



Regional Overview

2.2 Eurasia



EURASIA

Table 2.2.1: Epidemiology of HIV and viral hepatitis, and harm reduction response in Eurasia

Country/ territory with reported injecting drug use	People who inject drugs ⁽¹⁾	HIV prevalence among people who inject drugs (%) ⁽²⁾	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ⁽³⁾	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ⁽⁴⁾	Harm reduction response	
					NSP ^{(5, 6)a} ■	OST ^{(7)b} ■
Albania	4,000–6,000	0.5	28.8	11.5	✓2	✓6 (M)
Armenia	12,700 ⁽⁸⁾	6.3	nk	nk	✓12	✓4 (M)
Azerbaijan	71,283 ⁽⁹⁾	9.5 ⁽⁹⁾	57.9 ⁽⁹⁾	7.4 ⁽⁹⁾	✓17	✓2 (M)
Belarus	75,000	25.1 ⁽¹⁰⁾	65.4 ⁽¹¹⁾	6.9 ⁽¹¹⁾	✓34 ⁽¹¹⁾	✓19 ⁽¹¹⁾ (M)
Bosnia and Herzegovina	12,500 (9,500–15,500)	0.3	12–43.4 ^c	2–3	✓28	✓8 (B, M)
Bulgaria	19,000	10.6 ⁽¹²⁾	67.8	5.7	✓100 ⁽¹³⁾	✓31 (B, M)
Croatia	10,000 ⁽¹⁴⁾	0.48	39.30	6.5	✓102 (P)	✓ (B, M)
Czech Republic	45,600 ⁽¹⁵⁾	0.2-0.3 ⁽¹⁵⁾	18.6	15.1	✓105 (P)	✓372 ⁽¹⁶⁾ (B, M)
Estonia	13,801 (8,178–34,732)	50–60 ^{(17)d}	75	21.3	✓36	✓8 (B, M)
Georgia	49,000 ⁽¹⁸⁾	2.2 ⁽¹⁹⁾	66 ⁽¹⁹⁾	7.2	✓18	✓18 (B, M)
Hungary	2,910-3,577 ⁽²⁰⁾	0.0	24.1	0.5	✓46 ⁽¹¹⁾	✓15 ⁽²⁰⁾ (B, M)
Kazakhstan	116,840 ⁽²¹⁾	7.9 ⁽²²⁾	60.3 ⁽²³⁾	7.9	✓155 – 168	✓10 ⁽¹¹⁾ (M)
Kosovo	10,000-15,000 ⁽²⁴⁾	0	26.6 ⁽²⁵⁾	4.1 ⁽²⁵⁾	✓	✓3 (M)
Kyrgyzstan	25,500 ⁽²⁶⁾	12.4–14.6	50	nk	✓40 ⁽²⁷⁾	✓30 ^{(27)e} (M)
Latvia	12,573	9.4 ⁽²⁸⁾	74.2	1.6	✓19 ⁽²⁹⁾	✓10 ⁽²⁸⁾ (B, M)
Lithuania	6,056 ⁽³⁰⁾	3.2 ⁽³¹⁾ -12.5 ⁽³²⁾	57.1 ⁽³²⁾	13.4 ⁽³²⁾	✓14	✓19 (B, M)
Macedonia	15,000–20,000 ^f	0.12 ⁽³³⁾	64.5 ⁽³³⁾	nk	✓16 ⁽³³⁾	✓16 ⁽³³⁾ (M, B)
Moldova	30,200 ⁽³⁴⁾	7.9 ⁽¹⁶⁾	70.2–72.8 ⁽¹⁶⁾	3.4–14.2	✓28 ^{(11)g}	✓19 ^{(11)h} (M)
Montenegro	nk	1.1 ⁽³⁵⁾	53.6	nk	✓13	✓5 ⁽¹¹⁾ (M)
Poland	15,119 (10,444–19,794)	3 ⁽³⁶⁾	44.3-72.4 ⁽³⁶⁾	26.3-46.7 ⁽³⁶⁾	✓34 ⁽³⁶⁾	✓25 (B, M)
Romania	19,265	24.90 ⁱ	79 ⁽³⁷⁾	5	✓2 ⁽³⁸⁾	✓8 ⁽³⁹⁾ (B, M)
Russia	1,815,000 ^j	18–31 ⁽⁴⁰⁾	72.5% (51.9– 94.7) ⁽⁴¹⁾	2.6-7.1 ⁽⁴²⁾	✓4 ⁽⁴³⁾	✗
Serbia	30,383 (12,682–48,083) ⁽⁴⁴⁾	<5 ⁽⁴⁵⁾	61 ⁽⁴⁵⁾	68.95 (60.5 -77.4) ^{(46)k}	✓13 ⁽⁴⁵⁾	✓25 ⁽⁴⁷⁾ (B, M)
Slovakia	18,841 (13,732–34,343) ^l	0.3 ⁽⁴⁸⁾	37.8	28.1	✓5 ⁽¹¹⁾	✓7 (B, M)
Slovenia	6,100 (5,580–6,750)	1.9	28.5	2	✓10 ⁽¹¹⁾ (P)	✓10 ⁽¹¹⁾ (B, M)
Tajikistan	25,000 (20,000–30,000)	13.5 ⁽⁴⁹⁾	36.2	nk	✓51 ⁽¹¹⁾	✓6 ⁽¹¹⁾ (M)
Turkmenistan	nk	nk	nk	nk	2 ⁽⁵⁰⁾	✗
Ukraine	310,000	21.9 ⁽⁵¹⁾	27.1 ^m	4.5	✓1667	✓169 (B, M)
Uzbekistan	80,000 ⁿ	7.3 ⁽⁵²⁾	21.8 ⁽⁵²⁾	nk	✓235	✗

nk = not known

^a This includes all 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.

