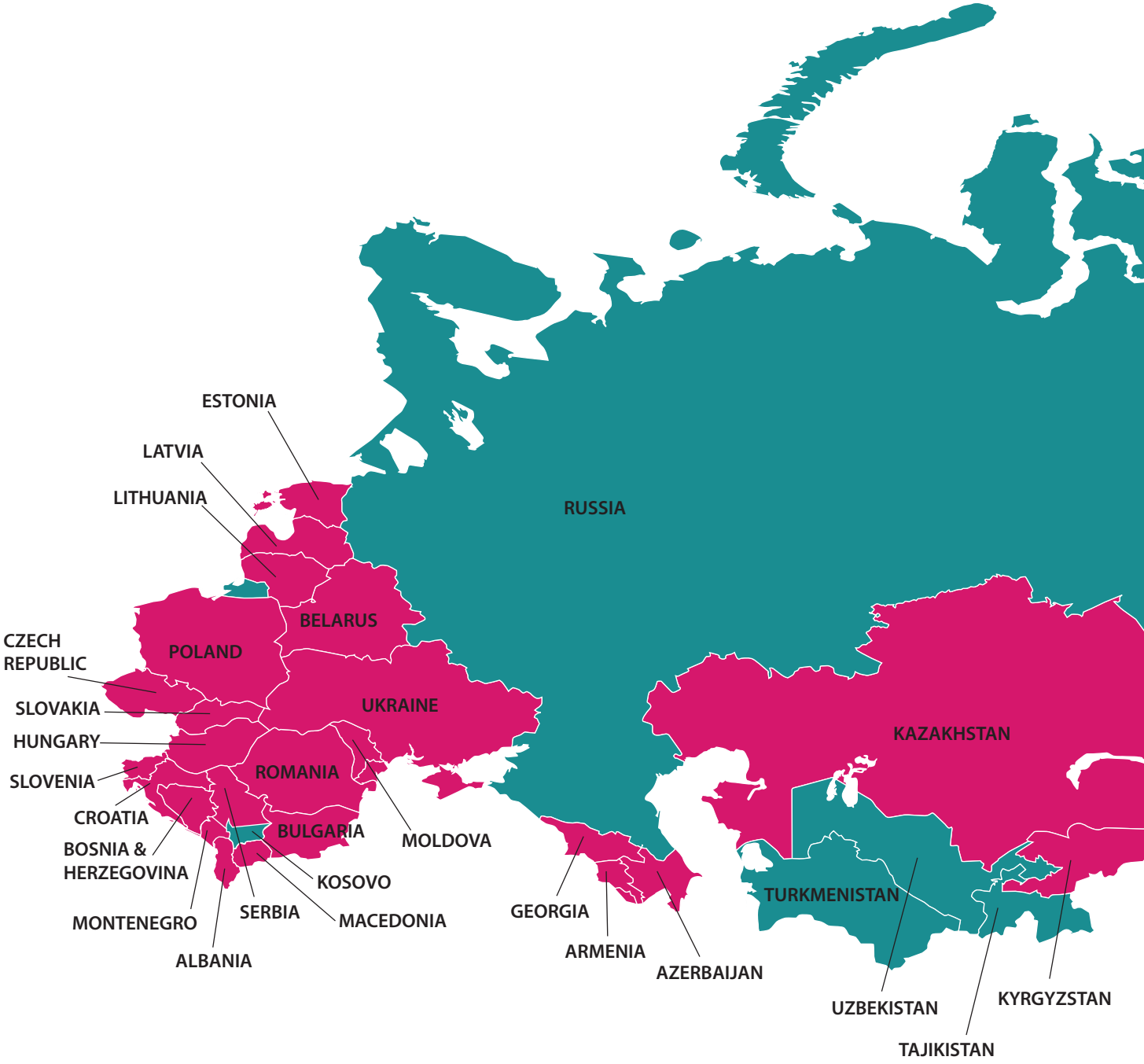
2.2 Regional Update: Eurasia



Map 2.2.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

Table 2.2.1: Harm Reduction in Eurasia

Country/territory with reported injecting drug use[a]	People who inject drugs[1]	Adult HIV prevalence amongst people who inject drugs[1]	Harm reduction response[2]	
			NSP[b]	OST[c]
Albania	nk	nk	✓(3)	✓(1) (M)
Armenia	2,000	13.4%	✓(7)	✓(1) (M)
Azerbaijan	300,000	13%	✓(12–14)	✓(2) (M)
Belarus	76,500 [4]	1.5%	✓(52–64)	✓(1) (M)
Bosnia and Herzegovina	nk	nk	✓(6)	✓(6–8) (M)
Bulgaria	20,250	0.4%	✓(100)	✓(17) (M,O)
Croatia	15,000[4]	0.6%	✓(42)	✓(B,M)
Czech Republic	30,000[4]	0.05%	✓(109) (P)	✓(47) (B,M)
Estonia	13,801	72.1%	✓(36)	✓(8) (B,M)
Georgia	127,833	1.63%	✓(2–9)	✓(6–12) (M)
Hungary	3,941	0%	✓(25)	✓(13) (B,M)
Kazakhstan	100,000	9.2%	✓(159)	✓(2) (M)
Kosovo	nk	0%	✓	x
Kyrgyzstan	25,000	8%	✓(40) (P)	✓(14–18) (M)
Latvia	nk	8.15%	✓(13–22)	✓(1–9) (B,M)
Lithuania	5,123	2.4%	✓(10–19)	✓(14–18) (B,M)
Former Yugoslav Republic of Macedonia	nk	nk	✓(15)	✓(9) (M)
Moldova	3,500[4]	21%[4]	✓(31)	✓(4–5)[c] (M)[4]
Montenegro	nk	nk	✓(18)	✓(M)
Poland	nk	8.9%	✓(27)	✓(22) (B,M)
Romania	nk	1.44%	✓(49)	✓(6–8) (B,M)
Russia	1,815,500	37.15%[d]	✓(70)	x
Serbia	nk	nk	✓(13)	✓(14) (M)
Slovakia	18,841	0%	✓(20)	✓(12) (B,M,O)
Slovenia	7,310	0.4%	✓(17) (P)	✓(20) (B,M,O)
Tajikistan	17,000	14.7%	✓(35–40)	x[e]
Turkmenistan	nk	nk	✓(2)	x
Ukraine	291,000[4]	32.4%[4]	✓(985–1,323) (P)	✓(B,M)
Uzbekistan	80,000	15.6%	✓(235)	x[f]

nk = not known

a The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets and (NP) = needles and syringes not available for purchase; where this is not referred to it is not known.
b The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine and (O) = any other form (including morphine and codeine).
c Sub-national data only.
d Year of estimate: 2003.
