

## 2.2 | Regional Update **Eurasia**



**Table 2.2.1:** Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Eurasia

Country/territory with reported injecting drug use	People who inject drugs <sup>a</sup>	HIV prevalence among people who inject drugs (%) <sup>a</sup>	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) <sup>b</sup>	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) <sup>b</sup>	Harm reduction response <sup>c</sup>	
					NSP <sup>d</sup>	OST <sup>e</sup>
Albania	4,500–5,000 <sup>f</sup>	<1% <sup>g</sup>	29.2 <sup>i</sup>	nk	✓ (3)	✓ (6) <sup>2</sup> (M)
Armenia	3310 (2797–4057) <sup>4</sup>	10.7 <sup>5</sup>	nk	nk	✓ (7)	✓ (4) <sup>2</sup> (M)
Azerbaijan	300,000 <sup>h</sup>	9.5 <sup>5</sup>	62.9 <sup>5</sup>	10.9 <sup>5</sup>	✓ (12–14)	✓ (2)(M)
Belarus	50,000 <sup>5</sup>	13 <sup>5</sup>	nk	nk	✓ (33) <sup>5</sup>	✓ (13) <sup>2</sup> (M)
Bosnia and Herzegovina	nk	nk	nk	nk	✓ (6)	✓ (8)(BN,M)
Bulgaria	20,250 (16,200–24,300)	2.2 <sup>(6) 7</sup>	62.3 <sup>(6) 8</sup>	3.1 <sup>(6) 9</sup>	✓ (100)	✓ (31) <sup>2</sup> (BN, M, O)
Croatia	8,500 <sup>9</sup>	0.0 <sup>i</sup>	27.1 <sup>(6) 8</sup>	2.4 <sup>(6) 9</sup>	✓ (42)	✓ (B,M)
Czech Republic	29,000 (25,494–33,823) <sup>(6)</sup>	0.0–0.6 <sup>7</sup>	13.6 <sup>6</sup>	15.1	✓ (109) (P)	✓ (150–240) <sup>2</sup> (B,M, BN)
Estonia	13,801 (8178–34,732)	54.3–89.9 <sup>(6) h 7</sup>	90.5	21.3	✓ (36)	✓ (10) <sup>10</sup> (B,M)
Georgia	40,000 <sup>11</sup>	3.9 <sup>5</sup>	58.2	7.2	✓ (10)	✓ (16) <sup>13</sup> (BN,M)
Hungary	5,699 <sup>12</sup>	0.0 <sup>7</sup>	21.4 <sup>(6) 8</sup>	0.3 <sup>(6) 9</sup>	✓ (25)	✓ (10) <sup>2</sup> (BN,M)
Kazakhstan	119,140 <sup>13</sup>	3.8 <sup>5</sup>	61.3	7.9	✓ (155) <sup>5</sup>	✓ (3) <sup>2</sup> (M)
Kosovo	nk	0	--	--	✓	✓ (3) <sup>14</sup> (M)
Kyrgyzstan	25,000 <sup>15</sup>	14.6 <sup>5</sup>	50 <sup>16</sup>	nk	✓ (29–49) <sup>5</sup> (P)	✓ (17–20) <sup>2</sup> (M)
Latvia	nk	11.2 <sup>5</sup>	50.0 <sup>(6) 8</sup>	nk	✓ (18) <sup>5</sup>	✓ (10) <sup>2</sup> (B,M)
Lithuania	5,458 <sup>16</sup>	0.0–21.4 <sup>(6) 7</sup>	70.3–89.7 <sup>(6) 8</sup>	3.3–8.9 <sup>9</sup>	✓ (12) <sup>17</sup>	✓ (21) <sup>17</sup> (B,M)
Macedonia	15,000–20,000 <sup>17</sup>	nk	70 <sup>18</sup>	nk	✓ (15)	✓ (10)(M, B) <sup>3</sup>
Moldova	31,562 <sup>5</sup>	16.4 <sup>5</sup>	42.7	nk	✓ (31)	✓ (10) <sup>i</sup> (M)
Montenegro	nk	nk	37.8 (22–53.6)	0	✓ (18)	✓ (3) <sup>2</sup> (M)
Poland	nk	6.8 <sup>7</sup>	44.3–72.4 <sup>(6) 8</sup>	2.5–3.8 <sup>9</sup>	✓ (27)	✓ (22)(B,M)
Romania	17,000 <sup>5</sup>	4.2 <sup>18</sup>	82.9 <sup>(6) 8</sup>	4.7 <sup>9</sup>	✓ (3)	✓ (7)(B,M)
Russia	1,815,000	37.15 (0.3–74) <sup>k</sup>	72.5 (49–96)	9	✓ (4)	✗
Serbia	30,383 (2682–48,083) <sup>5</sup>	2.4–4.5 <sup>(6) 5</sup>	60.5–77.4 <sup>(6) 5</sup>	nk	✓ (13)	✓ (30) <sup>2</sup> (B,BN,M)
Slovakia	18,841 (13,732–34,343)	0.3 <sup>7</sup>	40.3 <sup>(6) 8</sup>	nk	✓ (20)	✓ (2)(BN,B,M)
Slovenia	7,310	0.4 <sup>7</sup>	21.5 <sup>8</sup>	3.4 <sup>l</sup>	✓ (17)(P)	✓ (20)(BN,B,M,O)
Tajikistan	25,000 (20,000–30,000) <sup>19</sup>	16.3 <sup>20</sup>	61.3	nk	✓ (49)	✓ (3) <sup>2</sup> (M)
Turkmenistan	nk	nk	nk	nk	✓ (2)	✗
Ukraine	296,000 <sup>5</sup>	21.5 <sup>5</sup>	67 (60.9–73)	6.7	✓ (1667) <sup>5</sup>	✓ (131) <sup>2</sup> (B,M)
Uzbekistan	83,500	8.4 <sup>5</sup>	51.7	nk	✓ (235)	✗

nk= not known  
(6) = sub-national data

a Unless otherwise stated, data on the estimated number of people who inject drugs in each country are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745. The year of estimate is provided for each figure that is sourced from 2007 or earlier.

b Unless otherwise stated, estimates for hepatitis B and C are sourced from Nelson PK, Mathers BM, Cowie B, Hagan H, Des Jarlais D, Horyniak D & Degenhardt L (2011) Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews, Lancet, 378(9791): 571–583.

c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d 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.

e 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, (BN) = buprenorphine-naloxone combination, (O) = any other form (including morphine and codeine).

f Figure based on expert opinion and based on problem drug use rather than injecting only.

g Year of estimate: 2007.

h Year of estimate: 2005.

i Year of estimate: 2006.

j Seven of these are prison NSPs.

k Year of estimate: 2003.

l Year of estimate: 2002.

