Social, mental and economic consequences of the coronavirus pandemic to the vulnerable populations in SEE: Do we know them and how to recognise and respond to them?

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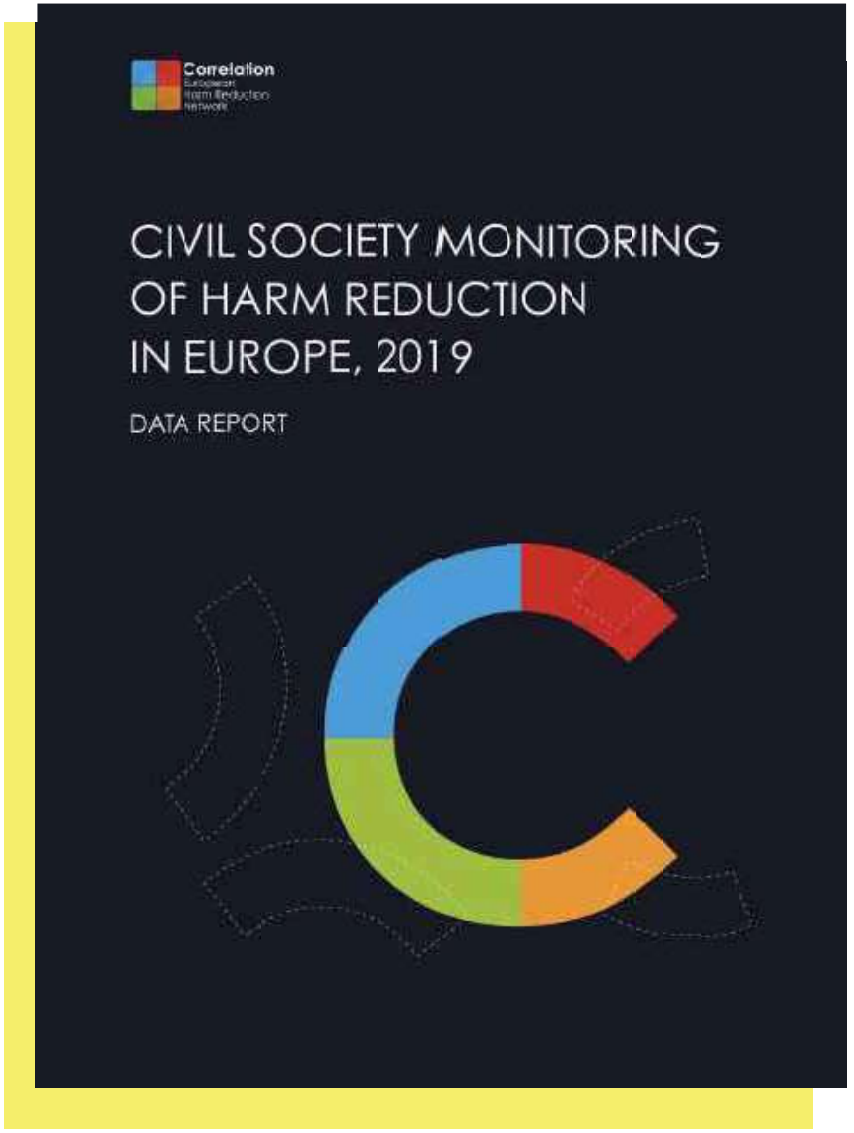
C-EHRN

Correlation - European Harm Reduction Netowrk is a civil society network and centre of expertise in the field of drug use, harm reduction and social inclusion. Since 2004, the network has been bringing together practice, research and policy. As such, the network connects harm reduction services, grass root and community-based organisations, research and health institutions from all over Europe.