e In March 2010 the launch of the first pilot OST programme was imminent.
f A pilot programme was shut down in 2009.

Harm Reduction in Eurasia

The Eurasia region, comprising Central and Eastern Europe, as well as Central Asia, is home to over 3.7 million people who inject drugs, representing almost one-quarter of people who inject drugs worldwide.[6] The largest numbers are found in Russia (1.8 million), Azerbaijan (300,000) and Ukraine (291,000).[2] Data indicate that some Eurasian countries have the highest adult population prevalences of injecting drug use in the world, including 5.21% in Azerbaijan, 4.19% in Georgia, 1.78% in Russia and 1.16% in Ukraine.[1] Injecting drug use is driving HIV epidemics in most countries in Eurasia, where an estimated one million people who inject drugs are living with HIV.[1] There is also an extremely high prevalence of hepatitis C among this group, which, due to lack of access to treatment, is a major cause of death (see Chapter 3.1 on viral hepatitis). However, the leading cause of death among opioid users in many Eurasian countries continues to be overdose (see Chapter 3.6 on overdose and overdose prevention).

While harm reduction service provision continued to increase generally in 2008 and 2009, coverage remains limited. Needle and syringe exchange (NSP) is now provided in all of the twenty-nine countries/territories of the region.[9] However, a recent regional estimate of only nine syringes being distributed per person per year indicates very poor coverage.[2] Twenty-four countries/territories have opioid substitution therapy (OST),[h] but most of the programmes remain pilots and have not been systematically scaled up. The most significant OST scale-up in recent years occurred in Ukraine, where as of April 2010 harm reduction services are operating in all twenty-seven Ukrainian regions to varying degrees.