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



## Harm reduction in Eurasia

Of the estimated 15.9 million (11–21.2 million) people who inject drugs (PWID) worldwide,<sup>20</sup> 3.7 million – nearly a quarter – live in Eastern Europe and Central Asia (Eurasia). Based on national-level estimates, the largest PWID populations are reported in Russia (1.8 million)<sup>21</sup> and Ukraine (296,000).<sup>22 m</sup>

Eurasia is the only region in the world where the number of people living with HIV has almost tripled since 2000, reaching an estimated total of 1.4 million (1.3 million–1.6 million) in 2009 compared with 760,000 (670,000–890,000) in 2001.<sup>20</sup> Injecting drug use (IDU) remains the leading route of HIV transmission in Eurasia.<sup>23</sup> An estimated one quarter of the 3.7 million PWID in Eurasia are living with HIV.<sup>21</sup> In several countries, particularly in Eastern Europe, HIV prevalence among PWID in prisons is substantially higher than prevalence in the general population.<sup>24</sup>

Viral hepatitis is considerably more widespread than HIV among PWID in Eurasia, with five countries in the region reporting hepatitis C (HCV) prevalence higher than 70% among this population. Estonia has the highest HCV prevalence among PWID (>90%), followed by Romania (82.9%), Serbia (77.4%), Russia (72.5%) and Lithuania (>70%).<sup>25</sup> The disproportionately high burden of HCV among PWID is exacerbated by limited access to testing and treatment, particularly for incarcerated PWID, who experience higher rates of viral hepatitis than PWID in the community.<sup>26</sup>

Increasing rates of HIV/tuberculosis (TB) co-infection and limited access to treatment for both diseases contribute to the increased vulnerability of PWID in Eurasia. Fatal overdose caused approximately 21% of deaths among all people living with HIV in Russia in 2007, second only to TB.<sup>27</sup>

Although harm reduction programmes across Eurasia have generally expanded since 2010, coverage remains low to medium by international targets.<sup>n</sup> Needle and syringe exchange programmes (NSPs) are available in all 25 countries of the region, but coverage varies widely among countries, from 19 syringes distributed per PWID per year in Latvia<sup>28</sup> to 174 per person per year in Estonia.<sup>29</sup> None of the 12 countries in the region for which coverage data are available reached the international recommended level of 200 syringes per person per year,<sup>30</sup> although five countries distributed between 100 and 200 syringes per person per year: Estonia, Kazakhstan, Kyrgyzstan, Slovakia<sup>31</sup> and Tajikistan.<sup>o</sup>

Twenty-six countries in the region, with the exception of Russia, Turkmenistan and Uzbekistan, implement opioid substitution

therapy (OST). Substantial scale-up of OST provision since 2010 has occurred in Bulgaria, the Czech Republic, Georgia, Lithuania, Moldova and Serbia, and new programmes were established in Tajikistan in 2010 and Kosovo in 2012.

Despite progress in several areas, harm reduction remains politically marginalised in some countries in the region, particularly Russia and Uzbekistan. Since 2010, Hungary's national drug strategy has been amended to exclude harm reduction as a priority and limit access to drug treatment instead of criminal sanctions for people who use drugs (PWUD).<sup>32</sup>

The international financial crisis and the restructuring of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has significantly affected harm reduction efforts in many countries in Eurasia, with the notable exception of successful Round 10 applicants Kazakhstan, Kyrgyzstan, Ukraine and Uzbekistan.<sup>33</sup> Since the cancellation of Round 11 in November 2011, a number of countries in the region, namely Armenia, Azerbaijan and Belarus, face a different set of eligibility criteria for new funding and potentially long-term funding cuts, as is the case of Albania.<sup>33</sup> Despite the inclusion of harm reduction in national HIV or drug strategies in 26 countries,<sup>p34</sup> the majority of governments in Eurasia do not financially support harm reduction programmes. Five countries reported non-governmental and non-Global Fund funding sources for harm reduction, while another 11 reported some governmental contributions toward the delivery of harm reduction programmes.<sup>q35</sup> Overall, non-governmental organisations (NGOs) are the main implementers of NSPs, either through stand-alone sites or in the context of broader HIV prevention services, while governmental institutions tend to manage OST provision. However, in several countries, including Tajikistan and Uzbekistan, more governmental institutions have initiated NSP provision with support from the Global Fund.

Civil society organisations (CSOs) and regional networks have played an increasingly important role in advocacy for harm reduction in Eurasia. Since 2010 the European Harm Reduction Network (EuroHRN)<sup>r</sup> which includes 13 countries in Eastern Europe,<sup>5</sup> was newly established with support from the European Commission, and the International Drug Policy Consortium (IDPC) initiated a new drug policy network for South East Europe.<sup>36</sup> In 2011, several important events took place in European capitals as part of the Count the Costs Campaign,<sup>t</sup> on the occasion of the 50th anniversary of the

m This report included both 250,000 and 296,000 PWIDs as population size estimates.

n According to the 2009 WHO, UNODC, UNAIDS target-setting guide, <100 syringes distributed per person who injects drugs per year is considered low coverage, 100–200 is medium coverage, and >200 is high coverage.

o Data extracted from UNGASS country reports, Country questionnaires, Petersen et al. (2012),<sup>16</sup> Latypov et al. (2012)<sup>3</sup> for: Armenia, Azerbaijan, Belarus, Estonia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Romania, Tajikistan and Ukraine.

p Figure includes Azerbaijan, which passed a new HIV law in 2010.

q Kyrgyzstan, Latvia, Romania, Russia, and Tajikistan reported additional funding sources in addition to government and GFATM, while Azerbaijan, Bulgaria, Bosnia & Herzegovina, Estonia, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland and Serbia reported governmental funding for OST/NSP and related activities.

r The European Harm Reduction Network (EuroHRN) has been recently formed by ten organisations with a shared interest in advocating for and sharing knowledge on harm reduction within Europe. It is made up of three sub-regional networks covering North, South and Eastern Europe and managed by a coordinator based at the Harm Reduction International in the UK. For more information see [www.eurohrn.eu](http://www.eurohrn.eu).

s Albania, Bosnia and Herzegovina, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Macedonia, Poland, Romania, Serbia, Slovakia, Slovenia.

t To learn more about Count the Costs, see [www.countthecosts.org](http://www.countthecosts.org).

