2.2 EURASIA

ALBANIA
ARMENIA
AZERBAIJAN
BELARUS
BOSNIA AND HERZEGOVINA
BULGARIA
CROATIA
CZECHIA
ESTONIA
GEORGIA
HUNGARY
KOSOVO
KAZAKHSTAN
KYRGYZSTAN
LATVIA
LITHUANIA
MOLDOVA
MONTENEGRO
NORTH MACEDONIA
POLAND
ROMANIA
RUSSIA
SERBIA
SLOVAKIA
SLOVENIA
TAJIKISTAN
TURKMENISTAN
UKRAINE
UZBEKISTAN

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	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response			
					NSP[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Albania	5,132-6,182[1]	0.5[2]	28.8[2]	11.5[2]	✓2[3,4]	✓6[3,4] (M,B)	x	x
Armenia	9,000[5]	1.9[5]	66.1[5]	nk	✓12[3,4]	✓4[3,4] (M)	x	x
Azerbaijan	60,000[6]	6.9[6]	43.9[7]	7.3[7]	✓17[8]	✓2[3,4] (M)	x	x
Belarus	66,500[9]	30.8[10]	58.2[10]	2.4[10]	✓34[11]	✓19[4,11] (M)	x	x
Bosnia and Herzegovina	12,500[9]	0.0[9,12]4	30.8[12]	0.2-3.1[12]	✓5[13]	✓12[12] (M,O)	x	x
Bulgaria	18,500[14]	6[15]	76.8[15]	5.0[15]	x[15,16]	✓30[15] (M,B,O)	x	x
Croatia	6,300[17]	0.5[17]	38.2[17]	0.9[8]	✓144[18]	✓[17] (M,B,O)	x	x
Czechia	43,700[19]	0.1[19]	14.7[19]	15.1[8]	✓164[18]	✓[19] (M,B,BN)	x	x
Estonia	8,600[20]	51.4[21]	79.7[21]	5.7[21]	✓41[4,18]	✓8[20] (M,B,BN)	✓[20]5	x
Georgia	52,500[22]	2.3[23]	65-75.0[23]	7.2[8]	✓22[3]	✓18[3] (M,BN)	x	x
Hungary	6,707[24]	0.2[24]6	49.7[24]	2.2[8]	✓40[18]	✓15[3] (M,B)	x	x
Kazakhstan	94,600[25]	7.9[26]	64.2[27]	7.9[8]	✓144[28]	✓13[25,26] (M)	x	x
Kosovo	5,819[29]	0.0[29]7	23.8[29]	4.1[30]	✓[30]	✓4[31] (M)	x	x
Kyrgyzstan	26,700[32]	14.3[33]	60.9[33]	nk	✓40[34]	✓31[35]	x	x
Latvia	7,100[36]	7.7[36]	56.8[36]	3.6[36]	✓28[18]	✓10[3] (M,B,BN)	x	x
Lithuania	8,900[37]	12.5[37]	77[37]	10.5[37]	✓11[18]	✓[18] (M,B,BN)	x	x
Moldova	36,900[9]	13.9-29.1[40]	32.7-62.1[41]	1.0-5.4[41]	✓28[42]	✓22[43]8 (M)	x	x
Montenegro	1,300[44]	0.5[6]	53.0[45]	1.4[45]	✓13[3]	✓5[3]	x	x
North Macedonia	6,756[38]	0.0[38]9	72[38]	5.6[38]	✓16[39]	✓16[39] (M,B)	x	x
Poland	14,670[46]	14.0-21.2[46]	57.9[46]	4.9[8]	✓51[18]	✓[46] (M,B)	x	x
Romania	81,500[8]10	15.9[47]	83.8[4]	5.2[4]	✓63[18]	✓[47] (M)	x	x
Russia	1,881,000[8]	48.1-75.2[48]	83.4-94.4[48]11	32.7-79.9[48]10	✓20[8]	x	x	x
Serbia	20,500[49]	0.0[8]	25.9[8]	3.6[8]	✓2[50]	✓23[49] (M,B)	x	x
Slovakia	20,000[8]	0.0[51]	42.3[51]	3.7[51]	✓14[18]	✓[51] (M,B,BN)	x	x
Slovenia	4,900[52]	0.0[52]	42.6[52]	4.6[52]	✓12[18]	✓10[4] (M,B,BN,O)	x	x
Tajikistan	22,200[53]	12.1[6]	61.3[8]	nk	✓53[54]	✓12[54] (M)	x	x
Turkmenistan	nk	nk	Nk	nk	x	x	x	x
Ukraine	317,000[55]	22.6[56]	63.9[57]	13.8[57] 12	✓2,380[56]	✓215[58] (M,B)	✓	x
Uzbekistan	48,000[59]	5.1[59]	15.7[59]	nk	✓230[60]	x	x	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.
4 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2016 in Bosnia and Herzegovina.
5 Naloxone can only be provided by medical personnel. In 2018, a nasal naloxone spray applicator was also made available.
6 Data from 2015; however, civil society report an increase in HIV diagnoses attributed to injecting drug use in 2019.
7 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2011, 2014 and 2018 in Kosovo.
8 Of these services, 13 are based in prisons.
9 No people who inject drugs were infected with HIV based on the results of the Integrated Biological and Behavioural Survey 2017 in the Republic of Macedonia.
10 National estimates for the number of people who inject drugs in Romania vary widely among different international agencies. The figure cited represents the most recent from an independent study.
11 Data received based on self-report among people who inject drugs who have tested HCV and HBV positive during the last 12 months (IBBS 2017).
12 Data received based on self-report among people who inject drugs who have HBV now or have had it before (IBBS 2017).