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DE REGENBOOG GROEP

HARM REDUCTION MUST GO ON

Position of European Harm Reduction Networks on COVID-19

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webinars

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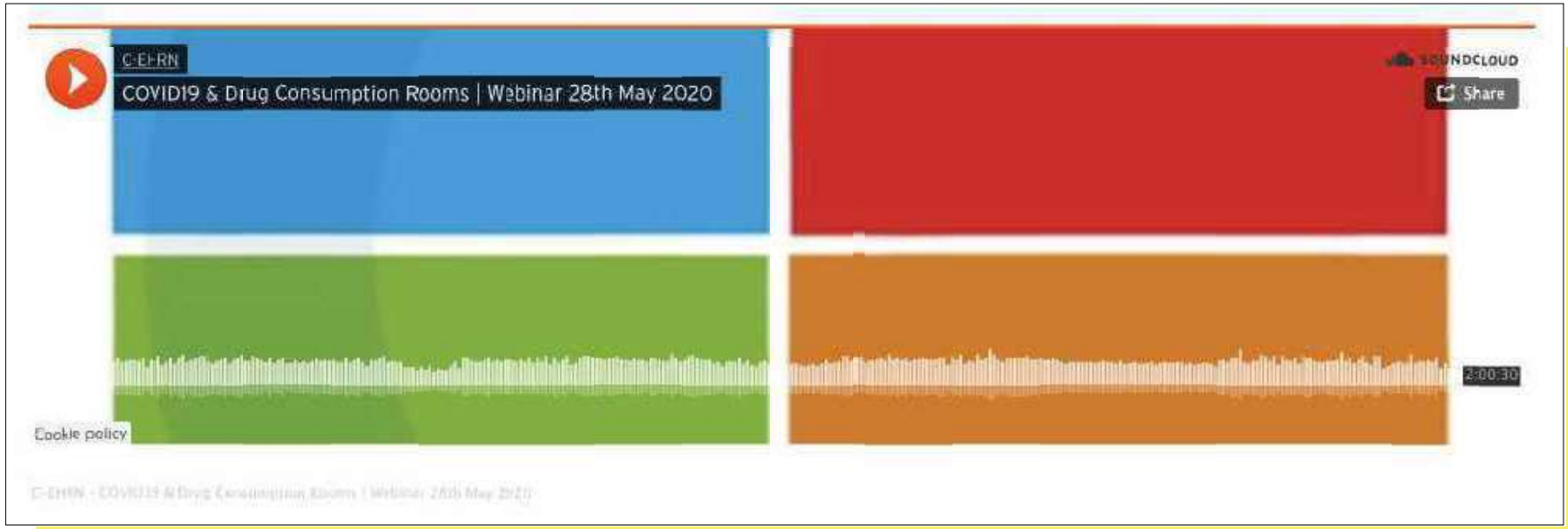
An important media for articulating knowledge exchange and data collection during this period has been the webinars | focus groups that the network has organised. They proved to be a very productive methdology for identifying common challenges in the field, highlight models of good practice, as well as to discuss policy recommendations to ensure sustainable services during and beyond of the COVID-19 pandemic



NOBODY LEFT OUTSIDE

Improving healthcare access for marginalised people

Correlation is part of the Nobody Left Outside initiative, a coalition of organisations representing marginalized communities, working together to improve access to health and support services. As a collective we have developed work together during the pandemic with the WHO European Officer for Investment for Health and Development, supporting them providing policy makers with community data regarding the particular challenges and impacts of the COVID-19 pandemic with which to evaluate government responses, a to recommend solutions based on principles of community participation, human rights, evidence base and equity.

European health equitity status

World Health Organization

Colectively, we developed a methodology of work that builds upon the framework of the WHO Health Equity Status Report. The idea in here, is to focus on the social determinants of health, and the relationship between health inequities and the conditions that are essential to live a healthy life, and the degree of investment, coverage and uptake of policies that influence health equity. Vulnerability is not a characteristic of specific groups, but rather a set of conditions which are (re)produced and reproduced, and therefore politically avoidable.

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health services | example of marginalization factors matrix

- High rates of underlying (often under-treated and poorly controlled) chronic diseases that directly or indirectly predispose people to severe COVID-19 disease and death, e.g. respiratory diseases (chronic obstructive airways disease and asthma), HIV, viral hepatitis, tuberculosis, cancer, cardiovascular disease, diabetes and mental illness. Smoking and drug and alcohol dependence are also prevalent in these groups.

- Restriction or closure of vital community health and support services due to COVID-19 has negative effects across these groups (e.g. homeless/shelter services, community-based testing centres (such as 'Checkpoint'), harm reduction, sexual health, support for victims of sexual or gender-based violence, social support). Online provision of some services has been helpful in some cases, but these may not be available to some marginalised communities.
[...]

homelessness	undocumented status	sex work	drug use	LGTBQI	Inprisoment
- COVID-19 exacerbates already limited access and targeted provision of healthcare toward population at high risk of ill health and early death -Limited access among highly vulnerable group risks late COVID-19 diagnosis, poor outcomes and onward transmission	- In most parts of Europe, people with irregular migration status have no access to primary health care or subsidised non-emergency care COVID-19 may be exempt from health charges in some countries, but this exemption can exclude those with pre-existing conditions. Hence the majority of undocumented migrants cannot seek	- Limited access/closure of community sexual health services (condom distribution, HIV and STI testing, care and counselling) increases health risks- Restriction or closure of vital community health and support services due to COVID-19 has negative effects across these groups (e.g. homeless/shelter services, community-based	- Disruption/closure of harm reduction services is detrimental to public health, as these services are often the only contact point for PWUDs to access the health and support services and information – including COVID-19 measures - Disruption in supplies of opioid substitution therapy and other essential medicines and drug use paraphernalia	- Experience of discrimination, stigma, gatekeeping, misgendering, and non-consented procedures can deter LGBTI people from seeking medical care - Lockdowns and travel restrictions severely limit access to vital specialist care for intersex people Transition-related medical care, which is life-saving care for trans people, may be	- Overcrowding, close proximity in daily activities, lack of adequate hygiene measures, poor ventilation, disproportionate prevalence of infectious diseases such as HIV, viral hepatitis, tuberculosis, high prevalence of mental illness, lack of harm reduction measures, limited access to testing, treatment and care services