Single Convention on Narcotic Drugs on 30 March 2011. 'Urban Drug Policies in the Globalized World', an international workshop conference that took place in Prague, Czech Republic, in 2010, brought together civil society partners and networks from Eurasia, enabling them to exchange information on policy and best practices.

## Developments in harm reduction implementation

### *Needle and syringe exchange programmes (NSPs)*

NSPs operate in all 29 countries and territories in Eastern Europe and Central Asia (see Table 2.2.1). Since 2010, three countries have scaled up provision: Kyrgyzstan, Tajikistan and Ukraine: for example, the number of NSP sites in Ukraine has increased significantly from 985–1323 reported in 2010 to 1667 in 2011.<sup>5</sup> During the same period, five countries have scaled back provision due to funding cuts: Belarus, Hungary, Kazakhstan, Lithuania and Russia.

Several countries reported that an increased proportion of PWID are being reached by NSP services. These include Armenia, Croatia and Kosovo, with coverage rates ranging from 10% in Georgia<sup>37</sup> to 72% in Belarus.<sup>35</sup> A recent report by the Eurasian Harm Reduction Network (EHRN) estimates that on average only 10% of PWID in Eastern Europe and 36% in Central Asia access NSPs.<sup>33</sup> New data covering the period from January 2010 to December 2011 submitted by countries to UNAIDS as part of Global AIDS Progress reporting indicate that sharing of injecting equipment varies widely across the region. The number of PWID who report using sterile equipment during their last injection ranges from only 15.58% in Romania to 95.5% in Ukraine.<sup>5</sup> New models of service delivery are applied in some countries including a pilot NSP in a prison in Tajikistan and a mobile NSP in Albania.<sup>4</sup>

However, even in countries that report increased availability of NSPs, research and consultations with PWID indicate that many actively avoid seeking health services due to the risk of being stigmatised, ostracised or discriminated against by health care providers.<sup>16, 35, 38</sup> Additional barriers to service access include limited or uneven geographical reach of programmes,<sup>35, 39</sup> fear of being threatened, abused, extorted or arrested by the police,<sup>35, 41–43</sup> criminalisation of possession of illicit substances or injecting equipment with traces of substances,<sup>44</sup> lack of political will and funding,<sup>45</sup> and limited or insufficient supply of injecting equipment.<sup>13, 35, 46</sup>

Overall, harm reduction programmes that focus on women who use drugs are in place in Georgia, Kyrgyzstan, Russia and Ukraine with the support of the Open Society Foundation,

UNICEF and GIZ. However, in most cases, although NSPs do not openly discriminate against women, gender-specific NSP services that recognise and address the specific barriers faced by women who inject drugs are limited or difficult to access. In Romania, cultural stereotypes and stigma prevent many women from accessing NSP.<sup>35</sup> In Tajikistan women who use drugs experience high levels of stigma, especially from male PWID.<sup>47</sup> Anecdotal reports from Macedonia and Albania indicate that the lack of NSP programmes sensitive to women's needs limits women's access to these services.<sup>35</sup> The intersection between drug use and sex work, particularly in the case of Roma sex workers in Hungary and Romania, renders addressing the needs of women drug users particularly challenging.<sup>35, 48</sup>

Access also appears to be limited for young PWID. Legal age restrictions or required parental consent prevent young people from accessing NSPs in Czech Republic, Estonia, Lithuania, Macedonia, Moldova and Romania.<sup>49–51</sup> However, since NSP services are often anonymous and client ages unrecorded, it is hard to assess whether some PWID are under 18.<sup>49</sup> There are no legal age restrictions reported for accessing NSPs in 16 countries in the region.<sup>v</sup> In Serbia a new law due to be implemented beginning in August 2012 will allow minors aged 15 and above to have exclusive privacy over their medical charts and consent rights regarding their health issues, meaning that parental consent will be no longer be required when accessing harm reduction services.<sup>52</sup>

### *Opioid substitution therapy (OST)*

OST is available in various forms in 26 countries and territories, with the exception of Russia, Turkmenistan and Uzbekistan. Despite the increased availability of OST at the national level, programmes continue to have limited reach, and coverage varies significantly among and within states. Ukraine has the highest number of clients on OST (6517),<sup>3</sup> while the Czech Republic has the highest estimated OST coverage in the region, with 40% of people who inject opiates enrolled in OST.<sup>3</sup> It is followed by Lithuania, Bulgaria and Poland, with rates of 13.1%,<sup>53</sup> 12% and 7% of PWID enrolled in OST, respectively.<sup>3</sup> In the majority of former Soviet countries coverage remains extremely limited, with under 5% of PWID accessing OST.<sup>3</sup> Although most programmes continue to have limited reach and are still in pilot stages,<sup>16</sup> the number of OST sites has increased in 16 countries and territories<sup>w</sup> since 2010.