MAP 2.2.1:
Availability of harm reduction services

2.2
Harm reduction in Eurasia[13]

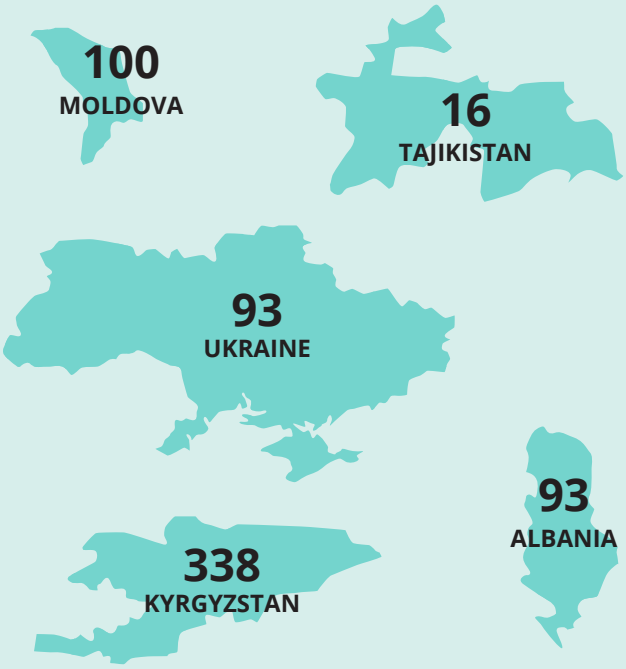
HIV AND ANTIRETROVIRAL THERAPY (ART)

77%

OF NEW HIV CASES IN EECA REGION WERE REGISTERED IN RUSSIA.

HARM REDUCTION IN PRISONS

THE NUMBER OF PEOPLE IN PRISON THAT RECEIVE OAT.



Drug checking is provided mostly through distribution of reagent test kits at festivals and nightlife settings in Czechia, Estonia, Georgia, Hungary, Lithuania, Slovenia, Poland and Ukraine but not as an official harm reduction intervention. There are still no official drug consumption rooms (DCRs) in the region; the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine, in 2019.

SUMY, UKRAINE, 2019

1. Overview

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There are approximately three million people who use drugs in Eurasia (no data is available for Turkmenistan). Every country in the region reports injecting drug use although, according to national experts,[14] injection as the primary route of administration has reduced in recent years. Cannabis followed by opioids remain the most commonly used drugs[61] and, according to recent studies,[62] new psychoactive substances (NPS) are increasingly popular in the post-Soviet part of the region due to their low price and high availability.

Harm reduction, while not always in these exact words, is mentioned in national government policies in 25 of the 29 countries in the region. Needle and syringe programmes (NSPs) are available in 27 out of 29 countries (excluding Turkmenistan and Bulgaria), and opioid agonist therapy (OAT) in 26 countries (except Russia, Uzbekistan and Turkmenistan). However, the coverage of services in most of the countries doesn't reach the minimum 20% recommended by the World Health Organization (WHO)[4] and the quality of services remains low and not client-oriented. Consequently, nearly half of new HIV infections in 2019 in the post-Soviet part of the region were attributed to injecting drug use.[63]

Twenty-one countries provide OAT in prisons, and only five have needle and syringe programmes (NSPs).

Naloxone and overdose prevention education is explicitly stated as part of the harm reduction programme for people who use drugs in Georgia, Kyrgyzstan, Moldova, Tajiskistan and Uzbekistan.[9] Take-home naloxone is available at harm reduction sites in Estonia, Kazakhstan, Kyrgyzstan, Moldova and several cities in Russia, with support from international donors. In Ukraine, naloxone is available without a prescription in pharmacies. Nasal naloxone is available in Estonia and there are plans to introduce it in Lithuania in 2020.

Drug checking is provided mostly through distribution of reagent test kits at festivals and nightlife settings in Slovenia, Hungary, Estonia, Czechia, Lithuania, Ukraine, Georgia and Poland but not as an official harm reduction intervention. There are still no official drug consumption rooms (DCRs) in the region; the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine, in 2019.

The COVID-19 crisis has brought some positive developments in the region, such as provision of take-home OAT, home delivery of harm reduction materials and provision of online consultations, but also led to the reduction of some services.

Since 2018, vending machines with harm reduction kits have been introduced in Georgia and substitution therapy for people who use amphetamine-type stimulants (ATS) in Czechia. There is still a lack of gender-sensitive services, particularly those aimed at sex workers, men who have sex with men, LGBTQI and young people who use drugs. Available harm reduction service packages are often limited to HIV prevention and lack psychosocial support such as housing, employment, legal assistance, protection from gender-based violence and psychotherapy.

Repressive drug policy and de facto criminalisation of people who use drugs lead to gross violations of human rights and are the main barriers to accessing services. In addition, Russia, Ukraine and Kazakhstan have recently moved to adopt legislative initiatives aimed at strengthening measures to combat drug-related advocacy (which the local governments refer to as "propaganda"), particularly on the internet, and increased the liability for the provision of such information. This raises concerns regarding the potential risks for social programmes focused on working with people who use drugs, and non-governmental organisations (NGOs) implementing those programmes.

According to an assessment of the costs of criminalisation conducted by the Eurasian Harm Reduction Association (EHRA) in 2018-2019, incarcerating people who use drugs in Eurasia costs two to six times more than providing health and social services such as OAT, NSP and social assistance.[64] However, in almost all the countries in the region, harm reduction and other health services are severely underfunded and depend on international donors, largely due to the criminalisation of people who use drugs. Withdrawal of international funding from the region has left gaps in service provision which governments are reluctant to fill. Civil society reports the closure of community organisations and a drop in the quality of services provided. The laws on 'foreign agents' and other restrictions on international financial support are exacerbating the situation in Russia and Belarus. The involvement of civil society and community organisations in service provision and decision making remains scarce but they continue to be important watchdogs. In addition, national advocacy organisations report to international human rights bodies and other protection mechanisms to improve the quality of life of people who use drugs in their countries.

