



GLOBAL DRUG POLICY AND THE HIV/IDU EPIDEMIC IN EASTERN EUROPE AND CENTRAL ASIA

***The critical need to scale up
opioid substitution therapy***

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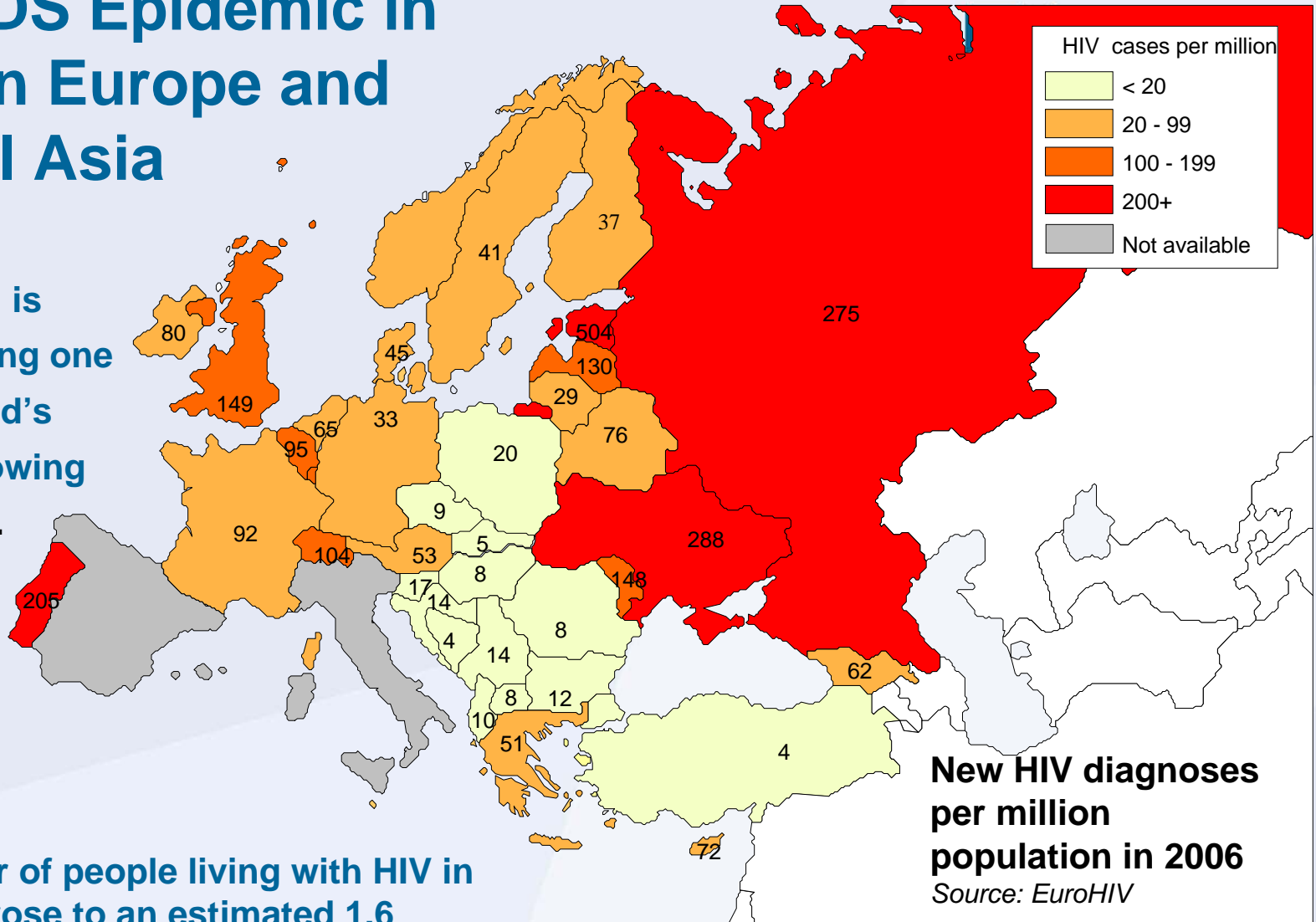
Outline of Presentation