Greater coverage in the Czech Republic and Croatia can be partially attributed to the fact that medications used for OST (except methadone) can be prescribed by general practitioners and purchased in pharmacies.<sup>3</sup> The opposite is the case in Estonia and Latvia, where prescription regulations limit access.<sup>35, 46</sup> Positive developments in OST delivery have

u The NSP in Albania has been newly integrated into the Break the Cycle (BTC) intervention model, which aims to enable PWID to use drugs safely by providing of services, skills and information and encouraging their commitment to not recruit others to drug use.

v Slovakia, Croatia, Bulgaria, Albania, Slovenia, Serbia, Hungary, Bosnia, Kosovo, Armenia, Belarus, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine.

w Albania, Armenia, Bosnia & Herzegovina, Bulgaria, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Macedonia, Moldova, Poland, Romania, Serbia and Ukraine.

been reported in Serbia and Bosnia and Herzegovina, where services have recently been decentralised.<sup>35</sup> Additional forms of OST in addition to methadone have been introduced in Serbia (buprenorphine and buprenorphine-naloxone combination), as well as in Czech Republic and Georgia (buprenorphine-naloxone combination).<sup>37</sup> In Bulgaria the quality of OST services is presently being addressed in a new set of guidelines for good clinical practice planned to come into force in 2012.<sup>3</sup>

Despite encouraging developments in OST provision in the region, a number of barriers remain around implementation and scale-up. Only nine countries – Albania, Bulgaria, Kyrgyzstan, Latvia, Lithuania, Macedonia, Poland, Serbia and Ukraine – reported access to takeaway doses. However, even in countries where takeaway OST is available, access is limited by strict regulations:<sup>3</sup> strict admission criteria are in place in at least seven countries, including proving a past history of opiate use, as well as one or several failed treatment attempts.<sup>55-57</sup> Scarce provision of OST outside major urban centres results in uneven coverage within countries,<sup>35</sup> and the cost of existing OST services, limited funding<sup>3,40,58</sup> and long waiting lists<sup>35</sup> pose additional barriers. Limited funding was cited as the reason why some services reportedly prescribe methadone doses below WHO recommendations in Kyrgyzstan<sup>55</sup> and Moldova.<sup>40</sup> In several Eurasian countries, protocols for administering OST are inappropriate or non-existent, and there is a need for increased capacity-building among staff.

Access to OST is also subject to strict age restrictions, with legal age restrictions in place in at least ten countries and parental consent needed for young people under 16 years old in Bosnia and Herzegovina and Slovakia.<sup>35</sup> Barriers faced by women who inject drugs are similar to those faced by men, although the limitation of civil rights, particularly the removal of parental rights, affects women disproportionately in several countries including Macedonia and Ukraine.<sup>59-60</sup> Often this is executed through the implementation of registries of PWUD at harm reduction services for women who inject drugs, rendering them vulnerable to discrimination and the loss of parental rights during child custody cases. Fear of stigma and discrimination remains a barrier to access for all PWID.<sup>35</sup>

### **Antiretroviral therapy (ART)**

Eurasia is home to nearly 1 million PWID living with HIV.<sup>61</sup> PWID comprise 62% of people living with HIV in the region but only 22% of those receiving antiretroviral therapy (ART).<sup>33</sup> The proportion of PWID living with HIV who receive ART in Eurasia varies between 3.5% in Kazakhstan and 10% in Moldova, although it should be noted that new data on exact coverage since 2010 were only available for three countries.<sup>16</sup> The highest numbers of PWID living with HIV who access ART are in Ukraine (1732)<sup>16</sup> and Poland (1372).<sup>61</sup> Providing PWID with fully comprehensive prevention, treatment and care services is particularly important given the high rates of co-infection with TB and viral hepatitis among this population.<sup>62</sup>

Accessing confidential voluntary counselling and testing (VCT) is an important element in increasing the uptake of ART for PWID. Recent country-level data from 2012 Global AIDS Progress reports submitted to UNAIDS indicate that the percentage of PWID who tested and are aware of their status ranged between 3.9% in Azerbaijan, 64.4% in Lithuania and 64.7% in Kazakhstan.<sup>63</sup> Barriers to testing for HIV included non-confidential VCT, parental consent requirements for those less than 18 years old,<sup>35</sup> availability of testing only in medical facilities, procedural delays,<sup>35</sup> funding issues for VCT programmes<sup>35</sup> and discrimination against PWID by health care providers.

Due to relatively low rates of HIV in Albania, Croatia, Georgia, Kosovo, Macedonia, Slovakia and Slovenia, most individuals in need of ART are reported to access it.<sup>35</sup> The requirement to undergo additional tests prior to initiating ART, the need for mandatory documentation that PWID have difficulty accessing such as local registration, national identity card and fixed residence, and lack of ART treatment guidelines for PWID all act as deterrents to their accessing ART in several countries in the region.<sup>35</sup>

Challenges with adherence to ART are generally linked to limited access to OST, stigma and discrimination by police and health care providers, a lack of counselling and support, limited funding for ART, geographical distance from treatment centres and complexity of ART regimens.<sup>10, 64</sup> Adherence among PWID is facilitated by socio-emotional support by family and friends and access to OST, such as methadone or buprenorphine, which attenuate the impact of active drug use on the uptake of ART.<sup>16</sup> Fears that adherence rates among PWID will be lower than among the general population are not supported by a recent systematic review and meta-analysis, which found rates of 60% adherence among PWID, which are similar to adherence rates found among the general adult population living with HIV that do not inject drugs.<sup>65</sup>

### **Viral hepatitis**

A recent systematic review of the global epidemiology of viral hepatitis (B and C) among PWID concluded that Eastern Europe was home to the largest population of PWID with HCV, or 2.3 million of the total estimated 10 million PWID living with HCV globally in 2010 (range 6.0–15.2 million).<sup>25</sup> Following HIV infection trends, Russia, where the largest PWID population in Eurasia resides, had the second largest population of PWID living with HCV in the world, after China. Prevalence data for HCV are available for 24 of the 29 countries and territories in Eurasia, ranging from 13.6% in the Czech Republic to 90.5% in Estonia. Lithuania, Romania and Estonia were the three countries with the highest recorded prevalence: 76.3–89.7% among PWID in two cities in 2006,<sup>66</sup> 82.9% among PWID in Bucharest in 2009<sup>66</sup> and 90.5% in 2002, respectively.<sup>25</sup>

Of the 1.2 million PWID living with hepatitis B (HBV) worldwide in 2010, 300,000 live in Eurasia; however, it should be noted

that<sup>25</sup> available data on HBV are of a lower quality than data on HCV. Only 11 of the 29 Eurasian countries and territories had ever conducted a prevalence study on HBV among PWID. Where data were available, prevalence varied widely from less than 1% in Montenegro and Hungary to over 20% in Estonia (see Table 2.2.1). The quality of prevalence data and the timing of the existing studies varied significantly among the 29 countries in the region, with no data available on either HCV or HBV from eight countries<sup>x</sup> and several countries' latest available data being from 2001 or earlier. Systematic research on the extent of viral hepatitis, particularly in light of the limited access to testing and treatment for both HCV and HBV among PWID,<sup>25</sup> is urgently required.