14 While preparing this report, Eurasian Harm Reduction Association conducted 26 interviews with national and regional experts.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Harm reduction, while not always in these exact words, is mentioned in national government policies in 25 of the 29 countries in the region (except Turkmenistan, Russia, Azerbaijan, Armenia). The coverage,[15] in terms of number of syringes distributed per person who injects drugs per year,[4] and the quality of existing services throughout the region remain low in countries where data on NSP coverage is available (Armenia, Azerbaijan, Belarus, Bulgaria, Georgia, Hungary, Latvia, Lithuania, Romania, Slovakia, Slovenia, Ukraine). Uneven geographical coverage was also reported as an issue. In Slovakia, for example, services exist only in the western part of the country.

Harm reduction services in Albania, Bosnia and Herzegovina, Hungary, Romania[67] and Russia[66] are extremely limited and are mainly implemented by civil society on a volunteer basis. Since the *Global State of Harm Reduction 2018*, and after extensive advocacy efforts, Bulgaria reopened one NSP site for a year, but it closed again when funding stopped in July 2020.[16] Insufficient coverage of NSPs could lead to serious public health consequences. A study following up with former NSP clients after the closure of NSPs in Belgrade and Budapest found that equipment sharing was prevalent in both cities, and access to sterile injecting equipment declined significantly, while access to other social services, HIV and hepatitis C testing and counselling also decreased among the former clients of the NSPs.[68]

A number of countries in the region also have mobile NSPs (including Belarus, Estonia, Georgia, Latvia, Russia, Slovenia and Ukraine) or outreach programmes which deliver syringes alongside other injecting equipment and healthcare services or referrals. In Estonia, two mobile NSP units which combine HIV, hepatitis C, tuberculosis (TB) and sexual transmitted infection testing and treatment began operating in 2018. Syringes are accessible via vending machines in Czechia, Hungary and Georgia.

Some countries have NSP sites only in fixed locations, some rely exclusively on outreach work, as for example, in Armenia. In Kyrgyzstan, there is a requirement for outreach workers to have at least one year of experience, which prevents many peers from applying to this position. Civil society in Kazakhstan reports poor quality syringes distributed by government-funded programmes, leading to the potential for increased unsafe injecting. A number of countries don't have HIV or hepatitis C testing at harm reduction sites due to unavailability of oral test kits and the legal limitations for civil society to perform tests containing blood samples.

Restrictive opening hours, poor quality equipment and stigma remain barriers to access to NSPs in many countries of the region. Repressive drug policies that criminalise even the small amount of substance left in a syringe after use have effectively stopped the collection of used syringes in Ukraine. The same issue is reported in Georgia. Funding for harm reduction services is also severely lacking in the region.

The package of tools and services provided is slowly adapting to the changing drug use patterns, in terms of substance and method of administration. Over the last ten years, injecting as a main route of administration has steadily declined.[69] Czechia, Hungary, Latvia and Slovakia reported stimulants as the primary drug injected,[69] and it is estimated that in Czechia around 75% of people use methamphetamine.[70] As a result, Czechia has the most progressive harm reduction services in the region, providing harm reduction equipment not only for injections but also for smoking, snorting and oral administration.

Throughout the region, women who use drugs experience a high level of stigma, discrimination and violence, making it harder for them to reach NSPs and other harm reduction services.[71] Shelters for survivors of domestic violence often do not accept women who use drugs and/or those who are living with HIV. In Hungary, for example, there was only one female-only NSP programme which was closed in 2014. The Eurasian Women's Network on AIDS[16] and the Narcofeminism[17] movement and its activists are advocating for inclusive and female-oriented services for women who use drugs and/or who are living with HIV.

15 The World Health Organization's NSP indicator sets coverage levels as follows: low coverage – fewer than 100 needles per person who inject drugs per year, mid – 100 to 199, high – more than 200.[65]

16 See: http://www.ewna.org

17 See: https://harmreductioneurasia.org/narcofeminism/

2.2
OPIOID AGONIST THERAPY (OAT)

There have been no significant changes in OAT provision in the region since 2018, with 26 countries providing OAT for people who use opioids. OAT is prohibited in Russia, Turkmenistan and Uzbekistan, despite WHO's recommendation and overwhelming evidence supporting its efficacy. Methadone remains the most widely used form of OAT in the region. Buprenorphine is not subsidised in most cases and is only available as an out-of-pocket expense. In addition to methadone and buprenorphine, Slovenia and Bulgaria also have slow-release morphine. Heroin-assisted therapy (HAT) as a form of OAT remains unavailable. In 2020, buprenorphine was included on the pharmaceuticals procurement list of a Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) grant to support OAT for 350 clients in Belarus.

OAT coverage varies considerably in the region and is extremely low in some states: less than 5% of the estimated number of people who use opioids are undergoing such treatment in Azerbaijan, Belarus, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, Tajikistan and Ukraine, and only seven countries (Bulgaria, Czechia, Georgia, Hungary, Lithuania, Macedonia and Serbia) have OAT coverage above 20% of those who need it. In Kazakhstan, the OAT programme has been implemented as a pilot programme since 2008. Ukraine has the largest OAT service in the region, providing treatment to 13,700[72] patients and is fully funded by the state. In a number of countries such as Czechia, Lithuania, and some regions of Ukraine, there are waiting lists to initiate treatment.

A repressive policy and legal environment, unequal coverage between rural and urban settings, stigmatisation of people who use drugs, and the requirement to abstain from illegal drugs all form barriers to access and adherence to OAT. Concurrent drug use could lead to expulsion from the programme in Azerbaijan, Belarus, Kazakhstan, Poland and Ukraine. The lack of take-home dosing in many countries (such as Azerbaijan, Belarus, Kazakhstan), the opposition of law enforcement officials, and a lack of trust between service providers and clients hinders access for people who inject drugs. Even in countries that have take-home OAT, its dispensing is highly restricted and only a small percentage of clients manages to meet the criteria. In Ukraine, for example, a person is required to be in the programme for at least half a year without any violations to be eligible for take-home OAT.

