individual quality of life in high risk behaviours.[2] It is concerned in enabling people to seek for better choices of health when adequate support, education and empowerment is available.[2] At the same level of any other major public health strategy, harm minimization focuses on decreasing adverse health, social and economic consequences.[3]

Harm is not only a physical damage. Harm is a set of multifactor problems that encompasses individual, community and society levels.[3] It has a broader spectrum of damages, and a particular circumstance in one case can define "harm" in a completely different way in another context.[3] Illicit drug harm crosses the individual physical damage with the use of the drug and needles sharing; community, with unsafe drug areas and increased rates of violence; and society with local market economic losses and extra expenditure in police workforce on criminal areas.[3] Therefore, harm minimization provides a middle way alternative in which the harmful behaviour can be reduced and the negative outcomes in society and individual controlled.[4]

Public health policies in harm minimisation vary among countries but primarily aim beneficial outcomes to community. This study aims in identifying drivers and barriers involved during the development of public policies on Harm Minimisation for injected drug users in two distinctive countries and cities (Sydney, Australia and Santos, Brazil). It draws lessons and policy historical experiences with both successful and failure outcomes. Sydney and Santos were selected by their similar social and economic contexts and burden of blood viral disease (Hepatitis A, B, C, HIV). We conducted a historical analysis of the development of Harm Minimisation policies by an open-ended review of published data.

Addressing the public health issue of injecting drug use

Injecting drug users (IDU) have higher chances of related social health problems compared to the general population.[5] Blood viral disease (Hepatitis A, B, C, HIV), skin infections, poor living conditions and malnutrition are the most known risks faced by these individuals.[5] Usually IDU are unemployed, homeless with low or no access to health care services by economic (affordability) or social issues.[6] Socially, marginalization and discrimination play an important role in exclusion.[6] Therefore, change is harder as no support chain in any spheres of society or health is available.[6]

Historically, Sydney's Kings Cross district have always been known as a bohemian region in where most city's tourist accommodation, entertainment and red-light district were located.[7] Organized crime, illegal casinos and alcohol trade made the place a district with the highest rates of violence.[7] By 1982, the outbreak of heroin and the first HIV case in St Vincent Hospital made IDU a major public health problem.[8] Nationally, the opioid overdose death cases increased from 70 to more 550 between 1979 and 1995.[8,9] Locally, the higher number of homeless, drug users and violence affected the region's property value and the criminalisation of drugs created a new illegal market.[8] IDU avoided injecting drugs in public fearing being arrested and started renting illegal business rooms for drug injection.[7] In association with it by 1985, 67% of all HIV cases occurred in New South Wales (NSW) state, where Sydney is located.[7] The lack of surveillance in the illegal injection rooms made 13% of all opioid injected drugs deaths in NSW occurred in Kings Cross.[7] The national profile of DIU were composed by males, in their late 20's years, unemployed, with an average of 9.9 years of school education and with no past drug treatment.[10] In a similar context Santos city in Brazil, especially the harbour district, had the same bohemian environment as Kings Cross.[11] Santos has the biggest harbour in South America

since the 18th century, which promoted the region a rapid growth and entertainment, clubs and illicit drug use increased simultaneously.[11] HIV epidemic in the region was ranked since 1989 the highest in the country (110,37 per 100,000 habitants), from these 20,6% of cases occurred between IDU.[11] Historically the first HIV case in Brazil, similarly to Australia, occurred in 1982.[11] The criminalization aspect of the "war on drugs" released in 1976 promoted a black market in which striptease clubs and cheap accommodation motels became common drug injection sites.[12] Additionally, the rates of Hepatitis B and C among IDU reached a prevalence of 84,8% and 33% in 1989.[13] Male, in their early 20's years, with less than 8 years of education, unemployed and within at least 1 arrest in the past was the city's IDU profile.[11]

The Australian experience with the national drug strategy

Australia launched by 1985 the first National Drug Strategy (NDS).[5,14] The Strategy focused on an integrated process that would respond to the HIV epidemic with a multiple set of policies and programs.[14] As part of NDS the Needle and Syringe Program (NSP) focused in education and prevention strategies.[14] By 1986 the program was already running in Kings Cross region.[14] The program initially delivered and collected sterile injecting equipment in medical centres while education, counselling and referral was provided passively.[14] Community centres, other health services, including pharmacies were also included in the program. 24 hours accessibility to injecting equipment's were possible by dispensing packs trough vending machines, also known as FitPacks™.[5] The packs contained a kit with sterile needles and syringes with a lock-in protection that avoided re-use.[5,14] They were also implemented in Emergency Departments for collection and in case of overdose patients had access to a 24hrs health staff support.[14]

Community, political and society support are fundamental for a successful program delivery.[15] The first Australian NSP had a strong political and public health leadership support. Australia's Health Minister, Neal Blewett, was committed with the issue leaded by policy-makers.[16] The strong and positive political partnership provided the support needed for implementation.[15] Society and Community had some opponent arguments during program release.[15] Fear of inappropriate discarded needles in public and general population risk, misunderstandings that the program would encourage individuals to drug use and increase rates of violence in the region were major criticisms.[15] Community support was reached after including community representation in the National Drug Committee and education.[15] Additionally, data from successful NSP overseas provided arguments to society in trusting the program and picturing its effectiveness in HIV control and Illicit Drug use.[14]