Access to HCV treatment among PWID remains extremely limited in Eurasia.<sup>67</sup> The high cost of patented Pegylated-Interferon used in the treatment of HCV (up to \$18,000 for a 48-week course in some countries in the region) remains a critical barrier to access.<sup>68</sup> Few countries (such as Kazakhstan, Russia, Lithuania, Estonia and Bulgaria) are reported to provide any state-funded HCV treatment, but obtaining concrete data on the qualification criteria for receiving treatment and the number of people treated remains challenging. In Russia, HCV treatment is provided by the state for those with HCV/HIV co-infection, but access continues to remain limited for those with a history of drug use, and particularly for people actively using drugs.<sup>68</sup> Diagnostic tests for viral hepatitis, mainly viral load qualitative and quantitative tests and genotype tests, remain unaffordable, ranging from \$10 in Ukraine to \$121 in Georgia, and are usually paid for by the patient.<sup>68</sup>

The WHO Regional Office for Europe (WHO-EURO) has developed HIV/HCV co-infection guidelines;<sup>69</sup> however, the absence of HCV mono-infection or co-infection treatment guidelines in some countries can pose an obstacle to expanding treatment access. Where such guidelines do exist, they do not address the special needs of PWID (for example, guidelines often fail to address treatment adherence and management of side effects). Additionally, some guidelines are not based on internationally recognised standards of care, which involves dual therapy with Pegylated-Interferon and ribavirin.<sup>70y</sup>

Lack of political commitment to make viral hepatitis a priority poses another critical barrier to expanding access to treatment. Civil society organisations (CSOs), including harm reduction and drug user groups, have mobilised in many Eurasian countries to seek improved access to HCV treatment by demanding that national governments increase their commitment to address HCV, including providing treatment for PWUD, and that pharmaceutical companies reduce prices for Pegylated-Interferon.<sup>71</sup>

## Tuberculosis (TB)

Six countries report that targeted harm reduction, HIV, viral hepatitis and TB testing and treatment services operate in an integrated manner in their country.<sup>z</sup> Most countries indicate that in the absence of integrated services, 'strong referral systems' between different services are in place. In Slovakia the NGO Odysseus has recently introduced low-threshold HIV/TB testing through outreach for marginalised groups, including migrants and mobile populations who engage in drug use.<sup>58</sup>

Efforts to reach PWID who may require TB testing and treatment are limited. Few countries in the region implement HBV vaccination among populations at higher risk of HIV.<sup>72</sup> In Romania, for instance, PWID are not included in routine TB testing or in national TB surveillance, despite being one of the groups at higher risk of acquiring the infection.<sup>35</sup> In some former Soviet countries, people living with HIV cannot start ART if they have opportunistic infections (such as TB), as these infections need to be treated first.<sup>16</sup> TB services in some settings also deny access to TB treatment to PWID who are living with HIV.<sup>16</sup> In addition to limited integration among services, another key barrier to TB testing and treatment is the lack of direct observation treatment short course (DOTS) in most countries, especially integrated in NSP or OST services.<sup>35, 73</sup> Barriers to accessing TB treatment vary by country: in Serbia, PWID without insurance have problems accessing TB treatment, in Kazakhstan PWID can only access treatment if they have a local registration document, and in Bulgaria, TB hospitals do not offer any drug dependence treatment, leading many PWUD to interrupt treatment and leave hospital early due to withdrawal symptoms.<sup>35</sup>

Improved referral systems and integration among ART programmes, harm reduction services and testing and treatment for TB and viral hepatitis remain to be urgently addressed in this region.

## Overdose responses

Overdose mortality in the region generally tends to be underestimated, and most governments in the region have not acknowledged the full extent of the overdose epidemic among PWID. For example, while national authorities in several Central Asian republics report conservative numbers of fatal overdoses, 25.1% of PWID surveyed in Kazakhstan, Kyrgyzstan and Tajikistan in 2010 reported having witnessed someone die due of an overdose in the past 12 months.<sup>74</sup> PWID in Eurasia also tend to have high prevalence of non-fatal overdose. For example, non-fatal overdose was experienced at least once by 59% of people injecting heroin surveyed across 16 Russian cities.<sup>75</sup>

x Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Kyrgyzstan, Macedonia and Turkmenistan.

y For example, the Russian guidelines indicate treatment with linear interferon, or other medicines, such as *phosphoglia*, which are not based on best practice or on guidelines developed by WHO.

z Bosnia & Herzegovina, Croatia, Bulgaria, Poland, Slovenia and Serbia.

For most countries where data are available, overdose prevention responses include limited or rare provision of overdose information material to PWUD, individual overdose risk assessment, overdose response training and risk education on drug-related deaths.<sup>58, 76</sup> Across the region, overdose prevention programmes are often sporadic and generally run by local NGOs.

Naloxone, a highly effective opioid antagonist used to reverse the effects of opiate overdose, is registered as a medication or included in the essential medicine list in all Eurasian countries, with the exception of Albania.<sup>76</sup> Across the region, naloxone is mainly available via doctors in emergency departments, hospitals and ambulance workers, as well as for community-based distribution in Armenia, Belarus, Estonia, Georgia, Russia and Ukraine.<sup>35</sup> Access through peers and harm reduction services in the community, such as NSP providers, is also reported in Georgia, Kazakhstan, Kyrgyzstan, Tajikistan and Russia; however, distribution often occurs unofficially via local NGOs.<sup>35, 76</sup> Despite the availability of naloxone in emergency departments and ambulances, supply is not consistent across all types of facilities and at all times.