In some regions of Ukraine, people must be hospitalised for 21 days in order to enrol into OAT, to confirm the diagnoses and titration of the therapy. This poses a huge barrier, especially for women with children. In Azerbaijan, failed treatment attempts are still included in enrolment criteria, potential clients must have someone to vouch for them, and priority is given to people with double diagnoses (drug dependence and HIV, TB, hepatitis C). An assessment of client satisfaction with OAT programmes conducted in Kyiv and Kyiv Oblast in 2019 showed that although a formally designated range of services is provided, their content and quality are not satisfactory. Most services are aimed at monitoring the patient's behaviour, rather than providing patient-centred support, and many do not improve a person's quality of life.[73] In the last two years, OAT programmes have been at risk of closure in Kazakhstan and Bulgaria. In Kazakhstan, methadone registration ends in December 2020, after which methadone will not be available in the country.

Many governments fully fund OAT provision in the region, including Azerbaijan, Bulgaria, Croatia, Czechia, Estonia, Georgia, Hungary, Latvia, Lithuania, Moldova, Poland, Serbia, Slovakia, Slovenia and Ukraine. Others such as Belarus, Tajikistan and Kazakhstan only cover part of the services. In most of these cases, the medication itself is funded through the Global Fund.

An assessment conducted[74] in 2019-2020 in Tajikistan[75], Belarus[76] and Ukraine[77] showed that the most significant problems with regard to the sustainability of OAT programmes in the context of transition from donor support to domestic funding are the availability and coverage of the programme, and financial resources allocated to them. Many governments will only cover the cost of the facilities, medical personnel, and medicine. Additional services such as psychosocial support and training for personnel are the two areas that suffer the most during the transition to national funding.

2.3 AMPHETAMINE-TYPE STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES

A growing trend in the use of amphetamine-type stimulants (ATS), synthetic opioids and new psychoactive substances (NPS) has emerged in Eurasia over the past decade. The popularity of NPS is attributed to their low price and wide availability through the dark net.[62] Repressive policies in the region have led to the emergence of new ways of selling drugs. Most sellers do not hand off drugs anymore, but rather stash them in geotagged hiding spots to be picked up by online buyers. The Russian dark net marketplace Hydra has 2.5 million registered accounts and 400,000 regular customers, according to an analysis[78] published in 2019.

The use of NPS can increase the risk of HIV due to multiple injections and increased number of sexual contacts; there are also reports of mental health issues linked to some NPS use.[62,79][18] ATS are reported to be the most popular injectable substances in Czechia, Latvia and Hungary. A study on NPS use conducted by EHRA and the Swansea University School of Law in 2019-2020 in Moldova[80], Belarus[81], Kazakhstan[82], Kyrgyzstan[83], Serbia[84] and Georgia[85] showed a lack of capacity of existing harm reduction services and health professionals trained to deal with NPS use. The main issues are lack of psychological support, limited access to mental health counselling and no protocols for dealing with NPS overdose. Except Czechia, no country in the region distributes harm reduction kits for safer smoking, snorting or oral use of the substances on a regular basis. At the same time, the number of syringes allocated per person per year is not enough for people who inject NPS, who can require up to 30 injections per day.

The use of new psychoactive substances by marginalised and vulnerable populations also appears to have increased in some places. In addition, unregulated drug markets increase the opportunity for adulteration and contamination of new psychoactive substances and controlled drugs by a range of potentially dangerous and sometimes highly toxic substances. Studies consistently find that drug use is more commonly reported in nightlife settings than among the general population.[86] In Eurasia, drug checking, which could help to both reduce overdoses and engage people who use drugs with the medical system, is provided mostly through the distribution of reagent test kits at music festivals and in nightlife settings. It is provided by civil society and community-based organisations in

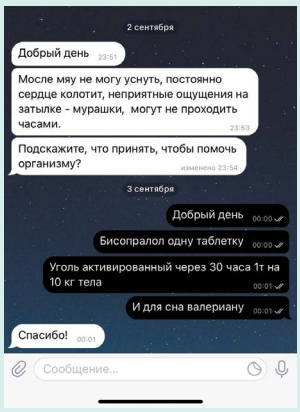
Harm reduction services in Albania, Bosnia and Herzegovina, Hungary, Romania and Russia are extremely limited and are mainly implemented by civil society on a volunteer basis.

Czechia, Estonia, Georgia, Hungary, Lithuania, Ukraine, Poland and Slovenia.

Stable drug checking services with adequate equipment exist only in Slovenia. In many cases, the requirement that service providers obtain licences to possess and work with scheduled substances prevents them from providing drug checking services and many countries do not accept drug checking as a valid reason to issue such licences.

18 Multiple injections are specific for Eurasia region, in other regions people predominantly smoke NPS.

Innovative harm reduction interventions in Eurasia



Photos by Artem Leshko.

ONLINE HARM REDUCTION IN SAINT PETERSBURG, RUSSIA

A Saint Petersburg organisation called Humanitarian Action launched an overdose bot in November 2019 in the messaging app Telegram[19] where people can get first aid in case of an overdose. Through this bot, one can also call an ambulance, both paid and free, and contact a peer consultant. Until recently, people could contact a peer consultant on NPS. This bot has around 2000 subscribers.

In addition, Humanitarian Action has an anonymous Telegram channel where it posts information about harm reduction and available services in Saint Petersburg and other regions. It also includes guidance for people who use drugs, statistics connected with harm reduction and examples of humane drug policies. There are already almost 2,300 subscribers, and the number is steadily growing. There are also closed chats for clients where they are added through outreach workers and case managers. The chat is a place where a person can get help if they need to be hospitalised, can be connected with the AIDS centre, or get an HIV self-test kit. Some people want to consult with a psychiatrist or discuss various issues related to drug use, so they write to the chat and other clients or professional consultants answer them.

Humanitarian Action also provides consultations on Hydra, a popular darknet marketplace. All these efforts raised the number of clients by 90% compared to the previous year.