- 1. Status of HIV and Injecting Drug Use in Eastern Europe and Central Asia**
- 2. International Drug Policy and The HIV Epidemic**
- 3. Challenges and barriers to scaling up Opioid Substitution Therapy**
- 4. AIDS 2010 in Vienna – opportunities for advancing the response**

HIV/AIDS Epidemic in Eastern Europe and Central Asia

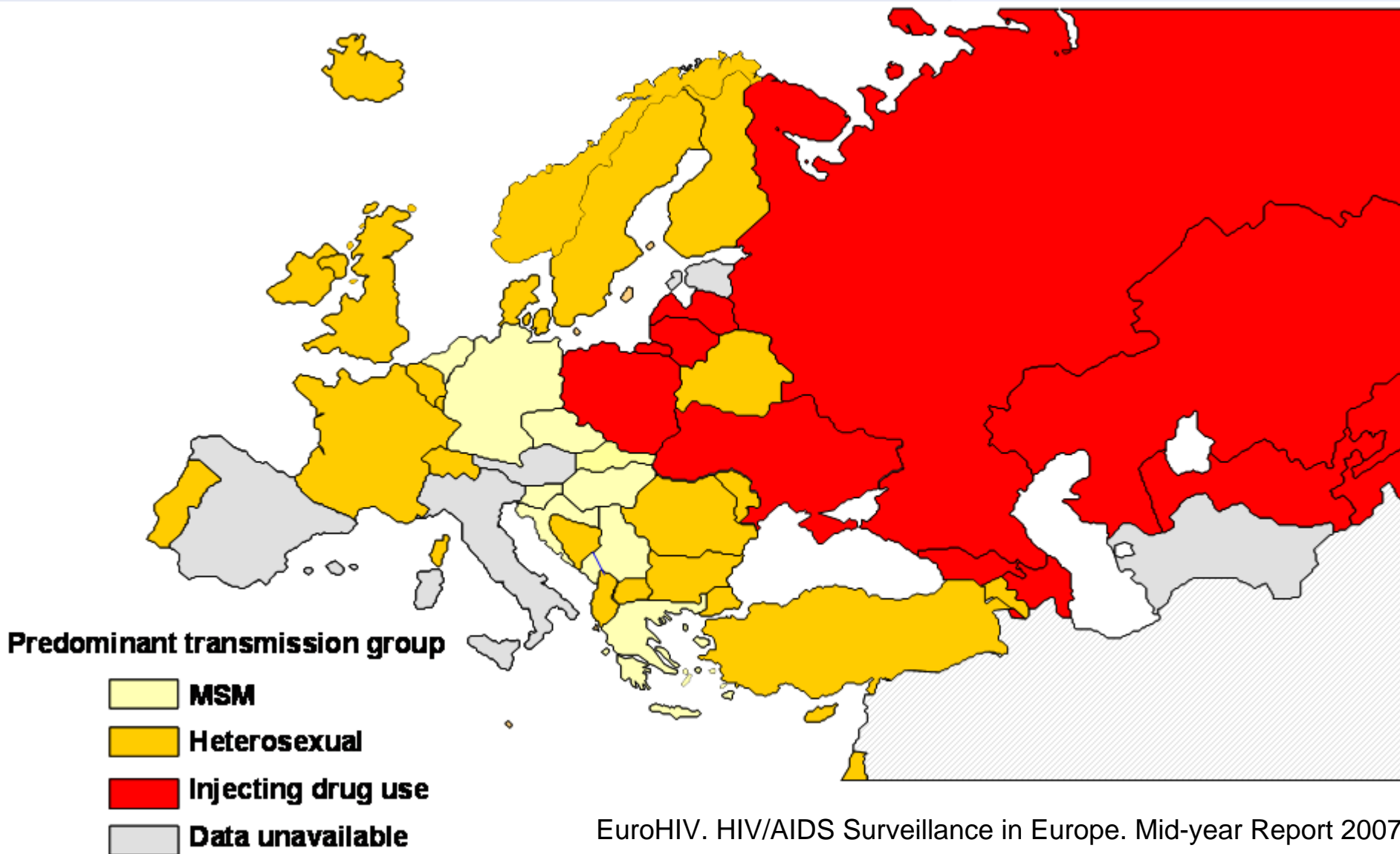
The region is experiencing one of the world's fastest-growing epidemics.