health services | example of recommendations matrix

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Ensuring access to health services & information	- Address barriers to primary healthcare and public health information, e.g. provide targeted outreach of information on COVID-19 information (prevention, care, rights, etc) in ways that reach them and in forms they can understand (e.g. in relevant languages) - Outreach services should employ COVID-19 prevention measures for staff, volunteers, peer support workers and service users (including sufficient provision of personal protective equipment) - Consider alternative service modes for specialist care and measures to reduce the number of necessary centre visits/contacts, e.g.
COVID-19 testing	- Prioritise testing (via outreach) for marginalised groups at high medical risk - - Generally, testing should be non-discriminatory (with respect to all factors in bullet 1 under health services)
Digital track & trace solutions	- The development, implementation and evaluation of digital tools should include marginalised groups, resolving rather than increasing inequities and considering the social and legal implications for these communities. Marginalised people should be supported and enabled to access such services (e.g. through internet vouchers, sim card data, training and induction) - In particular, protection of personal data and privacy must be ensured to avoid further discrimination, surveillance, immigration measures and policing) and specific measures will be necessary to ensure trust and uptake among marginalised groups.
Harm reduction & other support services	- Harm reduction services should be considered as essential services – continuity and sustainability of harm reduction and other services is vital during the pandemic (including needle and syringe programs, opioid substitution treatment, consumption rooms, naloxone provision, alcohol misuse services, sexual and reproductive health care, physical and sexual violence) - Harm reduction and support services should also be employed to provide advice and support on COVID-19 prevention and linkage - Alternative service modes should be considered (as above)
Post-COVID	- Successful interventions, good practice examples and lessons learned should be examined, maintained and further implemented/supported post COVID-19

civil society monitoring 2020

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2. What challenges did your harm reduction service face during the pandemic? Please check all that apply.

( ) We closed the facility
( ) We reduced opening hours/days
( ) PWUD were not allowed access due to lockdown
( ) Limitation in harm reduction supplies (syringes, sterilisation equipment)
( ) Limited access to protective equipment for staff and clients (surgical masks, sanitising materials)
( ) Reduction in types of harm reduction services available
( ) We adapted our service (masks, distance, Plexiglas, limited controlled access, etc.) to ensure the continuation of activities
( ) Others/comments

3. What positive changes or innovations in harm reduction services occurred at your organisation? Please check all that apply.

( ) Improvement in OST services
( ) Increased length of prescriptions and take-homes
( ) New phone or telemedicine services for OST
( ) increased interest and enrolment in OST
( ) home delivery for OST
( ) New forms of OST available
( ) Improvement regarding access to housing and shelters
( ) Increased or started Naloxone distribution
( ) Added new outreach services
( ) Education services on COVID and hygiene/safety for PWUD

6. The COVID pandemic has been reported to increase the risk of overdose for vulnerable PWUD, due to more people using alone less access to naloxone, increased respiratory risk, increased adulterated substances, etc. Have you noted an increase in OD in your region during the pandemic?
( ) Yes
( ) No
( ) I don't know

5. Which are the main difficulties that PWUD have to face in your country during the coronavirus pandemic? Please rate how important these difficulties are.

	Very problematic	Problematic	Somewhat problematic	Not a problem
Limited access to drugs				
Adulterated/low-quality drugs				
Increased drug prices				
Limited access to OST				
Limited access to DCRs				
Limited access to drug checking				
Limited access to medical services				
Limited access to housing				
Difficulties with the police when being in the street				
Social isolation				
Increase in mental health disorders				

9. What role did CSO's play in advocating or increasing services for PWUD during the pandemic?

conclusions

Intersectionality
Acknowledging that patterns of exclusion are equally experienced by different communities opens up the possibility for more effective, multidimensional, and collective response to the effects of COVID-19 in marginalized population. Drug use is a phenomenon that intersect with other categories of identity, and therefore subject to multiple processes of exclusion and of marginalization.

Politics of Data Collection:
Data and information is not neutral, depending on the focus and on the indicators, data can further stigmatisation or, instead takling it by focusing on the conditions under which vulnerability arises. Data collection is related to advocacy. What is rendered visible, and what is eroded? What are the consequences for communities for a selection of information?

Civil Society Point of View:
Related to the previous points, it is important to structuraly support communities collecting their own data, and establishing their own indicators. Building upon evidence-based frameworks and models, new information can be gathered on the impact of policies and services.

Cooperation:
COVID-19 has renewed the potential for new cooperations, exchanges of methodologies, alliances between marginalized communities, and the organizations that support and represent them. Altough the struggles might not been identical, all of them she common ground.

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conclusions

Ensure the continuity and sustainability of harm reduction and other low-therholds services.

Provide adequate funding for harm reduction.

Acknowledge the important and critical roles for harm reduction.

Continue developing specific guidelines and regulations.

Ensure the impact that policies have is properly understood, particularly when it comes to criminalization, lack of access to support and services, or adequate funding and materials.

Thank you very much for the invitiation, and your attention.

More information:

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