International financial support for harm reduction services has continued to rise in most Eastern European and Central Asian countries, particularly with the influx of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, since 2008, a number of countries in the region are no longer eligible for Global Fund funding as growing GDPs have moved them into the World Bank's 'middle income' category. Although the impact of this is yet to be quantified, it is clear that many national governments have not supplemented the need for continued funding and technical assistance to sustain and expand the delivery of harm reduction services. For those countries that are members of the European Union, the challenge is in finding funds to meet European Commission co-funding requirements. Throughout Eurasia, there remains an urgent need to bolster national government support, both political and financial, in order to ensure the sustainability of existing harm reduction services and create an inclusive framework for their continuing development.

g A Global Fund grant is supporting NSP in Kosovo, where the NGO Labyrinth is providing needles and syringes at three sites in Pristine, Prizren and Gilan.
h Tajikistan will soon bring this to twenty-five of the twenty-nine countries.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

At least one NSP site is operating in every country and territory in the Eurasian region. NSPs have increased in number since 2008 in several countries, including Kazakhstan, Tajikistan, Estonia, Ukraine, Kyrgyzstan and the Czech Republic.[3] For instance, since 2008 the number of sites providing NSPs increased from 362 to between 985 and 1,323 in Ukraine and from 129 to 159 in Kazakhstan.[7] [8] Newly available data since 2008 indicate that two NSP sites have been operating in Turkmenistan's capital, Ashgabat.[9]

With the possible exceptions of Moldova, the Czech Republic, Estonia and Kazakhstan, where reports indicate medium or high levels of syringe distribution coverage, the rest of the region has very low coverage.[i] [2] NSP sites in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan are reported to reach approximately one-third of people who inject drugs and to distribute an average of ninety-two needles and syringes per person per year.[j] [2] The reach and availability of services, particularly in countries in Eastern Europe, is even more limited. In sixteen countries in the region where data are available, only between 7% and 15% of people who inject drugs are accessing NSPs at least once a year and only nine needles and syringes are distributed annually per person injecting drugs.[2] Government reports on progress towards national universal access targets indicate that across eighteen countries in the region an average of only one NSP site is available per 1,000 people who inject drugs.[10]

NSP service provision has not significantly increased in Russia since 2008 and only seventy sites provide NSP services, distributing nearly seven million needles and syringes per year but reaching only 7% of people who inject drugs in this vast country.[2] In most of the EU member states (with the exception of the Czech Republic and to some extent Hungary and Slovenia), although harm reduction is an integral part of national drug and/or HIV policies, barriers to scaling up and mainstreaming these services include lack of sufficient funding, political commitment, leadership and technical assistance.[3]

Five countries in the region – Armenia, Kyrgyzstan, Moldova, Belarus and Romania – have needle and syringe exchange in prisons (see Chapter 3.5 on harm reduction in prisons).

Since 2008 more countries in the region have introduced pharmacy-based NSPs (including Kyrgyzstan and Ukraine) and have piloted vending machines for dispensing syringes.[2] However, government support for these initiatives has been mixed. Despite well-established harm reduction services in the Czech Republic, two pilot vending machines were dismantled by government authorities. Similarly, authorities from the Kaliningrad Regional Department of the Russian Federal Drug Control Service attempted to ban NSPs in September 2008, ultimately without success. In 2009 Hungarian policy makers also voiced opposition to NSPs.[3]

i According to the WHO, UNAIDS and UNODC target-setting guide, medium NSP coverage is >100 to <200 needles/syringes per injector per year and high coverage is >200 needles/syringes per injector per year. However, given the difficulties in determining the size of the population who inject drugs and NSP monitoring data, these estimates must be interpreted with caution.
j Almost reaching medium coverage levels (>100 to <200 needles/syringes per injector per year) as defined by WHO, UNODC and UNAIDS.

Opioid substitution therapy (OST)

Across the Eurasian region, all but five countries and territories have some form of OST provision. Programmes will soon begin operating in Tajikistan and Kosovo, but in Russia, Turkmenistan, Kosovo and Uzbekistan (where a pilot OST site was shut down in June 2009)[11] OST is not available.[2] Even where programmes exist, OST is accessible to less than 5% of opioid users, with some exceptions in Croatia, Slovenia, Hungary and the Czech Republic.[12] In Eastern Europe and Central Asia, only 1% of people who inject drugs are reported to be receiving OST[2] and OST programmes have generally remained at the pilot stage rather than systematically scaling up.

