

# 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. 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, decreased criminal activity, increased retention in treatment for chemical dependence, increased adherence to HIV medication, improved family relations, and successful return to employment.

## *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, an estimated 530,000 patients in Western Europe, 39,000 patients in Australia, and 4,000 in New Zealand. 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 France, 85,000 people had received buprenorphine treatment as of November 2006, with medication prescribed by general practitioners and available in pharmacies.

## *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 ever 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 2 percent of IDUs in countries with injection-driven HIV epidemics were accessing methadone or buprenorphine treatment in government clinics. The greatest share of patients were in China, where 320 clinics provided services to 36,000 people as of March 2007, and in Iran, where about 60,000 people received methadone and between 5,000-8,000 received buprenorphine through government clinics or private physicians.

In Eastern Europe and Central Asia, access to methadone or buprenorphine is similarly low; less than 2 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 scale-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, Kazakhstan, and Tajikistan—have received grants from international donors and pledged to start pilot projects.



## **BARRIERS TO MEDICATION-ASSISTED TREATMENT**

Even in countries where methadone and buprenorphine are technically available, access to treatment for patients in need is limited by many factors, including the high costs and low supply of medication, restrictive entry criteria for treatment programs, and lack of government commitment to scale up pilot projects.

### **High Costs and Low Supply**

#### ***Costs of medication***

Prices for buprenorphine and methadone vary widely around the world, and in some cases differ within countries depending on supplier, import fees, and local health care regulations and practice. In China, for example, where methadone is locally manufactured, the price of an average dose of the medication to patients varies between 5–10 Yuan a day (US\$0.66–1.30). Iran makes methadone available for approximately US\$0.25 for 100 milligrams, and generic buprenorphine for US\$1.30 for 8 milligrams. In other countries with injection-driven epidemics, governments pay higher prices for medication by agreement with pharmaceutical manufacturers. In Indonesia, for example, an average dose of methadone costs between US\$0.54 and US\$1.62, depending on location. Governments have occasionally exercised their ability to renegotiate the pricing structure; in Malaysia, the price of methadone started at US\$10 for 40 milligrams, but government negotiations with suppliers brought the price down to approximately US\$0.80 per 40 milligrams in 2007.

Methadone is generally cheaper than buprenorphine. In Ukraine, for example, methadone had not been dispensed as of December 2007, but government plans called for treatment with the medication at a price of approximately US\$9 per patient per month. Buprenorphine has been available since 2005 and as of late 2007 was prescribed to approximately 500 patients, but at about 10 times the cost expected for methadone.

Health care providers sometimes find other ways to pass costs on to patients. In Azerbaijan, for example, informal reports indicate that people are being asked to pay costs as high as US\$500 for treatment that was meant to be free. In Georgia, where only 225 patients had access to free treatment in 2007, the government is considering opening fee-for-service clinics where treatment would cost around 150 GEL (US\$95) per month. At more than half the average monthly salary, these fees would be prohibitive.

#### ***Irregular supply and treatment interruptions***

Supply interruptions, or the threat of them, have resulted in discontinuation of treatment or sudden reductions in dosages. In Simferopol, Ukraine, in late April 2007, clients reportedly received their doses “only every other day” for about two weeks. In Azerbaijan, methadone treatment was discontinued in 2005 when clinics did not receive new supplies. In Kyrgyzstan, patients had their methadone doses sharply reduced or were urged to stop treatment in 2005 due to delays in procurement and distribution.

#### ***Difficulties with law enforcement and police harassment***

The costs of receiving methadone or buprenorphine treatment often include harassment from law enforcement. In Kyrgyzstan, police have stationed themselves outside methadone clinics, often arresting patients or threatening to plant drugs on them unless they pay bribes. In Odessa, Ukraine, buprenorphine patients report that police officers regularly extort money and threaten to plant drugs on them. Although the Malaysian government endorsed the establishment of methadone treatment programs in 2005, laws and policies criminalizing drug users result in police raids and arrests at methadone programs. Methadone patients undergoing treatment in community clinics have their names added to the government registries of drug users. In Indonesia, organizations report that police are not well informed about methadone treatment’s legality and do not know that they are forbidden to make arrests in the clinic area; as a result, some patients report that they have become targets for the police because they use other drugs in addition to methadone.

