

Harm Reduction Developments | 2008

Countries with Injection-Driven HIV Epidemics



International Harm Reduction Development Program (IHRD)



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HARM REDUCTION DEVELOPMENTS 2008

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International Harm Reduction Development Program (IHRD)



www.soros.org/harm-reduction

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List of Acronyms

AFEW	AIDS Foundation East-West
AHRN	Asian Harm Reduction Network
ARHP	Asia Regional HIV/AIDS Project
ARV	antiretroviral therapy for HIV
AusAID	Australian Agency for International Development
CARHAP	Central Asia Regional HIV and AIDS Program
CEE/FSU	Central and Eastern Europe and the former Soviet Union
CEEHRN	Central and Eastern European Harm Reduction Network
CHALN	Canadian HIV/AIDS Legal Network
CIDA	Canadian International Development Agency
CND	Commission on Narcotic Drugs (United Nations)
DFID	Department for International Development (United Kingdom)
EATG	European AIDS Treatment Group
EU	European Union
GONGO	government-organized nongovernmental organization
GTZ	German Agency for Technical Cooperation
ICRC	International Committee of the Red Cross
IDU	injecting drug user
IHRD	International Harm Reduction Development Program (OSI)
IOM	Institute of Medicine (United States)
INCB	International Narcotics Control Board
INPUD	International Network of People who Use Drugs
MMT	methadone maintenance treatment
NGO	nongovernmental organization
OSI	Open Society Institute
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PLWHA	people living with HIV/AIDS
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WHO	World Health Organization

Sources

Information contained here was obtained from a variety of sources, including progress reports to the Global Fund to Fight AIDS, Tuberculosis and Malaria (available online at www.theglobalfund.org); the United Nations Office on Drugs and Crime (UNODC); the Joint United Nations Program on HIV/AIDS (UNAIDS); national AIDS and narcological centers; national prison authorities; peer-reviewed literature; media reports; and in-country correspondents contacted directly by the Open Society Institute.

Numbers of injecting drug users (IDUs) are midpoint estimates prepared for the United Nations Reference Group on HIV and Injecting Drug Use, as reported in: “Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution.” 2006. *Sexually Transmitted Infections* 82, iii 10-17.

Population estimates are taken from World Population Prospects: The 2006 Revision Population Database. United Nations Department of Economic and Social Affairs, Population Division.

Data on HIV infection and IDUs in prisons come from national prison authorities, UNODC’s HIV/AIDS unit, and research presented in: Dolan K, B Kite,

E Black, C Aceijas, and GV Stimson. 2007. “HIV in prison in low-income and middle-income countries.” *The Lancet Infectious Diseases* 7, 32-41. Some Ukraine data come from Ralf Jurgens’ presentation at the March 2007 Second Ukrainian Harm Reduction Conference in Kiev (“From evidence to commitment to action: Implementing HIV prevention measures in prisons in Ukraine”).

Coverage estimates of harm reduction services are from country reports and Urban Weber’s presentation “Harm Reduction is established in Eastern Europe,” delivered in Warsaw at the 18th International Conference on the Reduction of Drug-Related Harm on May 15, 2007.



Collecting blood samples in Kazan, Russia

International Harm Reduction Development Program: Mission and Strategies

Injecting drug use drives HIV epidemics in a growing number of countries in Asia and the former Soviet Union. UNAIDS identifies the Russian Federation's HIV epidemic as the largest in Europe, with an estimated 940,000 HIV cases in 2005. There are more people living with HIV in Russia and Ukraine than in the United States and Canada combined. Virtually all were infected in the last 10 years. As of March 2006, 83 percent of Russia's total registered HIV cases were among IDUs, and 7 of 10 cases were among those under the age of 30.

Outside of Africa, UNAIDS estimates that nearly one of three new HIV infections is now due to injecting drug use. Contaminated injection equipment accounts for the largest share of HIV infections not only in Russia and Ukraine, but in China, Indonesia, Malaysia, Vietnam, the Baltics, the former Soviet Union, and much of South America.

The International Harm Reduction Development Program (IHRD), a division of the Public Health Program 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.