Additional barriers to the effective implementation and scale-up of overdose responses, including naloxone provision, include laws limiting management and transportability of naloxone by non-medical personnel and delays in the provision of emergency care responses for overdose.<sup>58</sup> Ongoing advocacy in several countries, including Georgia, Kazakhstan, Kyrgyzstan, Russia and Tajikistan, aims to expand access to naloxone by building political commitment, ensuring local or international funding for naloxone programmes and advocating for the removal of policy and legal barriers that prevent NGOs from distributing naloxone. There is an urgent need for advocacy around scaling up the distribution of naloxone beyond medical services to harm reduction programmes, outreach workers and PWUD, their families and communities.

In December 2011, Tajikistan's Ministry of Health approved the distribution of naloxone via NGOs working directly with PWID. Three local NGOs (Apeiron, Volonter and ROST), in collaboration with Soros Foundation Tajikistan and the Global Health Research Center of Central Asia, successfully advocated for authorisation to store 500 vials of naloxone at a time at NGO locations around the country and to distribute these directly to clients as needed. In addition to issuing an order to allow NGOs to store naloxone, the Ministry of Health has also endorsed guidelines developed by civil society which formalise and legitimise naloxone distribution through community harm reduction sites. Although the decision limits activity only to NGOs that hold a pharmaceutical activity licence, prior to this decision, NGOs in Tajikistan were not legally permitted to store naloxone on their premises, posing a major barrier to access by people who need it most. Similarly, in Kyrgyzstan, civil society reports indicate that NGOs are now permitted to

distribute naloxone directly to their clients in Osh and Bishkek, through Kyrgyzstan's Global Fund Round 10 grant. Prior to this, NGOs were not allowed to store or distribute naloxone.<sup>77</sup>

### **Harm reduction in prisons**

Availability of harm reduction interventions in prisons is very limited across Eastern Europe and Central Asia, with wide variations in service coverage among countries and in facilities within countries. By mid-2012, five countries – Armenia, Kyrgyzstan, Moldova, Romania and Tajikistan – were implementing NSPs in prisons. OST is available in prisons in 18 of the 26 countries and territories that also provide OST in the community,<sup>3a</sup> including two new OST pilots in Bosnia and Herzegovina and Latvia since the beginning of 2012.<sup>3</sup> In several countries OST is available in prisons only to clients who were on treatment prior to incarceration; in others it is available only in custody centres, while in a third group it is only available in a limited number of centres.<sup>35</sup> For example, some degree of OST provision is reported in prisons in Croatia and pre-detention trial units in Albania, Georgia and Kyrgyzstan, although programmes are not available as an integral part of health services in Albanian prisons.

The Czech Republic, Hungary, Romania and Slovenia provide initiation of OST on entering prison and continuation of OST in the community upon release from prison to varying degrees. Continuation of OST in prison is available in Bulgaria, Estonia, Poland and Montenegro provided that the inmate was already receiving OST prior to arrest.

Data on prevalence of TB and HCV/HBV among PWID are lacking, mainly due to the lack of TB screening and HCV/ HBV testing in prisons. Nonetheless, the burden of TB, HCV/ HBV and HIV among prisoners is significant, especially given higher rates of co-morbidities than the general population.<sup>62</sup> Co-infection of HIV and TB in overcrowded prisons also poses significant challenges to both detention and health systems in Russia and post-Soviet Union countries,<sup>78</sup> especially given the highly rigid level of vertical integration of each system, which often results in lack of coordination.<sup>62</sup> Given the high proportion of PWID in prisons and correctional facilities and the high rate of re-offending among PWID, an important opportunity to reach this population is through integrated vaccination, testing and treatment for HCV and HBV within these settings.<sup>79-81</sup>

Barriers to implementation and scale-up of harm reduction interventions in prisons include lack of political will, denial of the existence of drug use in prisons, shortages of staff for medical services within prisons, lack of funding and data gaps on the extent of IDU in prisons across the region.

aa Albania, Armenia, Bulgaria, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kyrgyzstan, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia and Slovenia.

## Policy developments for harm reduction

In 2010, HRI reported that 25 Eurasian countries and territories had national HIV or drug policies explicitly supporting harm reduction.<sup>34</sup> Since then, seven countries – Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine – have finalised HIV strategies and national programmes that include harm reduction activities, in some cases focusing on scaling up NSP and OST, although in the case of Ukraine this strategy has yet to be approved.<sup>35</sup> The HIV law passed in Azerbaijan in 2010, which previously had no legal provisions in place regarding harm reduction, now emphasises the role of harm reduction in HIV prevention, including NSP and OST provision in penitentiaries.<sup>82</sup> Additional policy developments include Serbian by-laws to the new Law on Rehabilitation, Resocialisation and Treatment that legalise harm reduction and remove parental consent as a barrier for accessing NSP and OST, relaxation of OST criteria in Belarus and plans to implement community-based naloxone in Estonia.<sup>76</sup>

The decriminalisation of drug use in Estonia and the amendment of penalties for drug possession for personal use from incarceration to administrative offences in Kazakhstan and Poland<sup>35, 83-84</sup> constitute further favourable policy developments.

Despite an overall trend toward a policy environment conducive to harm reduction implementation and scale-up, a number of important challenges remain. Since 2010 the policy context for harm reduction has deteriorated or remained highly unfavourable in Hungary, Russia and Ukraine. The national drug policy in Russia portrays NSP as a threat to effective drug control, while the 2009–2011 HIV strategic plan in Uzbekistan fails to recognise harm reduction and cites drug use and sex work as antisocial behaviours.<sup>35</sup>

In December 2010, without prior consultation with civil society or medical professionals, the Hungarian government rejected the progressive harm-reduction-oriented drug strategy and introduced a new draft strategy excluding any mention of harm reduction. The new strategy does not list NSP and voluntary HIV/AIDS testing and counselling among its aims and refers to OST as a form of treatment that ‘may be necessary’ for those ‘who cannot be treated effectively with other methods.’<sup>85</sup> A recent review of OST provision across Eurasia evaluated Lithuania to have one of the least favourable policy environments in the region: Lithuania’s drug policy does not include services for PWID, while the national HIV programme includes no targets for NSP and OST services.<sup>55, 86-87</sup>