There has been some progress made since 2008, with OST programmes expanding in Albania, Georgia, Macedonia, Armenia, Kazakhstan and Azerbaijan.[3] Kazakhstan introduced OST in 2008 and now has two methadone maintenance treatment (MMT) sites serving fifty individuals in the two cities with the largest registered HIV-positive injecting drug using populations.[2] Armenia launched a pilot MMT programme in September 2009. Additional developments in OST site scale-up include a second OST clinic in Macedonia, two new MMT centres in Albania and up to twelve state-funded MMT sites reaching approximately 1,200 people in Georgia. Following a positive outcome evaluation of a pilot programme implemented during 2008, Belarus officially allowed the use of MMT as a registered opioid dependence treatment. In Tajikistan, the first pilot OST programme is expected to begin prescribing imminently.[3]

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports that legal obstacles to OST provision in a majority of the EU member states in Eurasia[k] have been removed, with OST regulation and implementation being assumed by health ministries.[13] Although there is limited access to OST in all of these countries, scale-up of services has been steadily progressing.

Despite positive developments in the region, several barriers remain to the provision and scale-up of OST. In most countries where OST is available, sites are located in the capital and/or another major city, making it challenging for all individuals who require treatment to make daily visits to the site(s). For instance, in Moldova, less than 1% of people who inject drugs have access to MMT and, as of August 2008, methadone programmes were available only in the capital city, Chisinau, and one other major city, Balti.[14]

Political and legal opposition to OST remains the biggest obstacle in Russia, the country with the highest number of people who inject drugs in the region and an HIV prevalence of more than 37% among that population. Russian officials defended the ban on OST at the 2009 Eastern Europe and Central Asia AIDS Conference and documented their position in the new Russian anti-drug policy strategy in December 2009. At the 53rd UN Commission on Narcotic Drugs (CND) in March 2010, the director of the Russian Federal Drug Control Service reiterated the Russian position, provoking disagreement from the UNODC executive director and the head of the European Commission's drug unit. The Uzbek government recently discontinued a pilot OST programme citing its ineffectiveness as justification for the action.[11] There is an urgent public health need to mobilise government support around the provision of evidence-based NSP and OST services for people who inject drugs.

k Estonia, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia.

As in 2008, other significant constraints for OST in the region include the sharing of medical information between health and law enforcement agencies across Central Asia, Georgia, Russia and Ukraine,[15] a failure to prioritise OST over abstinence-based programmes[l] [16] and a need to discard limitations on primary health care and non-governmental organisation (NGO) provision of OST.[17]

Scaling up harm reduction in Ukraine

With the introduction of a new harm reduction law in 2008 and significant scale-up of services, Ukraine's response has become one of the most comprehensive in the region. By late 2009 Ukraine had the largest number of people receiving OST (up to 5,000) among post-Soviet countries. By 2012 Ukraine plans to increase the number of OST clients to 11,300 people (500 people receiving buprenorphine and 10,800 receiving methadone). To sensitise Ukrainian society to wider OST coverage, a large-scale social campaign known as 'Return ticket' has been launched by people receiving OST. This campaign aims to stimulate open and evidence-based dialogue about drug dependence therapy and to build support among policy makers, law enforcement authorities and the general population.[3]

Antiretroviral therapy (ART)

Approximately one million people who inject drugs are living with HIV throughout the Eurasian region.[2] New estimates indicate that access to ART for people who inject drugs remains limited. Where data were available,[m] the highest estimates of people who inject drugs receiving ART were in Ukraine (1,860), Russia (1,331) and Poland (1,372). However, these estimates represent very low percentages of the total number of injecting drug users living with HIV, ranging from less than 2% in Ukraine to only 0.2% in Russia.[2]

Overall, ART coverage in eighteen Eurasian countries has reportedly risen from reaching 16% of people who needed it in late 2007 to 23% in late 2008.[10] Continued challenges are faced in programme planning, procurement and distribution, but to reach people who inject drugs, there is a need for further linkages between ART programmes and harm reduction services, particularly OST and peer support services.[3]

Policy developments for harm reduction

In 2008 twenty-four Eurasian countries/territories had national HIV or drug policies explicitly supporting harm reduction;[7] in 2010 this has increased to twenty-five.[n] Bosnia and Herzegovina established a National Office on Drugs as part of a newly developed national drug strategy in 2009. Certificates for all staff members of NGOs providing harm reduction services will be issued by the Ministries of Security and Health, bringing Bosnia and Herzegovina a few steps closer to the institutionalisation of harm reduction.[3]

l In order to access OST in Kazakhstan, Kyrgyzstan and Tajikistan, people must have a history of unsuccessful attempts at treatment through state abstinence-based programmes.

m All countries and territories except Turkmenistan, Romania, Hungary, Kosovo and Azerbaijan.

n Azerbaijan, Kosovo, Russia and Turkmenistan remain the exceptions.