SUBSTITUTION THERAPY FOR PEOPLE WHO USE ATS IN CZECHIA

Almost half of people, who use ATS, or around 15,000 - 20,000 people in Czechia inject methamphetamine every day. In 2020, pharmacologically-assisted treatment with methylphenidate was introduced for people who use methamphetamines. The commercial name of the drug is Ritalin, and it is used mainly for medication of attention deficit hyperactivity disorder (ADHD). This programme had existed unoffically for a while. However, the COVID-19 crisis, and the risk that crystal methamphetamine would not be available, propelled civil society to advocate for the release of official guidelines from the Society of Addictive Substances, which were certified by the Ministry of Health. Now the treatment can be provided by any facility that has a psychiatrist among its staff including drop-in centres. The main problem is capacity as the programme is only in its initial stage and there are thousands of people who need this kind of substitution treatment.

PINK HOUSE IN SOFIA, BULGARIA

Pink House - the last and only remaining drop-in centre for people who use drugs and are experiencing homelessness in Bulgaria - was at risk of closure at the end of April 2019 due to a lack of funding after the withdrawal of international donors. In order to prevent this from happening, the Centre for Humane Policy took over the administration of the House and launched an online crowdfunding campaign which gained extensive support. At the beginning of the campaign they managed to raise enough money to work for another three months and extend the working hours of the shelter from three hours three days per week to four hours every day including weekends. Later, two more smaller campaigns saw many people sign up for regular donations.

At the time of writing, Pink House has 200 registered clients, with 30-40 people coming every day. The permanent staff consists of only two people (a social worker and toxicologist), other members of the team work on a volunteer basis. At the House, clients can take a shower, wash their clothes, and receive food, clothes, assistance with documents, and legal support. Staff can also help connect people with medical services, and with hospitals to start HIV therapy.

A year after the crowdfunding campaign, Pink House still runs almost solely on private donations. The only two grants were from the Embassy of the Netherlands and a COVID-19-related grant from the Embassy of the United States.

19 Telegram is a messaging app, providing secure, encrypted communication.

MAP 2.2.1:
Access to naloxone in Eastern Europe and Central Asia (CEECA) region (community based survey)

Naloxone is accessible in the pharmacies without a perscription,[1] ambulance/ hospital has it and it's possible to get it in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, but ambulance/ hospital has it and it's possible to get naloxone in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, but ambulance/ hospital has it. It is not possible to get naloxone in the harm reduction programmes.

Naloxone is not accessible in the pharmacies at all, or without a perscription, ambulance/ hospital has no naloxone and harm reduction programmes do not provide it.[2]

No data

1 Naloxone is available in the pharmacies without a perscription at least in some cities.
2 In Albania, Montenegro and Russia some NGOs receive naloxone for a short - term distribution from private sources.

2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

A decreasing trend in the incidence of fatal drug overdoses can be observed in all Central Asian countries in the long run, albeit with signs of a recent increase in Kazakhstan. However, the number of drug overdoses varies significantly between the countries. While there were 238 reported fatal drug overdoses in Kazakhstan in 2017, there have been no registered fatal drug overdoses in Uzbekistan since 2016. [9] This reflects a decrease in the high-risk use of opiates. However, the proportion of deaths due to overdose is likely to be underestimated due to the limited ability of forensic medicine and forensic toxicology systems to detect overdoses on drugs other than opiates. Findings suggest that mortality risk for people engaging in high risk drug use[20] is three to seven times more when compared to peers of the same age and gender in the general population.[87] Factors associated with the increased mortality risk include regular injecting drug use over a long period of time, increased risk of acquiring blood-borne viruses, and other negative consequences like incarceration and a lack of housing.

Lithuania and Estonia are among the countries with the highest rates of drug-induced mortality among adults aged 15-64 years in Europe.[88] In Lithuania, opioids (mainly heroin, but also methadone, fentanyl and carfentanil) are involved in nine out of ten deaths with known toxicology results, and almost half of the fatalities occurred in the capital Vilnius. According to a bio-behavioural study of HIV prevalence and risk behaviour among vulnerable groups conducted in 2017 as part of a Global Fund grant in seven regions of the Russian Federation, 50% of people using drugs reported that they experienced an overdose at least once.[89] In 2019, in Saint Petersburg, Russia, 3916 people were hospitalised with overdoses - 10% more than in 2018. In Russia, Uzbekistan and Belarus, medical personnel have to notify the police about overdose cases.

In many countries in the region, naloxone is only available via prescription. Although emergency medical staff have access to the medication in all countries, for those most likely to witness an overdose, access is extremely limited. Naloxone is available at harm reduction sites in Estonia, Kazakhstan, Kyrgyzstan, Moldova and several cities in Russia, with support from international donors.[90] In Ukraine, naloxone has been available without prescription since 2019. Nasal naloxone is available in Estonia and it was introduced in Lithuania in 2020, where police in Vilnius carry nasal naloxone since October 2020. There are no specific overdose prevention measures for people who use NPS, despite the growing trend of NPS use and overdoses

20 According to the definition used in the mortality cohort studies in the referenced report, high risk drug use is injecting drug use or long-duration/ regular use of opioids, cocaine and/ or amphetamines.

attributed to it, especially in post-Soviet parts of the region.

There are still no drug consumption rooms (DCRs) in the region, although the first harm reduction site that allows drug use on its premises[21] was opened in Sumy, Ukraine, in 2019 with support from the local government. Civil society organisations continue to advocate for DCRs in Czechia, Estonia, Moldova, Poland and Slovenia.