The number of people living with HIV in the region rose to an estimated 1.6 million in 2007, with an estimated 150,000 new HIV infections.
 Source: UNAIDS, 2008



New HIV diagnoses per million population in 2006
 Source: EuroHIV

Main Modes of HIV Transmission in Europe and Central Asia



Estimated number of IDU per Region

Source: Mathers *et al.*, The Lancet, 2008, 372:1733



	Estimated number of people who inject drugs			Estimated number of people who inject drugs and who are HIV positive		
	Lower	Mid	Upper	Lower	Mid	Upper
Eastern Europe	2 540 000	3 476 500	4 543 500	18 500	940 000	2 422 000
Western Europe	816 000	1 044 000	1 299 000	39 000	114 000	210 500
East and southeast Asia	3 043 500	3 957 500	4 913 000	313 000	661 000	1 251 500
South Asia	434 000	569 500	726 500	34 500	74 500	135 500
Central Asia	182 500	247 500	321 000	16 500	29 000	47 000
Caribbean	137 500	186 000	241 500	6 000	24 000	52 500
Latin America	1 508 000	2 018 000	2 597 500	181 500	580 500	1 175 500
Canada and USA	1 604 500	2 270 500	3 140 000	127 000	347 000	709 000
Pacific Island states and territories	14 500	19 500	25 000	<250	500	500
Australia and New Zealand	105 000	173 500	236 500	500	2500	6000
Middle East and north Africa	89 000	121 000	156 500	1500	3500	6500
Sub-Saharan Africa*	534 500	1 778 500	3 022 500	26 000	221 000	572 000
Extrapolated global estimates	11 008 500	15 861 500	21 222 000	764 000	2 997 500	6 589 000

What is Harm Reduction?

A comprehensive package of evidence-based interventions that aim to reduce harm associated with drug use

► **emphasis on public health indicators and human rights**

1. Needle and syringe programmes (NSP)
2. **Opioid Substitution Therapy (OST)**
3. Voluntary Counseling and Testing (VCT)
4. Antiretroviral treatment (ART)
5. STI prevention and treatment
6. Condom programming
7. Targeted Information, Education and Communication (IEC)
8. Vaccination, diagnosis/tx of hepatitis
9. Diagnosis and treatment of TB



Photo: Hans Jürgen Burkard

Evidence 1: Impact of OST on Treatment of Opioid Drug Dependence



Regular use of OST is associated with reduction in harm associated with drug use including -

- Reduction in overall mortality and risk of overdose
- Retention in treatment over time
- Significant reduction in illicit drug use
- Improved general physical and mental health
- Improved social functioning; reintegration into workforce and education system
- Significant reduction in criminal activity
- Financial net savings in health care and criminal justice systems
- Reduction in complications for pregnant women and unborn children