Since 2010, stricter penalties<sup>ab</sup> for drug possession have been put in place in Russia and Ukraine.<sup>88-89</sup> For the first time, the Czech Republic introduced threshold quantities for possession of illegal drugs, with unauthorised possession for personal use continuing to hold an administrative penalty.<sup>90-91</sup> Although the impact of this policy is unclear, evidence from other settings suggests that the reduction in threshold quantities for personal use will result in reduced access to NSP and OST due to fear of police harassment and raids.<sup>92</sup> Georgia remains one of a few countries where the non-medical use of controlled drugs constitutes a criminal offence. This has a direct impact on both the rights and health of PWUD: currently there are more PWUD in prisons than there are in treatment facilities.<sup>93</sup>

### New legal highs

The past two years have seen an exponential increase in new psychoactive substances commonly referred to as ‘legal highs’ across Europe. Between 1997 and 2010 the early-warning system of the European Monitoring Agency on Drugs and Drug Addiction (EMCDDA) identified more than 150 legal highs, 65 in the past two years (24 in 2009 and 41 in 2010).<sup>94</sup>

Legal highs have contributed to the increased risk of HIV and viral hepatitis transmission in several countries in the region, particularly Hungary and Romania, where a significant proportion of heroin and amphetamine users have turned to injecting designer ‘legal highs’. Injection of ‘legal highs’ is often more frequent than heroin injection, with the potential to increase the sharing of injecting equipment.

The response from governments has generally been default criminalisation, even in the absence of clear evidence. Romania has criminalised 36 new substances in 2010, and over 900 shops were closed down in Poland.<sup>95-96</sup> In 2011 the Czech Republic and Slovakia joined the race and criminalised 33 and 42 new substances, respectively, in their countries.<sup>97 ac</sup> From 1 January 2012 nine new substances were banned in Hungary. Although the Hungarian government plans to introduce generic legislation aimed at preventing traffickers from creating new legal substitutes of prohibited substances, it has stated that it does not aim to criminalise PWUD, but only the distributors of new psychoactive substances.<sup>98</sup> This approach has led to the displacement of one substance with another, rather than a cessation of ‘legal high’ use.

ab These included harsher penalties for drug-related crimes including administrative detention for drug use for up to 15 days and life sentence for large-scale drug offences in Russia. In March 2012 the Federal Drug Control Service of the Russian Federation proposed an amendment to the Criminal Code providing for up to two years of prison or hard labour for drug use, if the episode of drug use is repeated within a year after the first drug use episode has been recorded. In addition, Ukraine’s Ministry of Health issued a resolution in 2010 setting very low threshold amounts of illicit drugs that trigger criminal liability; for instance, minimum amount of heroin is set at 0.005 g, thus making all individuals possessing one dose of heroin without intention to sell criminals.

ac Czech Republic Act No. 167/1998 Coll., on addictive substances, was amended in the spring of 2011. See <http://portal.gov.cz/zakon/106/2011>.

## Civil society and advocacy developments for harm reduction

Civil society has played an increasingly important role in effectively advocating for harm reduction in Eurasia and internationally. Active lobbying and advocacy from national and/or regional-level CSOs and networks has been instrumental in amending the Slovenian Penal Code to allow for the establishment of settings where illicit drugs may be consumed under medical supervision,<sup>35</sup> the development of the new HIV law in Azerbaijan and actively participating in the working group to change the law in Romania, all with varying degrees of success. Advocacy for wider availability of naloxone in Tajikistan resulted in guidelines for overdose prevention and management by the Ministry of Health,<sup>35</sup> while an aggressive campaign in Ukraine succeeded in overcoming the government's opposition to OST.<sup>3</sup> In Bosnia and Herzegovina the Ministry of Security, in cooperation with the Ministry of Health, initiated a process of accreditation of harm reduction NGOs, although this process is based on the assumption that harm reduction programmes will be funded by these two ministries after the contract with Global Fund expires in 2014.<sup>35</sup>

### Advocating for drug policy change in Poland

Civil society organisations in Poland have long been campaigning to reform the country's drug law. During 2010–2011 the Polish Drug Policy Network (PDPN) initiated a national advocacy campaign that aimed to amend the restrictive drug law in Poland.<sup>99</sup> Advocacy activities included legal actions such as cooperation with the Office of the Ombudsman for Addicts, active participation in public debate and numerous open letters including one signed by a former Polish president and other prominent figures<sup>100</sup> addressed to the Ministry of Health, Minister of Justice, Prime Minister, Polish Seim and Senate, and the National Bureau for Drug Prevention. PDPN also launched an online sign-on campaign targeting both Polish and international audiences to put pressure on Bronislaw Komorowski, the President of the Polish Republic, to sign the bill.

On 25 May 2011 the President signed an amendment to the country's drug law. The new amendment draws a greater distinction between drug dealers and drug users, and allows prosecutors the choice not to criminalise small-scale drug offenders. The next steps will be to ensure that the current amendment is implemented and to open a broader public debate on decriminalisation.

The Eurasian Network of People who Use Drugs (ENPUD) was established in February 2010 following a meeting of representatives of the drug user community and OST clients from Armenia, Georgia, Kyrgyzstan, Kazakhstan, Ukraine, Russia, Tajikistan, Uzbekistan and Moldova.<sup>101</sup> This initiative represents the first attempt by people who use or have previously used drugs in the region to join efforts at the regional level. ENPUD aims to facilitate greater involvement of PWUD in local and international drug policy, to improve the quality of medical, social and legal services. A strategic follow-up meeting and needs assessment exercise is planned to take place in Kiev in July 2012.

EHRN has continued to actively promote harm reduction and the rights of PWUD across 29 countries in Central and Eastern Europe and Central Asia. In 2011, EHRN mobilised and supported over 30 drug user activists to testify to the Global Commission on HIV and the Law on a range of human rights violations faced by their community. Their joint statement was voiced at the Regional Consultation of the Global Commission and was delivered at the UNAIDS Programme Coordinating Board (PCB).<sup>92</sup> At the 54<sup>th</sup> UN Commission on Narcotic Drugs (CND), EHRN organised a side event on overdose, 'Illicit Drug Overdose: Major Cause of Preventable Death', which was well attended by key multilateral agencies and civil society representatives. A key outcome of the event was the formation of a multisectoral initiative to develop internationally recognised overdose prevention guidelines.