2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

According to the 2020 UNAIDS report, 48% of all new HIV infections in Eurasia were attributed to injecting drug use, which is a 9% rise compared to 2018. However, transmission patterns vary from country to country.[91] Despite significant investments from external donors such as the Global Fund, 79% of the new cases in the WHO European Region were diagnosed in the East, which includes both Eastern Europe and Central Asia, and 77% of new cases in EECA region were registered in Russia.[92] HIV is concentrated among key populations, including men who have sex with men, people who use drugs, sex workers, and transgender people.[92] There are ten countries where HIV prevalence among people who inject drugs exceeds 10%: Moldova (29.1%), Poland (21.2%), Romania (15.6%), Lithuania (12.5%), Kyrgyzstan (14.2%), Estonia (51.4%), Ukraine (22.6%), Russia (up to 75.2%), Belarus (30.8%), Tajikistan (12.1%).[22]

In the majority of countries in the region, harm reduction services are part of the national HIV programme and mainly include services related to HIV prevention, access to HIV testing and referral to antiretroviral therapy (ART) for people who use drugs. ART is not included in harm reduction services even though the HIV prevention cascade[23] for people who use drugs is far from reaching the UNAIDS 90-90-90 targets.[93] Among the barriers to initiating treatment are centralised health systems, criminalisation of HIV transmission, and the lack of services responding to the specific needs of key population groups. In Russia, the country with the fastest growing HIV epidemic, one third of patients do not initiate treatment.[94]

In Eastern Europe and Central Asia in 2019, 70% of people living with HIV do not know their status, 44% of those who do know their status are on treatment and only 41% are virally suppressed. Aside from challenges to documenting the HIV care cascade in any population, there are several challenges specific to key populations. Due to the fear of discrimination and stigmatisation, people do not disclose same-sex practices, injecting drug use or sex work in the context of HIV care services, and healthcare workers commonly fail to ask about these behaviours.[95] A few countries that have data on HIV testing and status awareness among people who use drugs show quite good coverage: Albania 50.8%, Armenia 58.8%, Azerbaijan 18.6%, Belarus 59.7%, Bulgaria 100%, Czechia 55.1%, Estonia 72.6%, Kazakhstan 77%, Latvia 88.8%, North Macedonia 37.4%, Poland 97.2%, Romania 62%, Serbia 98.8%, Ukraine 43.1%.[96] HIV rapid testing at harm reduction sites performed by medical personnel or assisted by social workers is available in Estonia, Latvia, Lithuania, Poland, Russia and Ukraine. In Ukraine, assisted self-testing is included in harm reduction service packages for all clients twice a year. In Poland, there is an HIV helpline that assists with home self-testing, receiving two hundred calls per week.

Coverage of HIV prevention programmes among people who use drugs varies in the region: Albania 77.9%, Armenia 38.1%, Belarus 67.1%, Kyrgyzstan 40.4%, Moldova 39%, North Macedonia 67%, Tajikistan 67.2%.[96] ART coverage among people who use drugs also varies in the region: Belarus 40.5%, Bosnia 1.9%, Estonia 90.6%, Lithuania 21.8%, Poland 46.2%, Romania 32%, Tajikistan 57.7%, Ukraine 37.9%.[96]

According to HIV Justice Worldwide, Eastern Europe and Central Asia are the regions with the second highest number of laws criminalising HIV exposure, non-disclosure and transmission. Of the 19 countries where such laws have been adopted, 18 are in the Eurasia region. Russia and Belarus have the highest number of criminal cases related to HIV. In Uzbekistan, a person living with HIV can be prosecuted regardless of whether his/her partner wants to initiate a criminal case. In addition, every person in Uzbekistan is obliged to get an HIV test before marriage and, in the event of a positive result, their future spouse is notified.

In 2019, a punishment was introduced in Tajikistan

21 The programme works in a legal grey area, as it is not recognised officially as a DCR.

22 See regional table.

23 The HIV treatment cascade is a model that outlines the steps of care that people living with HIV go through from initial diagnosis to achieving viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage.

for those who refuse to receive HIV therapy. In 2018, Tajikistan became one of the few countries (and the only one in the region) to whom the Committee on Elimination of all Forms of Discrimination Against Women issued a recommendation to decriminalise the transmission of HIV, and repeal government decrees that prohibit women living with HIV from obtaining a medical degree, adopting a child, or being a legal guardian.

During the COVID-19 pandemic, the Eurasian Women's Network on AIDS supported by the UN Population Fund started a project, ARThelp, to ensure access to ART for people who are stuck in other countries during quarantine. In less than two months, 82 people from 13 countries received help through this service. The project highlighted the issue of migrant workers living with HIV in the post-Soviet region and their access to health services.

To achieve the 90-90-90 target set by UNAIDS, urgent scaling up of the nine core harm reduction interventions as recommended by WHO is needed in the region.

2.6
HARM REDUCTION IN PRISONS

UNAIDS estimates that 56–90% of people who inject drugs globally will be incarcerated at some stage during their life,[97] while about one third of people in prisons worldwide are estimated to have used drugs at least once during incarceration.[61] Coverage of treatment interventions offered to people in prison in Eurasia varies considerably by country but can include detoxification, individual and group counselling, treatment in therapeutic communities and in special inpatient wards. Azerbaijan, Uzbekistan and Belarus have special prisons for people convicted of drug offences.

The scale of NSPs in prisons remains stable. As in 2018, NSPs operate in prisons in five of the 29 countries in the Eurasia region: Armenia, Kyrgyzstan, North Macedonia, Moldova, Tajikistan.

OAT in prisons is currently available in 21 countries: Albania, Armenia, Bosnia and Herzegovina, Bulgaria, Croatia, Czechia, Estonia, Georgia, Hungary, Kyrgyzstan, Latvia, Lithuania, North Macedonia, Moldova, Montenegro, Poland, Romania, Serbia, Slovenia, Tajikistan and Ukraine.[98] Although OAT is available in prisons, this doesn't mean that it is widely accessible. In many countries, the quality and accessibility of OAT in prisons remain low. In Ukraine, just 93 people in prison receive OAT, in Moldova 100, in Tajikistan 16, in Albania 93, in Bosnia and Herzegovina 50, and in Kyrgyzstan 338.