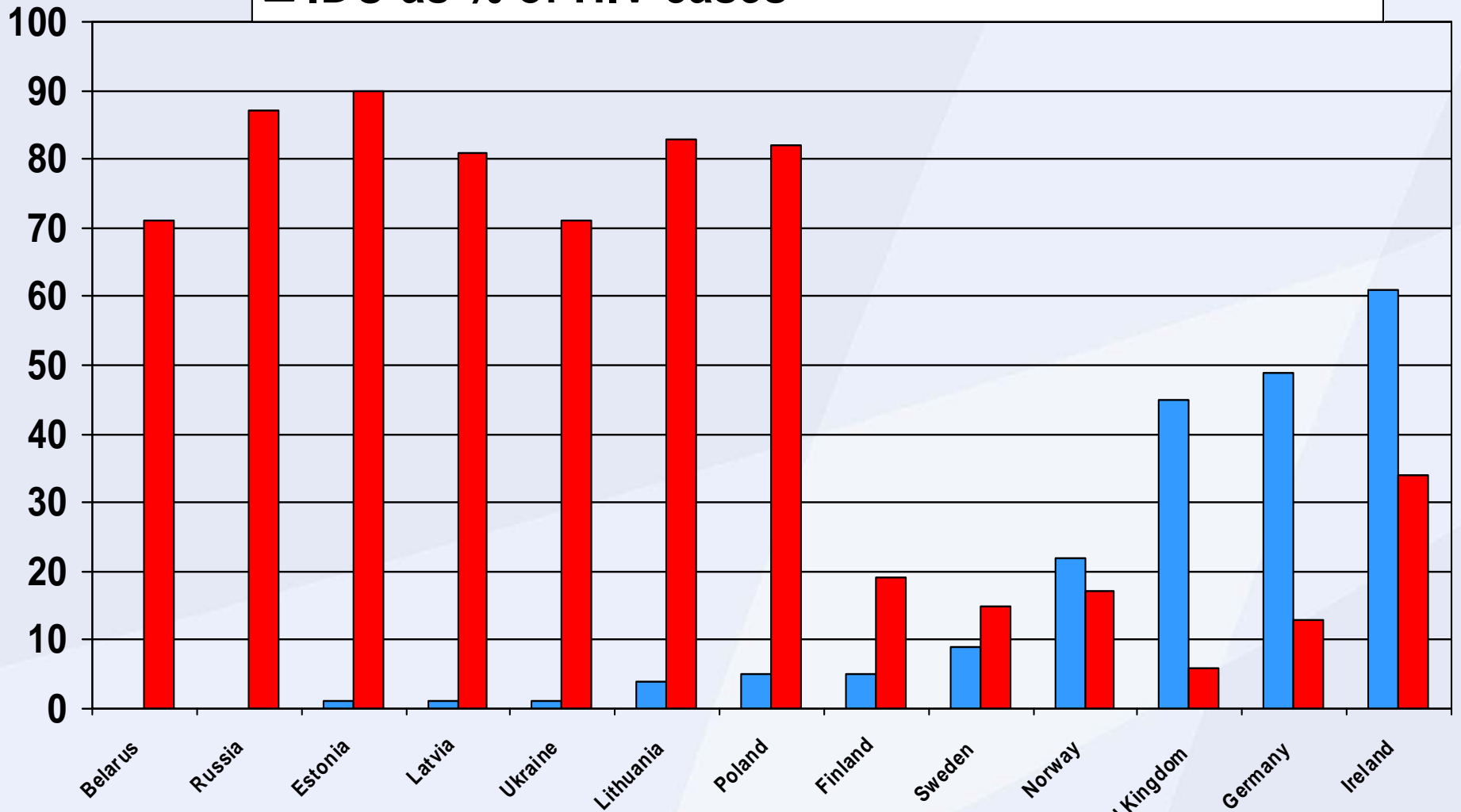
Evidence 2: Impact of OST on HIV Prevention, Treatment and Care



Regular use of OST has been demonstrated to

- Reduce sero-conversion and HIV prevalence
- Reduce risk for HIV transmission and infection
- Reduce both the proportion of IDUs who inject and the frequency of injection
- Slow long-term progression of HIV disease
- Increase adherence to antiretroviral therapy
- Promote right to highest attainable standard of health
- Provide opportunities for contact with / and increase access to health and social support systems – without OST, IDUs are more likely to get tested late and receive care late