In the majority of countries in the region (particularly Georgia, Russia and Ukraine), national drug policy documents and budgets continue to prioritise drug supply reduction as the key pillar of drug policy, resulting in an over-reliance on law enforcement and neglecting investment in drug demand or harm reduction. In Georgia, where drug use is highly criminalised, significantly more funds are attributed to drug testing than to treatment, and fines for users who test positive may reach up to 200% of the average monthly salary.[18] An initial draft of Russia's new national drug strategy in December 2009 explicitly mandated opposition to harm reduction, but a strong civil society response resulted in the clause being removed.[19] On the other hand, following in the footsteps of several Latin American states (see Chapter 2.5), Armenia decriminalised drug consumption in 2009.

Developments since 2008 indicate a growing emphasis on harm reduction and health within drug policy in some new EU states. For example, Hungary's 2010–2018 drug strategy outlined a multidisciplinary and balanced approach to supply and demand reduction, with harm reduction as a key component and endorsing human rights, access to health and evidence as main principles.[20] In Lithuania, research indicates that since EU accession, health spending per drug user has increased significantly.[17]

The adoption of the new Political Declaration on Drugs at the High Level Segment (HLS) of the 2009 CND provided a platform for several countries to declare political support for harm reduction. Twenty-six countries, including nine Eurasian states,[o] signed a statement declaring that they interpret the new declaration to support harm reduction.[21] However, the lack of explicit reference to harm reduction in the political declaration has already posed challenges. In Hungary, where a progressive drug policy was adopted in December 2009, harm reduction opponents referred to the declaration in ultimately unsuccessful attempts to exclude harm reduction from the national policy.[22]

Civil society and advocacy developments for harm reduction

Civil society participation in advocacy for harm reduction has increased in the past two years. 'Beyond 2008', a project that sought to include NGO perspectives in the development of the new Political Declaration on Drugs, was an important forum for mobilising civil society. It brought together forty representatives in two regional consultations and resulted in enhanced civil society participation at the HLS of the 2009 CND. National delegations from Albania, Ukraine and Georgia included civil society representatives. In addition, Ukraine, Kyrgyzstan and Georgia produced national reports assessing harm reduction policy in their countries from 1998 to 2008, which provided the basis for the messages delivered by their national delegations.[3]

Advocating for harm reduction in Russia

At the third Eastern Europe and Central Asia AIDS Conference (Moscow, 28 to 30 October 2009), it became clear that the Russian government did not plan to provide the funding pledged at the second conference for its most-at-risk populations. This could have resulted in the closure of more than 200 NGOs providing services for people who inject drugs and other at-risk populations. In one of the largest civil-society-led campaigns in the region, the Eurasian Harm Reduction Network (EHRN) and partners appealed to the GFATM Board of Directors to grant a two-year extension to the Russian 3rd Round GFATM Programme, GLOBUS (the largest source of financial support for harm reduction in Russia). More than 200 civil society organisations from around the world joined the campaign, including IHRA and several other regional and national harm reduction networks. In response to the appeal, the GFATM Board agreed to provide emergency funds of up to US$24 million until the end of 2011 to ensure the continuation of essential harm reduction programming in Russia.[23]

Since 2008 there have also been notable developments in civil society organising at the sub-regional and national levels. New civil society networks have been formed, including the Azerbaijan Harm Reduction Network and the Central Asian Network of People Living with HIV established in late 2009. Membership of the EHRN has continued to grow and in 2010 the Eurasian Network of People Who Use Drugs formed, covering Eastern Europe and Central Asia and linked to the International Network of People Who Use Drugs (INPUD).