In Georgia and Hungary[99], OAT is available only for short detoxification but not for long term maintenance treatment.[100] There is a plan to expand OAT provision from one to five prisons (one of which is for women) in Ukraine in 2020,[101] and there is a separate section on the availability of OAT in prisons and detention centres in the country's Drug Policy Action Plan for 2019-2020.[102] In Lithuania, OAT is available only in prisons and only for people who were already in the programme, and OAT is absent in detention centres leading to treatment interruptions.[103] In Albania, Latvia, Montenegro and Serbia OAT cannot be initiated within the prison, but is available as a continuation of medication. As reported in 2018, OAT is prohibited in Russia, Turkmenistan and Uzbekistan, both in prisons and in the community.

A recent review from the European Monitoring Centre for Drugs and Drug Addiction identified new psychoactive substance use in prisons in nine countries in the region, with synthetic cannabinoids identified as the most commonly used NPS.[104] In Latvia, the use of synthetic opioids in prison has been linked to increases in overdoses, as well as injecting and syringe sharing.[104] A 2018 survey indicated that almost half of the people in prison in Czechia had used an illicit drug in the 12 months prior to imprisonment, with methamphetamine reported as the most commonly used drug (30 %), followed by cannabis (28 %) and MDMA/ecstasy (12 %).[19]

People who inject opioids are also most vulnerable to overdose upon release from prison, yet post-release naloxone is reportedly unavailable in the region. In Estonia, everyone who has been incarcerated for a drug offence can receive naloxone training before being released but has to request it. People usually do not use the services due to the fear of being denied parole if they show any interest in using drugs (which is criminalised) upon release.

HIV, hepatitis C and active tuberculosis infection are disproportionally higher among prison populations, particularly among those who inject drugs in prison. A review of available studies found that people who inject drugs in

prison had six times the prevalence of HIV and more than eight times the prevalence of hepatitis C compared with the non-injecting prison population.[61] HIV testing and treatment is available in prisons in all countries in Eurasia. Hepatitis C testing, treatment and care in the region's prisons is scarce, which is also the case outside prisons. Only Slovakia and Slovenia offer hepatitis C treatment in all prisons; in Hungary and Ukraine, and to some extent in Bulgaria, Georgia, Romania and Serbia, it is in less than half.[105] Civil society reports that in most countries, condoms in prisons are not available or available to only a limited extent.

Between August and October 2019, the European Network of People Who Use Drugs and the European Prison Litigation Network documented 107 cases of rights violations in Ukraine, Russia, Moldova and Georgia against people in prison who use drugs. Among these were 33 cases of people experiencing abstinence syndrome during interrogation and 12 who, in addition to experiencing abstinence syndrome, had also not been provided with any legal support.[106]

Despite the implementation of harm reduction services in many countries in the region, for the vast majority of countries the policy environment is dominated by punitive drug policies.

3. Policy developments for harm reduction

Twenty-five of 29 countries in Eurasia have national HIV or drug policies that include references to harm reduction. At least four countries (Albania, Czechia, Estonia, Slovenia) have harm reduction as one of the four main pillars of their national Drugs Strategy. Despite the implementation of harm reduction services in many countries in the region, for the vast majority of countries the policy environment is dominated by punitive drug policies focused on supply reduction and criminalisation. Within this policy environment, hostility towards harm reduction is common. Russia, Ukraine and Kazakhstan have recently introduced legislative initiatives aimed at strengthening measures to combat drug-related information and advocacy, particularly on the internet, and have toughened the liability for such information.[107] This raises concerns related to the possible risks to social programmes focused on working with people who use drugs, and NGOs implementing those programmes. In Belarus, there are new cases of lack of confidentiality and sharing of personal data of OAT clients related to violations of parental rights due to drug dependence/OAT programme client status.[108]

National legislation on drugs in the former Soviet states sets low thresholds for possession offences, leading to prison sentences that are disproportionate in length to the associated drug arrest. In Kyrgyzstan, the so-called liberalisation of drug laws led to increased fines for drug possession (more than 1g of heroin) starting from USD 2577.[24][109] Similarly in Ukraine, a new law came into force in July 2020 with a minimum fine of USD 2000. In 2018, every seventh person convicted in Ukraine (10,144 of 73,659 people convicted of criminal offences) was convicted of drug crimes. Of those, 8,513 people (84%), were convicted of crimes of simple possession for personal use and, of those, 6,482 (76%) were convicted for possession of narcotics in miniscule amounts that ranged from 0.005g to 1g of heroin. People who use drugs and especially people who live with drug dependence are vulnerable to discrimination, arbitrary arrest and ill treatment by police. When people with drug dependence are criminally prosecuted for possession of small amounts of drugs for personal use, this amounts to detention solely on the basis of drug use or drug dependence.

In Estonia, changes to the Code of Misdemeanour and the Penal Code in 2015 created the possibility of terminating misdemeanour proceedings, or offering alternatives to coercive sanctions instead, if the person

24 Average wage in Kyrgyzstan is 233 USD.

subject to proceedings is willing to participate in a social support programme. Following these changes, the SÜTIK programme (short for Sõltlaste ühiskonnastamine tugiisikute kaasamisel in Estonian) was introduced. SÜTIK is a social support service that was developed for people who use or are dependent on drugs and who have been diverted by the police or have approached the service voluntarily. The SÜTIK programme is based on the Law Enforcement Assisted Diversion (LEAD) programme originally initiated in Seattle, USA, in 2011. It primarily enables police officers to refer people who use drugs who have committed a drug-related offence to a support person, as an alternative to punishment. The SÜTIK programme is funded by Estonia's National Institute for Health Development, and the service is generally delivered by non-governmental harm reduction organisations. The target group is people aged 18 or older who use drugs, and have been arrested for using or possessing a small amount of drugs and have been referred to the programme by the police, or who have turned to the service of their own volition. The majority of support workers are peers.[110] Another programme in Estonia which offers alternatives to coercive punishment to people who use cannabis is called VALIK (Estonian for "choice"). It consists of up to five or six sessions with a psychologist, who decides if the person needs additional services or treatment.