■ Substitution treatment coverage (% IDUs treated)
■ IDU as % of HIV cases

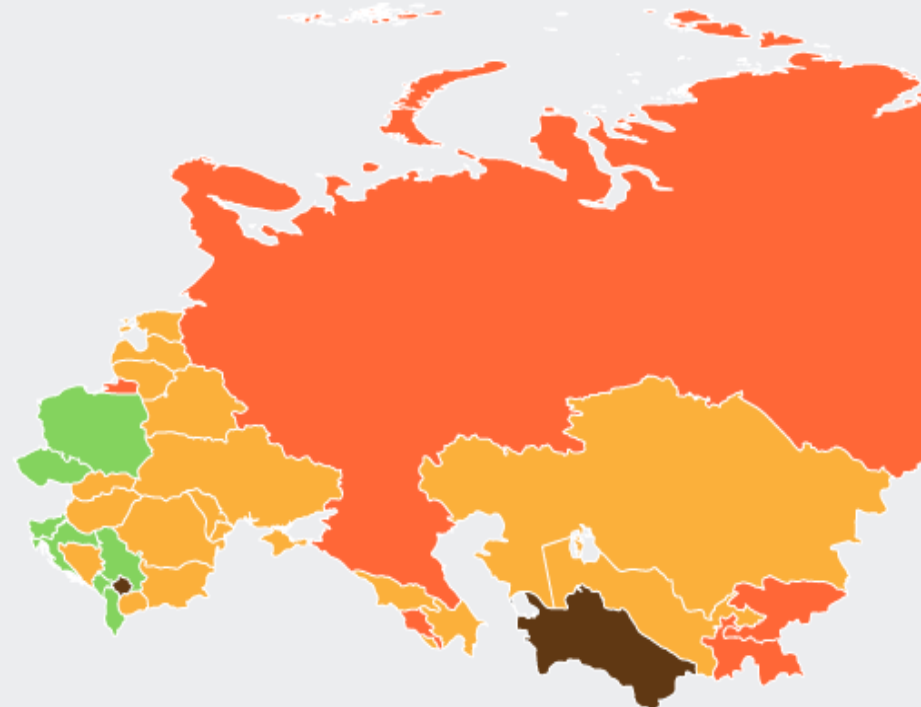


Access to Opioid Substitution Therapy

Country	NSP available*	OST available*	Drug consumption rooms*	NSP in prisons*	OST in prisons*
Albania	✓	✓	✗	✗	✓
Armenia	✓	✗	✗	✓	✗
Azerbaijan	✓	✓	✗	✗	✗
Belarus	✓	✓	✗	✗	✗
Bosnia & Herzegovina	✓	✓	✗	✗	✗
Bulgaria	✓	✓	✗	✗	✗
Croatia	✓	✓	✗	✗	✓
Czech Republic	✓	✓	✗	✗	✓
Estonia	✓	✓	✗	✗	✗
Georgia	✓	✓	✗	✗	✓
Hungary	✓	✓	✗	✗	✗
Kazakhstan	✓	✓	✗	✗	✗
Kosovo	✗	✗	✗	✗	✗
Kyrgyzstan	✓	✓	✗	✓	✗
Latvia	✓	✓	✗	✗	✗
Lithuania	✓	✓	✗	✗	✗
FYR of Macedonia	✓	✓	✗	✗	✓
Moldova	✓	✓	✗	✓	✓
Montenegro	✓	✓	✗	✗	✓
Poland	✓	✓	✗	✗	✓
Romania	✓	✓	✗	✓	✓
Russian Federation	✓	✗	✗	✗	✗
Serbia	✓	✓	✗	✗	✓
Slovakia	✓	✓	✗	✗	✗
Slovenia	✓	✓	✗	✗	✓
Tajikistan	✓	✗	✗	✗	✗
Turkmenistan	✗	✗	✗	✗	✗
Ukraine	✓	✓	✗	✗	✗
Uzbekistan	✓	✓	✗	✗	✗