^b (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

^c Based on a study conducted in five cities.

^d Based on a study conducted in two cities.

^e This figure is inclusive of 7 operating in prisons.

^f Data from EMCDDA 2010 based on people who inject drugs in Skopje.

^g There are an additional 16 sites operating in prisons.

^h There are an additional 13 sites operating in prisons.

ⁱ Civil society believes this figure to be higher.

^j Figure from 2007.

^k Based on findings from two cities.

^l Figure includes high-risk drug users. High-risk is considered to be recurrent drug use that causes negative consequences which may include health, psychological or social problems, or is placing the person at a high-risk of suffering such harms.

^m Year of reporting: 2012 for both HCV and HBV, Global Fund Round 6 Programme monitoring, Alliance Ukraine.

ⁿ Year of estimate: 2006. EMCDDA Country Profile: <http://www.emcdda.europa.eu/publications/country-overviews/uz#pdu>.



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



Harm reduction in Eurasia

Overview

Eurasia is one of the only regions of the world where HIV infection rates continue to rise at an alarming rate. This rise is most pronounced in the countries of Eastern Europe and Central Asia, where between 2010 and 2015, UNAIDS reported a 57% increase in new HIV infections.⁽⁵³⁾ In 2015, over half of these new HIV cases were among people who inject drugs.⁽⁵³⁾ Over 20% of new HIV diagnoses in Romania and the Baltic states of Estonia, Latvia and Lithuania are among people who inject drugs and similar levels are almost reached in Bulgaria.⁽⁵⁴⁾ It is estimated that 3.1 million people who inject drugs live in countries in this region,⁽⁵⁵⁾ 1.8 million of whom reside in Russia.⁽⁵⁶⁾ In 2015, it was in Russia that over 80% of the region's new HIV infections occurred,⁽⁵⁷⁾ a situation attributed in large part to the absence of HIV prevention measures in place such as needle and syringe programmes (NSPs) and opioid substitution therapy (OST). Since the *Global State* last reported in 2014, HIV prevalence rates among people who inject drugs have increased in Belarus, Kazakhstan, Montenegro, and Ukraine. However, according to reports from Ukraine there has been a decrease in HIV prevalence among people who inject drugs observed in the last 7 years.⁽⁵⁸⁾ Although people who inject drugs account for up to 80% of people living with HIV infections in the region, it is reported that only a small minority (20%) are accessing anti-retroviral therapy (ART).⁽⁵⁵⁾

Harm reduction service provision is available to some extent in the vast majority of countries in the region. Needle and syringe programmes are available in all 29 countries, but implementation levels vary widely. For example, only two NSP sites operate in Romania and four in Russia, none with the support of government, whereas 1,667 sites provide NSP in Ukraine (see Table 2.2.1). OST provision also varies considerably, but is notably low in much of the region, with less than 10 operational OST sites in many countries (see Table 2.2.1). In the majority of countries, even those which have received support from the Global Fund to support service implementation and scale-up, harm reduction service provision falls far short of epidemiological need, and remains below the UN recommended levels.⁽⁵⁹⁾

According to the most recent data from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), some countries in this region have witnessed

a decline in opioid use, and an increase in amphetamine use. For example, in Hungary in 2014, only 2% of people who use drugs entering services used heroin as their primary drug, compared to 19% for stimulants other than cocaine.⁽²⁰⁾ Similar trends have also been observed in Poland, where 36% of people entering services reported stimulants as their primary drug, compared to 5% reporting opioids during the same time period.⁽³⁶⁾ The Czech Republic has seen a marked increase in methamphetamine use from an estimated 20,000 people using methamphetamines in 2007, to over 36,000 in 2014, with injecting being the primary route of admission.⁽¹⁵⁾ From a sample of 10,108 people who use drugs in the Czech Republic in 2014, 7,038 reported methamphetamine as their primary substance, known locally as 'pervitin'.⁽¹⁵⁾ These changing patterns of drug use highlight that harm reduction services must adapt and respond to need accordingly. In general, people injecting amphetamines will do so more frequently than those using opioids for example, so NSPs operating in areas where amphetamine use is increasing must ensure a greater volume of injecting equipment is made available to clients.