4. Funding developments for harm reduction

The Eurasia region faces ever increasing gaps in funding for rights-based, quality harm reduction services, exacerbated by the transition from international to domestic funding. This has been especially true for the majority of Eurasian countries previously classified as low-income that have been reclassified to middle-income countries due to recent economic growth (except Tajikistan).[111]

In this context, governments respond differently and implement several scenarios following the withdrawal or absence of international support:[25]

- In some cases, the government steps up and begins covering NSP and OAT programmes including the procurement of OAT medication, harm reduction supplies and psychosocial support (for example in Ukraine, Georgia, Moldova).
- In other cases, the state supports the purchase of equipment, the cost of facilities and key staff but does not support peer involvement and psychosocial help. In order to support the integrated harm reduction service including psychosocial support, organisations have to submit the same project for several ministries (for example in Slovakia, Slovenia, Czechia).
- And in some other cases, the government covers the cost of facilities and the key staff but the purchase of medication and harm reduction equipment are covered from external funds (for example Kazakhstan, Belarus).

In Belarus, Kyrgyzstan, Moldova and Ukraine, harm reduction and HIV-related services are gradually moving from donor to state funding, mostly using public tenders and social contracting mechanisms. Despite commitment by governments to continue HIV prevention among key groups, this transition has significantly weakened community systems and interrupted services. Lack of political support for harm reduction, not only as an HIV prevention measure but as a social service, is one of the main obstacles to sustainable and sufficient funding for quality programmes.

Southeastern Europe is a region where the withdrawal of the Global Fund has led to the collapse of services in countries including Albania, Bosnia and Herzegovina, Bulgaria, Romania and Serbia . In 2019, EHRA published a case study on sustainability bridge funding in Bosnia and Herzegovina, Montenegro and Serbia as a safety net mechanism to respond to gaps in funding and mitigate

25 Country examples are provided based on interviews with national experts.

adverse effects of donor funding withdrawal.[112] In 2016, the Global Fund adopted a Sustainability, Transition and Co-Financing Policy[113] which now allows countries to plan for their disease response after the withdrawal of donor support. According to this policy, a country's status as "transitioning" will be defined at an early stage, giving a country time to plan and prepare for taking over the funding of services. The Global Fund "bridges" the impact of funding withdrawal by providing investment into the health system as part of the national grant to help a country to establish sustainable programmes and through providing a "transition grant." Some donor and civil society stakeholders believe that a special mechanism - which could be called the Sustainability Bridge Fund (SBF) - should be introduced to ensure that countries have the required capacity to maintain and scale up their response to end HIV, TB and malaria after they are no longer eligible for international funding. Additionally, it could also help mitigate the damage of failed transitions if and when they arise. In 2017, the Civil Society Sustainability Network (CSSN) issued an Info Note[114] suggesting the areas such an SBF could target. According to CSSN, the SBF should be complementary to the existing donor transition efforts and could also work as a mechanism for coordination and communication among relevant donors during and after the transition.

In Estonia, all harm reduction services are covered by the state. In Poland, a government decision to allocate funding to harm reduction from money accumulated from gambling taxation has reportedly led to an increase for both harm reduction and drug treatment in the country.[115] In Bulgaria, after extensive advocacy efforts in July 2019, the Ministry of Health signed a contract with a number of NGOs to cover services for people who use drugs, men who have sex with men, and sex workers. A year later, however, the contract was not extended and NGOs have been forced to close all the services and, as of September 2020, there is no working NSP in the country.[16] In Hungary, funding for harm reduction was cut due to political reasons. The largest harm reduction programmes closed down in 2014 and coverage is still very low.[99]

Available packages and quality of harm reduction services while transitioning from international to domestic funding are decreasing even if services are supported. In Ukraine, for example, the unit cost of NSP programmes has decreased from USD 46.40[116] in 2012, to less than USD 20[117] in 2020 per client per year which covers only two HIV tests, two TB screenings, nine consultations, 120 syringes, 120 alcohol swabs, 20 condoms and two lubricants. The rest of the services included in the standard[118] are covered by international donors or municipal budgets.

Funding (domestic and international) for HIV responses in eastern Europe and central Asia (excluding the Russian Federation) peaked in 2017, before declining by 14% between 2017 and 2019, leaving the region at just 56% of its 2020 resource target.[119] HIV response funding from domestic sources increased by 24% from 2010 to 2019, while contributions from the Global Fund and all other international sources decreased by 10%.[119] Although the data shows an increase in government HIV spending in all countries in Eurasia, the incidence of HIV continues to increase[120] due to lack of support for specific services for key populations. Repressive enforcement of drug laws, including harsh criminal penalties and the registration of people who use drugs who are convicted, force people away from public health services into hidden environments, increasing their risk-taking behaviours and heightening the chance of acquiring or transmitting HIV.[119] To address these challenges, a multi-country three-year project - "Sustainability of services for key populations in the Eastern Europe and Central Asia region" (2019-2021)[121] - was financed by the Global Fund to the maximum extent possible: USD 13 million, with a focus on 14 countries and 25 cities in the region. In addition, the Elton John AIDS Foundation and Gilead Sciences have partnered together on the RADIAN[122] initiative. In 2019, they presented the 'Model Cities' and 'Unmet Need' funds.[26]

In order to help ensure the sustainable development of civil society organisations that provide harm reduction and other services for key population groups, EHRA gathered 20 case studies of alternatives to donor or government funding opportunities in 2019.[123]

26 The 'Model Cities' fund will provide funding for non-profit, academic and research organisations from 2020-2025, to deliver measurable impact in the fight against HIV/AIDS in key EECA cities and regions (Chelyabinsk Oblast, Irkutsk Oblast, Kemerovo Oblast, Krasnoyarsk Krai, Leningrad Oblast - not including City of St Petersburg, Novosibirsk Oblast, Orenburg Oblast, Perm Krai, Samara Oblast, Sverdlovsk Oblast, Tomsk Oblast, Tyumen Oblast). The 'Unmet Need' fund is supporting projects across Eastern Europe and Central Asia, focusing on HIV/AIDS-related prevention and care, education, community empowerment, and novel partnerships.[122]

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