HARM REDUCTION PROGRAMMES

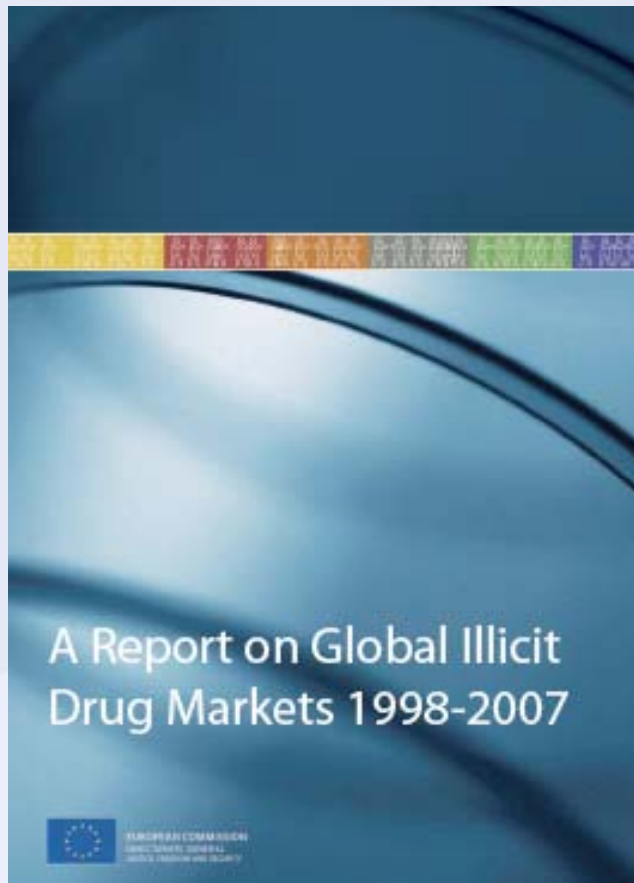
-  NSP and OST available
-  NSP available
-  OST available
-  Neither available



*International Harm Reduction Association (March 2009) [Harm Reduction Policy and Practice Worldwide: An overview of national support for harm reduction in policy and practice](#)

A Decade of Neglect: EU Report on Global Illicit Drug Use

The 'war on drugs'?



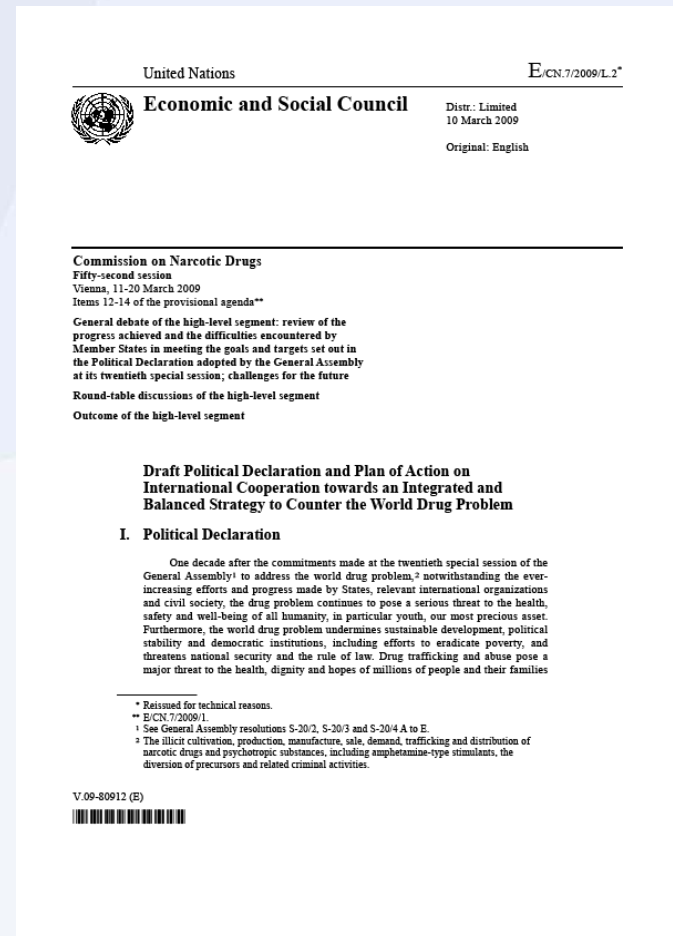
- no evidence that the global drug problem was reduced during the period from 1998 to 2007
- the threat from illicit drug trafficking is increasing in regions where poverty, conflict, a lack of security, poor health and socio-economic deprivation prevails
- the world drugs situation became more complex; despite tougher sentencing of the sellers and users of cocaine and heroin; in some countries there is no evidence that drugs are more difficult to obtain