Several national networks have increasingly sought a voice in drug, HIV and harm reduction legislation and policy. For instance, the Georgian Harm Reduction Network collected 58,000 signatures to reduce the strict sanctions for drug use and personal possession of drugs in 2008. In the same year successful national mobilisation of partners led by the National Association of People Living with HIV halted the interruption of ART in Latvia. In October 2009 the Romanian Harm Reduction Network and its members sent a position letter to the Romanian Prime Minister criticising the decision to restructure the oldest OST clinic in the country and discontinue MMT to 290 patients. This action resulted in a meeting with the Minister of Health and the subsequent transfer of the patients to other treatment facilities.[3]

While there are many examples of strong civil society in the region, there is a clear need for capacity building and technical assistance, particularly around accessing and managing GFATM funds. Assessments in Armenia, Belarus and Tajikistan indicated that one of the leading obstacles to the broader participation of civil society in the HIV response is the prohibitively strict criteria for sub-recipient selection set up by the principal recipients in each country. Awareness and understanding of GFATM processes is limited in many Eurasian civil society organisations focused on harm reduction, as is their capacity to bid for involvement in a GFATM programme. It is hoped that the GFATM community systems strengthening framework will increase access to funds for civil society organisations (see Chapter 3.7 on resourcing harm reduction).[24]

o Bulgaria, Estonia, Georgia, Hungary, Latvia, Lithuania, Poland, Romania and Slovenia.

Multilaterals and donors: Developments for harm reduction

The international financial crisis has affected harm reduction services throughout the region. Where national governments do fund harm reduction programmes, spending on such services remains disproportionately low, with the crisis leading to further spending cuts in many countries. For instance, the Lithuanian AIDS Center was merged with the Centre for Prevention and Control of Communicable Diseases at the end of 2009, raising concerns that the quality and scale of care provided to people living with HIV may be compromised. In Kyrgyzstan, the National Drug Control Agency was abolished during recent government reforms and its functions were transferred to the Ministry of Internal Affairs, which had also recently downsized. Budget cuts to already limited services will have significant negative outcomes and result in increased health care costs in the long term.[3]

While the Global Fund remains the main funder of harm reduction in the region, there have been some developments over the past two years. In 2008 several countries in the region became ineligible for Global Fund funding as their economies expanded beyond the low-income country criteria.[p] Also, in late 2008, the Global Fund requested that a number of recent Eurasian grantees improve efficiency and cut costs; for example, by as much as 10% in Ukraine. The Global Fund conducted an internal audit in 2009 of all three components of the Kyrgyzstan programme, resulting in the decision to freeze new financial transfers temporarily.

EU member states in Eurasia have increasingly struggled with securing funds to replace dwindling international support for harm reduction activities. In most cases, countries are unable to co-fund to the extent (between 20% and 40% of the total programme cost) required by the European Commission (EC) and so they lack the capacity necessary to apply and implement programmes though EC mechanisms.

The WHO, UNODC and UNAIDS continue to play a major role in the provision of technical assistance across the region, including piloting OST, developing clinical protocols and facilitating advocacy and policy dialogue on harm reduction. In addition, in 2009 the World Bank, with technical support from EHRN, established the Central Asian Information and Training Center on Harm Reduction within the Central Asia AIDS Control Project (CAAP).[3]

UN Special Rapporteurs call for harm reduction

In 2009 reports from UN Special Rapporteurs on the Right to the Highest Attainable Standard of Health and on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment called for the decriminalisation of drug use and increased access to health care, including OST and ART, in Poland and Kyrgyzstan. The Polish report stated that the promised scale-up of methadone clinics to reach 20% of those in need by 2010 was not a high enough target and represented a minimal step towards addressing the problem. Access remains poor outside major cities such as Warsaw and Krakow and the report urged local authorities in Gdansk to provide a methadone maintenance programme as soon as possible.[25] The report on Kyrgyzstan stated that HIV among people who inject drugs required urgent attention as a matter of public health and human rights. It also called for reform of national drug legislation, which still allows penalties for drug use.[26]

UNODC also coordinates projects in a number of Eurasian countries that play a significant role in national and local capacity building for harm reduction. For instance, through the TREATNET project, UNODC facilitates capacity building on evidence-based approaches to drug dependency treatment in Central Asia. The UNODC regional office maintains a project focused on HIV prevention, treatment and care among people who inject drugs in Estonia, Latvia and Lithuania, including the provision of technical assistance to various stakeholders on harm reduction in prisons. UNODC and WHO are also among the main donors (along with German bilateral funds from GTZ) of the EHRN Harm Reduction Knowledge Hub for Europe, which has recently developed and tested new technical assistance tools, including training modules on gender-specific harm reduction services and overdose prevention programming.[3]

p The key criteria for GFATM eligibility is the low-income economy of a country, assuming that middle- and high-income countries can and will cover health-related costs themselves.

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