Opioid use is not in decline across the whole region, however, with some countries witnessing an increase in opioid use (including synthetic opioids) among those entering drug services. For example, the majority of people entering drug dependence treatment in Estonia report using fentanyl,⁽⁵⁶⁾ the vast majority of people on the Register of Persons Treated for Psychoactive Drug Abuse in Croatia are treated for opioid use,⁽¹⁴⁾ and 42% of people entering services in Romania report opioids as their primary drug.⁽⁶⁰⁾

Overdose continues to be a major cause of death among people who inject drugs in countries within this region, as it was when the *Global State* last reported in 2014. Where evidence is available, rates of overdose are high, with 21-24% of people who inject drugs in Central Asia reporting having experienced a non-fatal overdose in the past year.⁽⁶¹⁾ The implementation of opioid overdose prevention strategies, such as naloxone distribution among people who use drugs, remains limited to pilot projects in a small number of countries in the region. Drug consumption rooms (DCRs) where people who use drugs are able to consume them with medical support or supervision, are another strategy to reduce drug-related deaths.⁽⁶²⁾ No country in this region has a DCR yet, but in 2015, in Ljubljana, Slovenia an NGO



obtained funding to prepare and operate a pilot drug consumption room to begin in 2016.⁽⁶³⁾

One of the most significant developments in the region in recent years is the departure of the Global Fund support for HIV work from countries such as Romania, Estonia, Serbia, Bosnia and Herzegovina, and Macedonia. This transition has resulted in a dramatic reduction in the number of NGOs delivering services, and in some countries has affected the spectrum and quality of harm reduction. For example, in Serbia following the end of the Global Fund, only one out of four NGOs providing NSPs continue to operate on a limited scale through trained outreach workers, with other NGOs providing needles via outreach on a volunteer basis until they could no longer provide the service.⁽⁶⁴⁾ Civil society state that there is a need for regulatory reform to ensure that NGOs are able to provide services through national funding mechanisms. This includes development of social contracting mechanisms, as well as licensing and accreditation of NGOs to make them eligible to apply for and receive government funding.⁽¹¹⁾ The role of NGOs and community-led service providers in HIV prevention is still not by many governments. At present, in much of Eurasia, national governments continue to be more inclined to direct funds towards antiretroviral therapy or rehabilitation services rather than harm reduction measures, despite the proven effectiveness of NSP and OST in reducing viral transmission among people who inject drugs.^(65, 66)

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

The number of sites providing NSP has increased in eight countries in the region since the Global State last reported in 2014. These are Belarus (33 to 34 sites), Georgia (14 to 18 sites), Hungary (29 to 46 sites), Latvia (18 to 19 sites), Lithuania (11 to 14 sites), Moldova (23 to 28 sites), Poland (12 to 24 sites) and Tajikistan (43 to 53 sites). Bulgaria, Kyrgyzstan, Romania, Slovakia and Slovenia have witnessed a decrease in NSPs, but the majority of countries (16) have seen no change in the number of NSP sites operating. The coverage of these programmes remains low across the region. In Macedonia in 2015, for example, the 16 NSP sites available in the country reached just 3,900 of the estimated 17,500 people who inject drugs.⁽³³⁾ Among Eastern European and Central Asian countries reporting to UNAIDS, only Kyrgyzstan claimed to implement NSP at

coverage levels considered high by UN standards (over 200 needles/syringes distributed per person who injects drugs per year).⁽⁵⁷⁾ It is important to note, however, that these data represent the most robust estimates, which are not necessarily recent. Despite the scaling-up of NSP services in some countries in the region, NSP coverage continues to remain insufficient to meet need and an urgent need for further investment in this service is essential, particularly in light of increasing trends towards methamphetamine injecting.⁽¹¹⁾

Inadequate financial support from national government remains the primary constraint to sustainable NSP services. Many governments do not financially support the provision of this service, including Albania, Armenia, Azerbaijan, Belarus, Georgia, Kosovo, Kyrgyzstan, Macedonia, Tajikistan, Ukraine, and Uzbekistan.⁽¹¹⁾ In Armenia, the National AIDS Program 2011-2016, which was approved by the government, explicitly references NSP as a component of HIV prevention. However, the Ministry of Health has no explicit legal act on supplying NSPs and there are no government departments involved in supporting the service. It is, however, legal to provide NSP in Armenia.⁽¹¹⁾

Where government funding is not made available, countries often depend on international donor funding, which has been consistently decreasing in this region.⁽⁶⁷⁾ In light of the changing funding landscape, some governments provide partial funding for NSP provision, such as Bosnia and Herzegovina, Kazakhstan, Lithuania, Montenegro and Romania.⁽¹¹⁾ In others, such as Croatia, the Czech Republic, Estonia, Hungary, Poland, Slovenia and Slovakia, NSP is solely supported by government funds.⁽¹¹⁾ In countries such as the Czech Republic and Estonia, this financial support is coupled with political support for harm reduction and as such, funding to sustain these services is considered to be relatively stable. In others such as Hungary, government investment in NSP falls far short of what is required to support services to meet the needs of people who inject drugs.⁽⁶⁸⁾

In some countries where the Global Fund grants have reduced or come to an end, civil society report that NSP service provision has reduced in scope and/or scale as a result, for example in Albania, Macedonia, Romania, Serbia, Montenegro and Russia.^o Inadequate funding remains a consistent constraint to accessible and high-quality NSP provision in the region. Other barriers cited by civil society include repressive policy and legal environments, unequal coverage between urban and rural settings, a lack of legislative regulation of services, restrictive opening hours and poor quality injecting equipment.⁽¹¹⁾

^o Data relating to this reduction in service provision has only been updated in Romania. At the time of reporting no up-to-date site numbers were available for Albania, Macedonia, Serbia or Russia, and the statement is based on civil society reports from the region.