### **Entry Requirements and Restrictions**

#### ***Waiting lists***

Injecting drug users are often discouraged from entering treatment programs because of long waiting lists. In Ukraine, 300 people are reportedly on waiting lists. In Poland, the number of people receiving treatment has not risen above 1,000, or 2.5 percent of estimated IDUs, since treatment began in 1992. Waiting lists in several cities in Poland are over 500 names long—greater than the number of those on treatment. Waiting lists are also reported in Georgia, Indonesia, Kyrgyzstan, and Malaysia.

#### ***Limited number of clinics and lack of take-home doses***

While the United States and Western European countries allow buprenorphine provision through pharmacies and

“take home” methadone doses for stable patients, these are prohibited in most countries of Eastern Europe and Central Asia. In Ukraine, participants are generally required to visit an AIDS center or narcological dispensary every day to receive their dose of buprenorphine, and to go without on Sunday when centers are closed. In Simferopol, the AIDS center is the only facility offering buprenorphine in the entire region, which means some patients must travel several hours each day to the center from cities such as Yalta and Sevastopol. Patients are only allowed to receive medication at the clinic near their permanent residence, making travel effectively impossible.

### **Unavailable at hospitals**

In China, methadone is largely unavailable at hospitals, meaning that patients must sacrifice one form of lifesaving care to receive another. In Ukraine, maternity hospitals frequently do not offer methadone or buprenorphine, forcing pregnant women to risk painful withdrawal and risk to the fetus when in labor.

### **Age requirements or history of multiple documented attempts at abstinence**

In Ukraine, patients must be at least 18 years old, and have tried to quit illicit drug use at least three times through rehabilitation or detoxification programs. In Georgia, patients must be over the age of 25; be drug users for more than three years; be injecting for at least one year; and be able to document an unsuccessful treatment in a licensed institution. Some clinics also expel patients who test positive for drug use while enrolled in treatment, though this problem can frequently be addressed by adjusting the dose of medicine.

While programs often allow fast-track entry for certain applicants—such as those with HIV, TB, cancer, diabetes, and mental disorders, or for pregnant women—general restrictions and the need to produce documentation frequently delay treatment for IDUs.

### **Review by commission**

Many countries, including Azerbaijan, Estonia, Georgia, Kyrgyzstan, Moldova, Poland, and Ukraine, require that patient cases be reviewed by commissions of as many as six members prior to entry into treatment.

In Estonia, two psychiatrists must determine a person's eligibility. Latvia and Lithuania require that commissions review patient eligibility; the Lithuanian commission is established by the chief doctor of the hospital. In Moldova, a commission of six people in the National Narcological Dispensary reviews an application. In Kyrgyzstan, the commission requires two years

of drug use, several unsuccessful treatment attempts, opioid dependence complications, associated diseases, or pregnancy, as well as individual indications “deemed significant.”

In Georgia, a supervisory council of the Ministry of Health, Labor and Social Affairs reviews the cases of IDUs who do not meet the entry requirements for a methadone program. This council is composed of ministry representatives, several doctors from the Institute of Narcology, and one NGO representative; until recently, it also included a journalist.