Political Declaration, 52nd Commission on Narcotic Drugs, March 2009 –



The central policy making body of the United Nations in drug related matters

- UN has dual drug control obligations: to ensure adequate availability of controlled medicines for medical and scientific purposes, while preventing illicit trafficking in and use of such drugs.
- Drug control laws, policies, and practices in many countries directly interfere with harm reduction including opioid substitution therapy and other HIV services for people who use drugs



Political Declaration, 52nd CND – Deliberations on Harm Reduction



- **The scientific debate on whether harm reduction is effective is at an end; UNAIDS, WHO and UNODC endorse harm reduction; over 80 UN Member States from all regions of the world have introduced these measures.**
- **However, while there is reference to the link between drug misuse and HIV (paragraph 20), there is no explicit reference to harm reduction anywhere in the Political Declaration.**
- **A group of 26 countries led by Germany, including Switzerland - called for inclusion of harm reduction measures in the interpretation of language of the Political Declaration.**
- **However, counter-statements from countries such as The Russian Federation, Colombia, Cuba and Japan opposed any reference to harm reduction in the Political Declaration and outcomes documents.**

How does the Commission on Narcotic Drugs affect the HIV response?

The political debate continues resulting in –

- ▶▶ **Lack of ‘system-wide coherence’ on harm reduction between UN policies, strategies and organizations**
- ▶▶ **Millions of vulnerable people with opioid drug dependence are denied access to life saving opioid substitution therapy (methadone and buprenorphine)**
- ▶▶ **Millions more are denied access to controlled medicines for pain relief and palliative care**

Despite overwhelming evidence – *OST in Selected Countries of EECA**

As of 2007, less than 2% of IDUs in EECA were accessing OST

Country	Year Introduced	On OST '08	Estimated IDUs**
Lithuania	1995	410 in 14 Centers	8,500
Kyrgyzstan	2002	735 in 7 Centers	44,398
Georgia	2005	250 in 3 Centers	12,420
Belarus	2007	50 in 1 Center	45,842
Ukraine	2004	1956	400,000

OST is illegal in the Russian Federation (with over 2 million IDUs)

Kazakhstan introduced OST in 2009 (2 Pilot Projects)

****IAS Commissioned Report from Eurasian Harm Reduction Network, 2008***

*****Source: IHRD; Harm Reduction Developments, 2008***

Challenges and Barriers to Access - 1

- **Perpetual ‘pilot phase’** – limited number of clinics, long waiting lists, inability to administer take home doses
- **Health systems constraints** - irregular supply, treatment interruptions, health care worker shortages and regulation of licensing addiction specialists
- **Cost of drugs** – up to 10 times more for buprenorphine; transportation under armed escort drives up costs of drugs
- **Standard of treatment:** disparities between regional and international standards; require multiple specialists to authorize treatment; age limitations;

PUBLIC HEALTH FACT SHEET

Barriers to Access: Medication-Assisted Treatment and Injection-Driven HIV Epidemics