Opioid substitution therapy (OST)

OST continues to be prohibited in Russia and Turkmenistan, despite its proven effectiveness as a first line of treatment for people who inject drugs⁽⁶⁹⁾ and the recommendation within UN guidelines to provide this as a key HIV prevention measure.⁽⁵⁹⁾ While 26 countries have some OST provision, coverage varies considerably and remains extremely low in some states.⁽¹¹⁾ OST is provided to less than 1% of people who inject drugs in Azerbaijan and Kazakhstan (0.2%),⁽⁵⁷⁾ 3% in Armenia, Moldova, Ukraine and Tajikistan,⁽¹¹⁾ approximately 4.9% in Kyrgyzstan and 5.3% in Belarus.⁽⁵⁷⁾ One of the greatest barriers to effective service delivery of OST is the fact that many NGOs are simply prohibited to deliver it and that services are based within government premises.⁽¹¹⁾ Increases in OST provision have been seen in seven countries in the region since the Global State last reported in 2014. An increase has been observed in Belarus (14 to 19 sites), Hungary (12 to 15 sites), Kyrgyzstan (20 to 30 sites), Latvia (4 to 10 sites), Macedonia (12 to 16 sites), and Montenegro (3 to 5 sites), with the greatest increase in Poland, which has seen site provision increase from 3 to 25 sites. Moldova, Romania, Serbia, Slovenia, and Tajikistan have all witnessed a decrease in OST sites, but the vast majority of countries (14) where OST is available have seen no change in service provision.

Unlike NSP, many governments fully fund OST provision, including Azerbaijan (although this service is only available in the city of Baku), Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Montenegro, Serbia, Slovakia and Slovenia.⁽¹¹⁾ In Hungary, Latvia and Lithuania, methadone prescription is financed by the government, and although buprenorphine can be prescribed, this must be financed by the individual.^(20, 28, 70) In Montenegro, buprenorphine was introduced in mid-2015, but it is still not used at national level, as doctors are afraid to prescribe it due to the absence of medical protocols.⁽¹¹⁾ In some countries OST is partially government funded, such as Georgia and Albania. In Albania, OST is financed partially through a Global Fund grant and partially from the Ministry of Finance. The NGO Aksion Plus initiated a small-scale buprenorphine project in Tirana, Albania, through financing from a special fund of laundered money seized from assets and illegal drug trafficking.⁽¹¹⁾

In Kazakhstan, methadone continues to be procured through a grant by the Global Fund whilst staff costs at sites are covered by the government.⁽²³⁾

Viral hepatitis

Hepatitis C prevalence rates among people who inject drugs are extremely high in many countries in Eurasia, reaching 50% or higher in 16 countries (Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Macedonia, Moldova, Montenegro, Poland, Romania, Russia, and Serbia) from a total of 27 which provide data. Prevalence rates for hepatitis C are generally far higher than HIV rates for people who inject drugs across the region, although data limitations make it difficult to assess changes in the epidemic accurately. Hungary's reported hepatitis C prevalence rate among people who inject drugs is 24.1%, yet hepatitis C prevalence among people injecting stimulants during the same reporting year (2014) was far higher, at 74%.⁽²⁰⁾

In a number of countries, rapid screening for the hepatitis C virus cannot be carried out at community-based harm reduction sites. Where such screening is available for people who inject drugs the test often depends on whether the person has state insurance or is able to cover the cost of testing themselves.⁽¹¹⁾ Exceptions to this can be seen in the Czech Republic, where hepatitis C testing and treatment is available to people who inject drugs in 39 clinics, including those in prisons.⁽¹⁵⁾ Slovenia also provides hepatitis C treatment free of charge for all, although it is unclear how accessible this is for people who inject drugs.⁽⁶³⁾ In 2015, Georgia launched a new hepatitis C elimination programme, with a donation of hepatitis C treatment from one of the largest healthcare providers. The new universal treatment plan should extend coverage from 5,000 to 20,000 in the coming years and will include people who use/inject drugs.⁽⁷¹⁾ In Lithuania, Moldova, and Romania, hepatitis C treatment is limited to holders of health insurance. In Russia, Tajikistan, Ukraine and Armenia, hepatitis C treatment is expected to be covered in full by the individual.⁽¹¹⁾ However, Ukraine has access for some treatment provision under a Global Fund grant.⁽⁵⁸⁾ The high cost of treatment, therefore, remains a key obstacle to access in most countries. Stigma and discrimination related to drug use, as well as widespread misconceptions among treatment specialists about a lack of adherence to treatment by people who use drugs, create further barriers. In Latvia, Montenegro, Serbia, and Albania, people who inject drugs are required to stop using drugs prior to receiving treatment.⁽¹¹⁾



Overdose

Overdose continues to be a major cause of death among people who inject drugs in the region, with an estimated 100,000 people dying from an overdose-related death in Russia alone each year.⁽⁷²⁾ In 2014, rates of overdose-related death reached 113 per million in Estonia.⁽⁵⁶⁾ In the Czech Republic, which has one of the strongest harm reduction responses in the region, overall mortality rates for people using OST were relatively low, ranging from 3.5 to 7.2 deaths per 1,000 person years. In Bratislava, Slovakia, this rate was marginally higher at 7.3 deaths per 1,000 person years.⁽⁷³⁾ However, it is difficult to assess the true scale of overdose morbidity and mortality due to inconsistent reporting and differences in surveillance systems, which have led to systematic under-reporting of overdose-related death.