### **Police control of entry**

Changes to the protocol for entry into treatment are crucial to the scale-up of methadone and buprenorphine programs. In China, where expansion of methadone treatment has been widely praised, officials used to require that patients undergo up to a year of detention in compulsory detoxification facilities or forced labor camps prior to entry into a methadone program. Police often held the right to grant or deny admission. In July 2006, China relaxed these requirements, though some clinics still impose them. Current guidelines indicate four conditions for entry into the program: patients must pass multiple times through drug treatment; must be over the age of 20; must be residents of the county, city, or district of the organization providing the treatment, or have a temporary residence permit; and must exhibit “civilized behavior.” The age limit is waived if the individual is HIV positive. Enrollment as a methadone patient requires that the patient's name be added to the government registry of people who use illegal drugs. Being listed on the registry makes one liable to be handcuffed and taken to the police station to undergo forced urine testing, even in the absence of illicit use, when using a government-issued ID to do such things as check into a hotel or file a household registration.

### **HIV positive status requirement**

Some countries, including Ukraine and Uzbekistan, began medication-assisted treatment with restrictions limiting the number of those who are not HIV-infected who can receive treatment. Such a requirement effectively provides an incentive for HIV infection while denying treatment to those at risk.

### **Perpetual Pilot Status**

Many methadone and buprenorphine treatment programs suffer “death by pilot,” when a program remains

restricted in scale for years while government authorities evaluate its viability. Belarus began a pilot program for medication-assisted treatment in 2005 but the first patient did not receive treatment until 2007, despite the Global Fund's willingness to pay for the costs of the medication. In Poland, only about 1,000 people receive methadone treatment 16 years after methadone was introduced. In Kyrgyzstan, six years after methadone prescription began, fewer than 200 people received treatment as of June 2007. Expansion to four additional clinics was achieved by year's end.

## MEDICATION-ASSISTED TREATMENT IN PRISON

The World Health Organization's "Guidelines on HIV and AIDS in Prisons" recommend that prisoners on methadone maintenance prior to imprisonment should be able to continue this treatment while in prison. Unfortunately, in Eastern Europe and Asia, such treatment remains largely unavailable to those incarcerated. Among developing and transitional countries where the largest share of HIV cases are among IDUs, Indonesia, Iran, and Moldova alone allowed

patients to begin medication-assisted treatment in prison in 2007, while Poland offered short-term treatment only to patients who were on medication prior to incarceration. As of mid-2007, 22 prisoners received methadone in Moldova but were required to taper their dosage after six months, which caused many of the prisoners to experience symptoms of withdrawal. In Indonesia, methadone was available to 33 prisoners as of June 2006.

Iran, where methadone treatment became available in prisons in 2003, is a notable exception. Methadone treatment in prison is part of a larger package of HIV prevention interventions provided through "triangular clinics." The clinics focus on three priority areas: addressing IDUs through a harm reduction approach, treating sexually transmitted infections, and providing care and support for people living with HIV/AIDS. At the end of 2006, there were 55 triangular clinics in prisons, covering 33 percent of all prisoners, in addition to another 34 clinics in after-care centers outside of prisons. As of January 2007 the triangular clinics provided methadone maintenance therapy to 55 percent of prisoners in need, with plans to cover 80–99 percent by 2008. The clinics also provide needle and syringe exchange to prisoners and a few are providing antiretroviral therapy.

Experience has shown that methadone and buprenorphine are powerful tools for treating drug addiction, increasing access to HIV prevention and treatment, and improving the quality of life for individuals, families, and communities. Yet countless people continue to suffer because of delays in provision of these life-saving medications and a lack of large-scale, accessible treatment programs. For millions of opiate users in developing and transitional countries, increased commitment to treatment availability will mean a new chance for improved health, function, and social participation.

For more information and a footnoted version of this fact sheet, go to [www.soros.org/harm-reduction](http://www.soros.org/harm-reduction)

### International Harm Reduction Development Program (IHRD)

Founded in 1995, the International Harm Reduction Development Program (IHRD) of the Open Society Institute (OSI) works to reduce HIV and other harms related to injecting drug use, and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. IHRD, which has supported more than 200 harm reduction service organizations in Central and Eastern Europe, the former Soviet Union, and Asia, bases its activities on the understanding that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability and quality of needle exchange, drug treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the opportunities for political engagement by people who use drugs and who are living with HIV.