Legally in Sydney IDU could not be prosecuted for possession of needles or syringes after the amend *NSW Drug Misuse and Trafficking Act* in 1985.[17] The impact of the decriminalization decreased the chances of IDU discard contaminated injecting equipment in public areas as being in possession of needles were used in the past for prosecution.[18] Socially, they were not criminalized anymore and a non-judgemental approach brought a marginalized community closer to health services.[14]

The overall NSP evaluation promoted an increase of 10% in IDU seeking for treatment.[19] The prevalence of individuals using drugs decreased (0,6% to 0,4% between 1997 and 2004).[14] HIV infection dropped from 14% (1986) to 1% (1992).[19] In 20 years of program the re-use of needles progressively decreased from 31% (1995) to 16% (2004).[19] 82% of Kings Cross community agreed with the NSP in the region; state-wise the community support reached 90% and nationally 96%.[20] Robbery dropped by 15% and thefts by 34% in Kings Cross region from 1986 to 2004.[14] Overall, is important to address that the integrated model of NSP in Australia promoted its effective outcome.

The Brazilian experience: the fragilities of the harm minimisation program

In Santos the first harm minimization program started in 1989 ran by the city's harbour Local Health District (LHD).[11] During the NSP, clean needles and syringe was offered by primary health care providers that in-site tried to engage IDU into safer practices.[11] Education in health programs and referral were provided as an attempt to bring IDU closer to health services.[11]

Locally a scope of fragilities was faced during policy and program implementation. No actual federal or state funding were provided directly to the NSP.[11] Socially, a community criticism against the NSP group based on the comment of "supporting a marginalized group that was involved in crimes" rose.[21] The community reaction reflected the country's strong historical Legislative component of the "war on drugs".[21] The South-American "war on drugs" led by United States in the 1980's, especially in Colombia, militarized the aspect in a totalitarian practice rather than humanistic.[22] In the same poll of major drugs dealers, drug users were addressed as "dangerous", "terrorists", "treat for nationalism" and blamed for the crime rates.[21] Following the same trend as other Latin American countries, the Brazilian Legislation maintained a strong prosecution act against drug users.[21] And even though Brazil was re-democratized in 1985, after a long Dictatorship period, the prosecution of imprisonment for 3 to 15 years for trafficking or drug use was maintained (Law 6.368/76)[23] The effect of the Law n.6.388/76 promoted the prosecution of the Santos Harbour LHD Director and the NSP Coordinator for association and incentive for drug use.[21] In less than 1year Santos NSP program was discontinued and no evaluation data was able to be addressed.[21] Consequently, the rates of HIV continued to increase in the region and from 20,6% in 1989 reached 51% in 1991 among IDU (24, 25).

Final considerations

Kings Cross and Santos Harbour had similar public health contexts. Our analysis was able to identify trends in criminalization of drugs, program implementation and the role of community support. Australian strong partnership and major support from the political sphere played an important role in effectiveness. Opposite to that, the lack of political support in a more totalitarian approach promoted the end of the Brazilian NSP program.[26]

In both contexts the outbreak of HIV and Hepatitis among IDU demanded an urgent public health approach to control the blood-borne virus transmission.[2] Reinforced by the World Health Organization[27] a comprehensive harm minimization program should include prevention, intervention, education and advocacy. In an IDU context 3 focal points should be set:

a. health promotion programs focusing in safer injection

b. intervention with NSP with surveillance of health providers

c. advocacy for social and legislative decriminalization of needle and syringe possession.[2]

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However, the opportunities for micro-improvements in both programs took different outcomes, as political, societal and community dealt with the program differently.

It is clear in harm minimization, as a public health policy, the adoption of legal measures in decriminalizing either drugs and/or syringes and needles possession. An important driver for the Australian NSP program was the early creation of a National Policy, followed by the 1985 NSW act. Brazil only by 2001 released its own National Anti-Drug Policy (NADP).[28] Such policy supports the creation and implementation of harm minimization strategies with focus on health promotion and infection control, but its expansion remains restricted by the prosecution of drug users.[28] By 2006, the Law n. 11.343/2006 overruled the prosecution of drug users in the previous Law n.6.388/76, and input definitions between drug users and drug dealers.[29] However, such definitions between a drug user and drug dealer are contradictory and the prohibitionist discourse with the idealization of a society free of drugs maintained the 'war on drugs' environment active and running.[30]

Observing the arbitrariness of Brazilian legal system towards drug misuse and trafficking, draws a lesson of the importance of political and legal support for harm minimization effectiveness. Findings also suggested that political support and the judiciary cannot be detached from health policy. Therefore, public health leaders must understand the political dimensions and continue to propose integrated solutions as drivers for legislative change with every program implementation.

Strengths and weaknesses of the article

Among strengths this paper has used an innovative non-clinical case study approach to shed light on the role of political and community support in Harm Minimization Public Policy planning, co-design and implementation. Moreover, it has highlighted how differently pockets of society react towards a progressive health policy on a topic that is highly marginalized and not commonly prioritize on public health agenda. Given the methodology was based only upon open published data fully quantitative data analysis was not performed due to lack of available data on prevalence, incidence. Additionally, the evaluation of the Brazilian program was not performed and can be consider as an identified weakness of this study.

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Conflicts of interest

The author declares that there was no conflict of interest.

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