Naloxone, a highly effective opioid antagonist used to reverse the effects of opioid overdose, remains extremely limited in the region. In at least Kazakhstan, Latvia, Montenegro, Romania, Serbia, Slovenia and Uzbekistan, there are neither overdose prevention programmes in the form of education nor naloxone peer-distribution.⁽¹¹⁾ In Belarus, Bulgaria, and Russia, peer education programmes regarding overdose are provided, but naloxone is unavailable.⁽¹¹⁾ Naloxone became available via the three mobile NSP units in Lithuania in 2015, but the number of kits provided is not known.⁽⁷⁰⁾ In Estonia in 2013, the National Institute for Health Development launched a pilot take-home naloxone programme due to the high-rate of overdose-related deaths in the country. People who use opioids and their families were taught to recognise the signs of an overdose and administer naloxone.⁽⁷⁴⁾ Between 2013 and 2015, 1,630 naloxone kits were distributed. It is reported that overdose-related deaths reduced by over half, from 170 in 2012, to 84 in 2015.⁽⁶⁸⁾ In a recent Global AIDS Progress Report to UNAIDS, the Estonian government also report that naloxone became available within prisons in 2015.⁽⁷⁵⁾

The vast majority of people who use opioids in the region have no access to life-saving naloxone.⁽¹¹⁾ Barriers to increasing access to naloxone include overregulation of both the management of naloxone by non-medical staff, including prohibitions against injection by non-medical staff, and of the provision of naloxone by medical staff.⁽¹¹⁾

Tuberculosis (TB)

Multi-drug resistant TB rates are among the highest in the world in Eurasia.⁽⁷⁶⁾ Data on TB prevalence among people who inject drugs are sparse, and without these, it is difficult to assess the true scale of TB among people who inject drugs in the region.

In all countries in the region, TB screening and treatment is available for the general population, which theoretically includes people who inject drugs. In Estonia, for example, it is reported that free TB screening is provided for people who inject drugs, people living with HIV, those living in shelters, prisoners and other groups considered to be at heightened risk of TB infection that may not be covered by health insurance.⁽⁷⁴⁾ However, throughout the region, TB testing and treatment services are not generally tailored to the needs of people who inject drugs, and are rarely linked to HIV or harm reduction services meaning many people are lost via the referral process to specialised TB facilities.⁽¹¹⁾ A study undertaken in Ukraine illustrated the improvement in healthcare quality indicators for people who inject drugs that can be achieved using an integrated service delivery model.⁽⁷⁷⁾ However, funding for such linked services is not only limited, but is rapidly depleting in the region due to the retreat of international donors such as the Global Fund.

In recent years, due to a change in the eligibility criteria for a number of countries, Global Fund grants supporting TB programmes have ended, and many governments are yet to allocate sufficient funding to address the significant gap in provision which has been left behind.⁽¹¹⁾

Antiretroviral therapy (ART)

In the majority of countries in the region there is a distinct lack of integration of HIV testing and treatment services within harm reduction programmes.⁽¹¹⁾ Where integration of these services does exist, it often depends on ad-hoc collaboration between harm reduction services and specialised medical facilities. This integration is driven by personal contacts and does not offer full or even coverage. In many countries this leads to late HIV diagnosis, low coverage of ART among people who inject drugs, and suboptimal adherence to treatment.⁽¹¹⁾ ART coverage remains extremely low in much of the region, with only 21% of people living with HIV accessing treatment in Eastern Europe and Central Asia.⁽⁵³⁾ This poor coverage is particularly pronounced among people who inject drugs. In Russia, for example, people who inject drugs make up 67% of the cumulative

HIV cases, and yet represent only 25% of those receiving ART.⁽⁷⁸⁾ In contrast, notable progress has been achieved in Ukraine, where increased government investment has resulted in a dramatic rise in people receiving ART from 12,751 in 2010, to 43,790 people in 2013.⁽⁷⁹⁾

Disproportionately poor access to ART among people who inject drugs is further compounded by additional barriers in Armenia, Estonia, Lithuania and Tajikistan, where NGOs are prohibited from performing rapid testing for HIV and hepatitis C due to regulations that require them to hold a special medical license. To bypass this barrier, some NGOs collaborate with medical institutions to provide testing.⁽¹¹⁾