In 2010 the South East Europe NGO Drug Policy Network, an initiative led by NGOs in the region and supported by the International Drug Policy Consortium, was launched. The network aims to create open and objective dialogue with experts, key policymakers in national governments, regional bodies and international organisations to promote humane and effective drug policies.

As part of the international Count the Costs campaign supported by the Open Society Foundations, the Hungarian Civil Liberties Union (HCLU) and the European Drug Policy Initiative (EDPI) coordinated actions in five European cities – Sofia, Bucharest, Warsaw, Oslo and Porto – to raise public awareness on the health and human rights costs of the war on drugs, to mark the 50th anniversary of the Single Convention on Narcotic Drugs in June 2011.<sup>102</sup>

CSOs in Eurasia are well positioned to engage in ongoing advocacy to reverse the disproportionate focus on punitive approaches to IDU, common in countries in the region.<sup>103</sup> In the current precarious funding environment, the provision of adequate financing for CSOs and local organisations of PWUD to enable them to continue this important work is particularly crucial.<sup>33</sup>

## Multilaterals and donors: developments for harm reduction

Increased engagement by multilateral agencies in harm reduction implementation is reported in Albania, Bosnia and Herzegovina, Latvia, Kyrgyzstan, Serbia and Tajikistan. UNICEF is an active partner in research among young PWID and in preparation of the new Law on Rehabilitation, Re-socialisation and Treatment in Serbia but plans to scale down its activities in Romania. UNODC supports ongoing harm reduction services in prisons in Latvia and Tajikistan and at the time of publication was investigating how to best support the scale-up of harm reduction services in prisons in Albania, Serbia and Macedonia in partnership with EHRN. UNDP is the primary recipient for Global Fund grants in Kyrgyzstan and Tajikistan, both of which include support for harm reduction services.

Funding for harm reduction responses in Eastern Europe and Central Asia largely originates from the Global Fund. The Global Fund invested over US\$366 million for harm reduction in Eurasia alone – more than all other international sources combined (see Table 2.2.2).<sup>33</sup> Other donors that support harm reduction in the region include the European Commission, OSF, UNAIDS, UNODC, UNDP and UNICEF. Along with international donors, additional funding for harm reduction is contributed by national governments in Azerbaijan, Bulgaria, Bosnia and Herzegovina, Czech Republic, Croatia, Estonia, Georgia, Hungary, Kazakhstan, Latvia, Lithuania, Macedonia, Montenegro, Poland, Slovenia, Slovakia and Serbia.<sup>35</sup> Overall, government funding prioritises provision of medical services and OST, as well as NSP and OST in prisons, while CSOs and international partners largely support NSP and community-based harm reduction separately or in the context of comprehensive HIV prevention programmes.<sup>3, 35</sup>

**Table 2.2.2:** Approved Global Fund investments targeting PWID in Eastern Europe and Central Asia Round 1 (2002) to Round 10 (2010)<sup>104</sup>

COUNTRY / TERRITORY	TOTAL (US\$)	
Albania	1,400,000	
Armenia	3,100,000	*
Azerbaijan	6,000,000	*
Belarus	17,500,000	*
Bosnia & Herzegovina	9,800,000	*
Bulgaria	9,500,000	
Croatia	600,000	
Estonia	2,700,000	
Georgia	12,700,000	*
Kazakhstan	29,800,000	*
Kosovo	2,000,000	
Kyrgyzstan	25,800,000	*
Macedonia	15,600,000	*
Moldova	7,200,000	*
Montenegro	1,600,000	*
Romania	4,200,000	
Russian Federation	38,400,000	
Serbia	6,500,000	*
Tajikistan	15,600,000	
Ukraine	143,900,000	*
Uzbekistan	12,200,000	*
<b>TOTAL</b>	<b>366,100,000</b>	

### Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

\* Figure includes projections for future years of grants that have not yet been formally committed.

Increased state support for harm reduction is expected in Macedonia; in 2011 the Ministry of Health financed the provision of 30,000 syringes and 50,000 condoms via NSPs for the first time.<sup>73</sup> In Bosnia and Herzegovina, a new NGO accreditation process may result in more harm reduction programmes funded by the state in the coming years; currently only 40% of harm reduction programmes are funded by the national government.<sup>35</sup> In other countries where the state supports harm reduction, funding is allocated on an annual basis, and government funds are often delayed and insufficient to sustain and scale-up service coverage to levels needed to have an impact on HIV and viral hepatitis epidemics.<sup>58</sup> The financial crisis has had significant effects on the governmental allocations in these countries. For example, funds decreased by 50% in 2009–2010 in Latvia, with cuts disproportionately affecting populations at higher risk of HIV and the health budget for prisons,<sup>35</sup> and significant cuts were made to the NSP budget in Lithuania.<sup>87</sup>

The cancellation of Round 11 and insufficient donor contributions to the Global Fund have had a major impact in the region. Compared with ten national and one regional

HIV grant proposals originally planned for Round 11 and the second wave of National Strategy Applications (NSAs), only Russia (two NGO grants, including the Russian Harm Reduction Network/ESVERO after a special decision by the Global Fund Board to allow it to apply), Serbia and Tajikistan applied for HIV support from the Transitional Funding Mechanism (TFM) by the 31 March 2012 deadline.<sup>33</sup> As of 2012, six countries are not eligible for Global Fund funding, although NGOs from Bulgaria, Latvia, Lithuania and Russia can apply for support under the NGO scheme.<sup>ad</sup> Almost all harm reduction services in Azerbaijan, Bulgaria, partly in Bosnia and Herzegovina, Kosovo, Serbia, Azerbaijan and Macedonia are funded by the Global Fund.<sup>ae</sup> Of significant concern is the situation in Albania, Armenia and Moldova, where harm reduction services are at risk of closure after March 2012 when the Global Fund grant comes to an end. Of the five Eurasian countries that applied for Round 10, Georgia, Kazakhstan, Ukraine and Uzbekistan were successful. Harm reduction through Round 10 funding includes planned OST scale-up in Kazakhstan; HIV prevention for most-at-risk populations, including harm reduction services for PWID in Ukraine; as well as NSP, testing and vaccination for viral hepatitis, and OST for PWID in Uzbekistan.<sup>35</sup>

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