In July 2005, the World Health Organization added methadone and buprenorphine to its Model List of Essential Medicines.¹ Methadone and buprenorphine are two of the best studied and most effective treatments for opiate addiction. Regular use of these medications, sometimes referred to as medication-assisted or substitution treatment, has been associated with decreased injecting drug use,² decreased criminal activity,³ increased retention in treatment for chemical dependence,⁴ increased adherence to HIV medication,⁵ improved family relations,⁶ and successful return to employment.⁷

Available in developed countries
In developed countries, medication-assisted treatment is a standard option for people who are dependent on opiates, with more than 800,000 patients prescribed buprenorphine or methadone as of 2005: 237,000 patients in the United States,⁸ an estimated 310,000 patients in Western Europe,⁹ 39,000 patients in Australia,¹⁰ and 4,000 in New Zealand.¹¹ Many European countries facing growing HIV epidemics among injecting drug users (IDUs) have rapidly scaled up treatment. Germany, for example, legalized methadone treatment in 1987; by 2005, the country had about 60,000 patients on treatment. In Thailand, 85,000 people had received buprenorphine treatment as of November 2006, with medication prescribed by general practitioners and available in pharmacies.¹²

Inaccessible in developing countries
In developing and transitional countries with injection-driven HIV epidemics, methadone and buprenorphine remain largely unavailable or inaccessible. With injection drug use accounting for over greater numbers of HIV infections—UNAIDS estimates that nearly one-third of new infections outside Africa are among IDUs—the implications of failure to provide treatment are striking. As of 2007, less than a percent of IDUs in countries with injection-driven HIV epidemics were accessing methadone or buprenorphine treatment in government clinics.¹³ The greatest share of patients were in China, where 320 clinics provided services to 36,000 people as of March 2007,¹⁴ and in Iran, where about 60,000 people received methadone and between 5,000-8,000 received buprenorphine through government clinics or private physicians.¹⁵ In Eastern Europe and Central Asia, access to methadone or buprenorphine is similarly low, but less than a percent of estimated IDUs receive treatment. Some progress is being made, however: The Global Fund to Fight AIDS, Tuberculosis and Malaria has supported methadone or buprenorphine treatment take-up or pilot projects in countries with injection-driven epidemics, including Azerbaijan, Belarus, China, Estonia, Georgia, Indonesia, Kyrgyzstan, Moldova, Ukraine, and Uzbekistan. China, Iran, Malaysia, and Ukraine all plan to increase the scale of methadone or buprenorphine programs sharply in the coming years, while other countries—including Vietnam,

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International Harm Reduction Development Program (IHRD)

Challenges and Barriers - 2



Photo: Hans Jürgen Burkard

- **Harsh drug control policies and police harassment:** interfere with recruitment and retention in OST and HIV treatment; no OST in prisons and detention centers; forced labor
- **Stigma against drug use is very high** - limited public support for OST from policy makers, law enforcement, media and even the medical community
- **Lack of trust in the scientific evidence on OST;** limited - knowledge amongst scientific community; operations research on program effectiveness; research to define demand and to generate evidence from within the region

AIDS 2010 in Vienna as a bridge to Eastern Europe and Central Asia.



Presents New Opportunities to –

- ▶ **Promote scientific evidence supporting** removal of legal and regulatory barriers against expanding harm reduction and OST.
- ▶ **Promote efforts to destigmatize drug dependence** and recognize it as a chronic relapsing illness with serious public health consequences
- ▶ **Mobilize high-level support:** engage EU & EECA governments; parliamentarians; civil society, and health professionals



Creating opportunities through AIDS 2010 in Vienna



- **Regional representatives on the Conference Organizing Committee**
- **Translation of all sessions into Russian**
- **Non-abstract driven sessions on priority issues affecting Eastern Europe and Central Asia**
- **Strategies to mobilize participation from Eastern Europe, including scholarships**
- **Support to research and documentation to generate much needed evidence from within the region**

See you In Vienna ! www.aids2010.org