Harm reduction in prisons

Extremely punitive drug laws and policies across the region have given rise to some of the world's highest incarceration rates. Of the 29 countries in Eurasia, 19 still have incarceration rates that exceed the world average of 146 prisoners per 100,000 population, with 10 exceeding 200: Turkmenistan (583), Russia (445), Belarus (306), Georgia (274), Lithuania (268), Latvia (239), Azerbaijan (236), Kazakhstan (234), Estonia (216), and Moldova (215).⁽⁸⁰⁾ People who inject drugs reportedly represent about one third of prisoners in the region, although they could make up between 50-80% of the prison population in some countries.⁽⁸¹⁾ Similar to all other regions of the world, injecting drug use in prisons in Eurasia is common, with prevalence estimates ranging from 3% to 55%.⁽⁸¹⁾ When all of these factors converge, the result is a much higher prevalence of HIV, HCV and TB in prisons than outside of prisons. For example, HIV prevalence in prisons exceeds 10% in Latvia (20.4%), Ukraine (19.4%), Estonia (14.1%), and Kyrgyzstan (10.3%), and remains significantly higher than in the broader community in Uzbekistan (4.7%), Lithuania (3.4%), Kazakhstan (3.9%), Azerbaijan (3.7%), Armenia (2.4%), Tajikistan (2.4%), Moldova (2.6%), and Georgia (0.9%).⁽⁸¹⁾

Despite this reality, harm reduction services remain scarce in the region's prisons. Needle and syringe programmes are currently only provided in prisons in Armenia (all 11 prisons)⁽⁸²⁾, Kyrgyzstan (7 prisons),⁽²⁷⁾ Moldova (13 prisons on the 'right bank' and 3 prisons in the autonomous region of Transnistria)⁽³⁴⁾ and Tajikistan (1 prison).⁽⁸³⁾ In theory, NSPs are also available in 8 prisons in Romania, but prisoners reportedly do not access them for fear of negative consequences⁽⁸⁴⁾ Despite their proven success, the few prison-based NSPs operating in the region face an uncertain future due to loss of funding from international donors.⁽⁸¹⁾

Provision of OST in prisons is slightly more widespread, with the service currently available in at least one prison in 18 countries in the region. Quality and accessibility, however, vary considerably, both between and within countries. For example, in Bosnia and Herzegovina, prisoners can initiate OST at Orasje prison, but in Tuzla and Zenica prisons in Sarajevo, the service is only available to prisoners who were receiving it prior to incarceration.⁽⁸⁵⁾ In Albania,⁽⁸⁶⁾ Bulgaria,⁽¹¹⁾ Latvia,⁽⁸⁷⁾ Lithuania⁽⁷⁰⁾ Montenegro,⁽¹¹⁾ and Serbia,⁽¹¹⁾ OST cannot be initiated in prisons at all. Meanwhile, OST is only available for detoxification in some pre-trial detention facilities in Georgia.⁽⁸¹⁾ A blanket prohibition on OST continues to be upheld in Russia, Turkmenistan and Uzbekistan, and the service is still unavailable in prisons in Azerbaijan, Hungary, Kazakhstan, Kosovo, Slovakia, Ukraine (although legislation from 2011 permits OST in prisons)⁽⁸⁸⁾ and Tajikistan. While guidelines on OST in prisons have been developed in Tajikistan, actual implementation of the service was last reported to be under consideration.⁽⁸³⁾ Positively, however, since the Global State last reported in 2014, OST was expanded to two more prisons in Moldova.⁽³⁴⁾

More countries must follow Moldova's example and introduce, expand and/or remove any barriers to accessing NSPs and OST in their prisons as a matter of urgency. Not only is this a legally binding obligation under international human rights law, but it could also considerably reduce HIV transmission. Recent scientific modeling of the impact of incarceration and scale-up of OST in prisons on HIV transmission among people who inject drugs in Ukraine suggests that if prison-based OST were initiated in the country, 19.8% of HIV infections would be averted between 2015-2030, and community coverage of OST would increase by 8.3%.⁽⁸¹⁾

Civil society reports that HIV treatment is available in prisons in all countries across the region, although the regulation, quality and coverage of this service varies considerably.⁽¹¹⁾ Azerbaijan and Kyrgyzstan are considered to provide high coverage of ART for people living with HIV who are diagnosed within prison,^(89, 90) and Poland has reportedly increased ART coverage in the last 5 years, with all prisoners living with HIV now able to access the service.⁽⁹¹⁾ In some countries, such as Tajikistan, ART coverage in prisons (43% in 2014) is substantially higher than it is outside of prisons.⁽⁸³⁾ Meanwhile, less than 4% of people living with HIV in Ukrainian prisons currently have access to ART,⁽⁹²⁾ while frequent lack of medication in Russian prisons that ART availability is sporadic.⁽¹¹⁾ In some prisons in Bosnia and Herzegovina, HIV treatment is not available.⁽⁸⁵⁾



Importantly, where ART and other essential health services are available in prisons, barriers of all kinds continue to impede their access. For instance, in the Czech Republic, prisoners are required to pay a “regulatory fee” of CZK30 for every medical appointment and every prescription, which - as a rule - is not reimbursed by health insurance.⁽⁹³⁾

Information on hepatitis C testing, treatment and care in the region’s prisons is scarce, but civil society reports that it typically reflects the situation outside of prisons.⁽¹¹⁾ In Georgia, a recently launched internationally funded HCV elimination strategy has included prisoners, enabling them to access costly new direct-acting antiviral treatments.⁽⁹⁴⁾ At the same time, the European Committee for the Prevention of Torture recently reported that funding for peg-interferon treatment for HCV in relation to newly detected cases was being discontinued in Serbian prisons.⁽⁹⁵⁾ Across the border in Bosnia and Herzegovina, prisoners are reportedly being prescribed non-evidence-based treatments, such as artichoke tablets, which are believed by some health professionals to cure HCV.⁽⁸⁵⁾

Civil society reports that testing and treatment for TB is likely available in all prisons in the region.⁽¹¹⁾ In Georgia, all prisons are now covered by the national programme for the Prevention of Tuberculosis which has resulted in a 52% reduction in TB prevalence in the prison system since 2012.⁽⁹⁶⁾ Information on naloxone in prisons is limited, but news that Estonia introduced a take home naloxone programme from prisons in 2015, with prisoners who inject drugs now being trained in its use prior to release, is promising.⁽⁷⁵⁾ In terms of condom provision, civil society reports that in most countries’ prisons, condoms are either available to a limited extent in prisons where there are relevant NGO projects distributing them, or not available at all.⁽¹¹⁾

Policy developments for harm reduction

The majority of countries (26 of 29) have national HIV or drug policies that include explicit support for harm reduction.⁽⁵⁰⁾ However, most countries also have strongly punitive drug policies which emphasise criminalisation of drug use and possession. Within this policy environment, hostility towards harm reduction is common. National legislation on drugs in the former Soviet states includes tables that set thresholds for considering illicit drug seizures as ‘small’, ‘large’, and ‘extremely large’, with associated criminal laws and prison terms. Thresholds for possession which lead to

imprisonment are low, especially in comparison to the commonly disproportionate length of prison sentences for offenders.⁽¹¹⁾ At the time of reporting the only two countries which had decriminalised the possession and use of small quantities of drugs in the region were the Czech Republic and Armenia. In Armenia, use and possession of small amount of drugs for personal use is not a criminal offence. However, the administrative fine for possession is so high that many cannot afford to pay and instead are arrested for non-payment.⁽¹¹⁾ The low prevalence of HIV among people who inject drugs in the Czech Republic has been attributed to decriminalisation combined with sustained and scaled-up NSP and OST provision.⁽⁹⁷⁾

Legislation in the vast majority of countries does not include options for providing non-criminal measures as an alternative to prison for drug use or possession. Moreover, in countries where such non-criminal options are available, these are often not utilised. For example, in Estonia, a lack of motivation by law enforcement and criminal justice institutions to use non-criminal options, along with an absence of implementation mechanisms, results in criminal sanctions remaining the norm.⁽¹¹⁾ Civil society report that fear of potential arrest and criminal penalties among people who use drugs significantly interferes with the utilisation and provision of NSP and OST services in the region, where data is often shared with the police.⁽¹¹⁾

In April 2016, during the United Nations General Assembly Special Session (UNGASS) on the drugs in New York, the Czech Republic, Estonia, Latvia, Lithuania, Poland, Romania and Slovenia all made statements in explicit support of harm reduction⁽⁹⁸⁾ The European Union (EU)’s common position, which included Macedonia, Serbia, Ukraine, Albania, Bosnia & Herzegovina, Moldova and Georgia, also stated that harm reduction, as a proven effective measure in preventing overdose and the transmission of blood borne diseases, should be further promoted and implemented.⁽⁹⁸⁾ It is important to note, however, that the expressions of international support among these countries have not yet been matched by financial or political commitments.

Civil society and advocacy developments for harm reduction

Civil society continue to play a crucial role in advocating for harm reduction in the region and internationally. In recent years, the changing funding landscape has increasingly required civil society to focus their advocacy

on the sustainability of harm reduction funding in the region. In 2014, the Eurasian Harm Reduction Network (EHRN) became the principal recipient for the first Global Fund regional HIV/AIDS grant in Eastern Europe and Central Asia (EECA) and created a regional research and advocacy programme, 'Harm Reduction Works! – Fund it!'. The goal of this programme is to strengthen advocacy by civil society, including people who use drugs, for sufficient, strategic and sustainable investments in harm reduction as HIV prevention in the region.⁽⁹⁹⁾ The project, which covers Belarus, Georgia, Kazakhstan, Moldova, Tajikistan and Lithuania, is due to end in March 2017, when the results of the programme will be published.

In 2015, EHRN and the Global Fund co-organised a technical consultation in Istanbul, Turkey, bringing together key stakeholders^p to shape an appropriate technical framework for the transition from Global Fund funding to national funding, and the sustainability of HIV and TB programmes in the region. Also in 2015, in Tbilisi, Georgia, the Regional High Level Dialogue on Successful Transition to Domestic Funding of HIV and TB Response in Eastern Europe and Central Asia 'Road to Success' meeting was held. 318 delegates from 31 countries gathered, representing governments from Eastern Europe and Central Asia (EECA), civil society organisations, key populations and communities, international organisations and technical agencies with the goal of discussing commitments and principles of the successful transition process from donor to national funding.

In early 2016, the Georgia Network of People Who Use Drugs (GeNPUD) established the Georgian National Drug Policy Platform (GNDDP), creating a broad national drug policy platform.⁽¹¹⁾ The GNDDP unites a broad range of over 30 organisations, which include community organisations and drug user activists, service delivery organisations, drug clinics and medical personnel, researchers and academics, human rights organisations and activists. Members agreed on three priority areas: 1) drug policy reform 2) improving the availability and quality of services, and 3) reducing stigma and raising public awareness. It is the first time that representatives of different sectors were able to come together, agree on common goals and pool their efforts in petitioning governments to take action in the field of drug use and harm reduction initiatives.⁽¹¹⁾

There are some well-established networks of people who use drugs in the region, with the Eurasian Network of People Who use Drugs (ENPUD) at regional level, and country-based active drug user networks in Macedonia, Georgia, Azerbaijan, Kyrgyzstan, Montenegro and Romania.⁽¹¹⁾

Funding developments for harm reduction

Since the *Global State* last reported in 2014, there have been a number of civil society initiatives with a focus on advocacy for harm reduction funding in this region. EHRN's 'Harm Reduction Works! – Fund It' project has examined funding levels and challenges for NSP and OST in Belarus, Georgia, Kazakhstan, Moldova, Tajikistan and Lithuania. A project report released in 2015 stated that harm reduction in the region remained heavily dependent on international donor support. It raised serious concerns regarding the lack of commitment of the Government of Georgia to fund NSPs, the minimal domestic contributions in Moldova and Tajikistan (15% and 2% respectively), the lack of domestic support for OST in Kazakhstan and at the limitations of domestic support in Lithuania which do not allow harm reduction services to meet the national need.⁽¹⁰⁰⁾ In Ukraine, the government recently committed to coverage of some methadone after the threat of a reduction in Global Fund support, and in the municipality of St Petersburg in Russia, the government are also expected to begin supporting needle and syringe programming. Both of these contributions, however, will be insufficient to match the reduction in Global Fund support, or to reach the desired coverage levels.⁽¹⁰¹⁾

Research carried out by HRI within an EC-funded project 'Harm Reduction Works!^q also examined the sustainability of harm reduction funding in European Union states within the Eurasia region. These are generally the countries with the more established harm reduction programmes in the Eurasia region with, for example, civil society reporting that funding for harm reduction in the Czech Republic and Estonia was considered to be relatively stable and secure. However, there were grave concerns raised about the potential for rapid increases in HIV infection among people who inject drugs in some countries due to poor funding or an imminent end to funding for harm reduction. For example, currently in Bulgaria, a Global Fund grant is ending without any indication that government will fund existing harm reduction services to continue operating. In Romania, there has been a decrease in the already limited harm reduction service provision in recent years as a result of funding cuts, with some, though insufficient, investment by the municipality of Bucharest.⁽¹⁰¹⁾ Similarly, minimal domestic support for harm reduction in Hungary continues to limit the extent to which services can prevent epidemics from rapidly increasing among people injecting drugs. There remain

^p Including national government agencies, donor organisations, technical support providers, UN agencies, civil society organisations and communities.

^q Jointly coordinated by EHRN and HRI running from 2014-2016.



many challenges in establishing existing spending on harm reduction, highlighting the need for greater transparency among governments and donors on their harm reduction investments and for this spending to be systematically tracked. This information is urgently needed if the limited available funds are to be invested optimally and according to epidemiological need.^f By far the biggest challenge to the sustainability of harm reduction in this region, however, remains the lack of political acceptance of harm reduction and the unwillingness of governments to invest what is required.

Transition from Global Fund support to national funding for harm reduction

In most countries in Eurasia, harm reduction programmes have been introduced and financially supported by international donors, with national funding supporting all OST and NSP delivery in only a few EU Member States. In all other cases the Global Fund has been the single major funding source for these programmes. However, the Global Fund has been revisiting its priorities and funding policies and has been gradually withdrawing from many countries within Eurasia. Due to this, these countries have engaged in the process of transition from Global Fund funding to national funding for HIV and TB programmes. Experience accumulated in relation to sustainability of donor funded programmes, and the results of Global Fund withdrawal from Albania, Romania, Bulgaria, Estonia, Montenegro, Russia and Serbia, suggest that this will be a challenging process and that there are considerable risks to the sustainability of HIV programmes in the region. Since the *Global State* last reported, there has been a rise in HIV prevalence among people who inject drugs in Montenegro and a decrease in harm reduction services in Romania going from 7 NSPs in 2014, to 3 in 2016, and from 13 OST sites in 2014, to 8 in 2016.

In the environment of ever-limited funding and an abundance of competing priorities for scarce public health resources, harm reduction interventions, still subjects of political and ideological controversy, seem to be most vulnerable. Furthermore, countries lack mechanisms to finance NGOs through government budgets. In Georgia, NSPs are projected to receive no domestic funding, however a transition plan is being finalised for government approval for the beginning of 2017, which should include funding for NSPs.⁽¹⁰²⁾

In Tajikistan, just 1.6% of NSP costs will be received from government funding, with the government covering 15% of costs in Moldova.⁽¹¹⁾ Starting from 2015, the Global Fund has reduced its financial support to Russia by approximately 30%, which immediately resulted in a dramatic decrease in the coverage of already limited harm reduction services. Support is set to end entirely by 2018. The total number of HIV prevention projects among key populations has decreased from 62 to only 19, and annual coverage of harm reduction services decreased by over 60% from 66,351 in 2014, to 25,390 in 2015.⁽¹⁰³⁾ It is likely that many other transition countries will not be able to sustain the existing harm reduction programmes at even a low level of coverage, let alone scale up to UN recommended standards.

^f The report will be published in the coming months by HRI.

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