Reducing Harm through Services

Needle exchange, methadone and buprenorphine, overdose prevention, and legal support

An overwhelming body of scientific evidence supports the efficacy of needle exchange and prescription of methadone and

buprenorphine in reducing HIV risk. Services that IHRD has supported include:

- needle exchange programs in Central and Eastern Europe, the former Soviet Union, China, and Malaysia;
- addiction treatment with methadone or buprenorphine in countries such as Albania, Kyrgyzstan, Lithuania, and Ukraine;
- the formation of harm reduction networks in Central and Eastern Europe, Russia, and Central Asia to help programs exchange information and advocate for change;
- prison-based harm reduction programs, including needle exchange in Kyrgyzstan and Moldova;
- counseling and outreach efforts that provide drug users, their families, and friends with accurate information about HIV, hepatitis C, and overdose;
- legal services to help fight discrimination and prevent legal abuses; and
- trainings for police, HIV physicians, drug treatment specialists, and harm reduction program staff.

Reducing Harm through Technical Assistance

New models of treatment for HIV and drug dependence

Support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and from bilateral and multilateral donors such as the UK Department for International Development (DFID), the Canadian International Development Agency (CIDA), and the World Bank has greatly increased funding available for harm reduction. The need for assistance in implementing and

scaling up such services at the country level, however, remains acute. Technical assistance provided by IHRD has facilitated:

- expansion of antiretroviral treatment (ARV) in Russia, and the development of the first HIV treatment protocols that include drug users;
- integration of programs providing HIV prevention, HIV treatment, buprenorphine treatment, and tuberculosis treatment in Ukraine;
- support in the preparation and implementation of Global Fund grants for harm reduction in Azerbaijan, Georgia, Kazakhstan, Moldova, Russia, Tajikistan, Thailand, and Ukraine; and
- bilateral funding of harm reduction initiatives in Central Asia, and monitoring to ensure that the money is used appropriately.

Reducing Harm through Advocacy

Policies based on evidence rather than ideology

Key harm reduction services, including needle exchange and methadone and buprenorphine treatment, remain inaccessible in a number of countries. Existing harm reduction programs cannot be effective if fear of harassment, arrest or incarceration makes drug users reluctant to use them. IHRD has worked with policymakers at local, provincial, national, and international levels to:

- encourage the United Nations and national governments to support proven measures such as needle exchange and methadone and buprenorphine treatment at the UN Commission on Narcotic Drugs, the Human Rights Commission, the UNAIDS Program Coordinating Board, and in national plans;

- highlight the role that incarceration and forced institutionalization play in accelerating the HIV epidemic, and the policy changes that can reduce overcrowding, disease risk, and human rights violations;
- increase funding for and political commitment to the provision of HIV prevention, treatment, and care for IDUs; and
- sponsor policy dialogues, conferences, satellite sessions, and study tours to explore solutions and demonstrate lessons learned in harm reduction.

Reducing Harm through Community Mobilization

Working with people who use drugs and people living with HIV

More than two decades of the AIDS epidemic have shown that so-called vulnerable or hard-to-reach populations are often their own best advocates. Yet people who use drugs are too frequently excluded from even those mechanisms that are supposed to increase the participation of people living with HIV in shaping AIDS policy. IHRD has supported active participation of affected communities through:

- funding and technical support for organizations of drug users and people with HIV in 15 countries in

Eastern Europe, the former Soviet Union, and Asia (these groups work on issues as varied as peer support and education, HIV treatment advocacy, and media campaigns);

- sponsorship of participation by people who use drugs and people who are living with HIV in international conferences as well as in regional and national conferences in Asia and the former Soviet Union;
- work with groups such as the European AIDS Treatment Group, the Global Network of People Living with HIV/AIDS (GNP+), and the Collaborative Fund for HIV Treatment Preparedness/International Treatment Preparedness Coalition on programs to increase HIV treatment literacy, ensure transparent and effective procurement of ARV, and challenge the systematic exclusion of drug users from care; and
- training and grants to support community mobilization, monitoring of prevention and treatment programs funded by the Global Fund and other donors, and documentation of human rights abuses.

For more information on IHRD and the OSI Public Health Program, see www.soros.org/harm-reduction



Needle exchange site in St. Petersburg, Russia

Summary

In 2007, IDUs comprised the largest share of total HIV cases in at least 20 nations in Asia and the former Soviet Union.

The percentage of cases attributed to injecting drug use is over 70 percent in some countries in Eastern Europe and Central Asia, the region where HIV is growing fastest. In many of these countries, harm reduction has made important inroads—all countries in Eastern Europe and the former Soviet Union except Turkmenistan had needle exchange programs in 2007. In most, programs remain too small to contain the HIV epidemic. Reports that new HIV cases among drug users have stabilized often reflect trends in testing rather than the impact of prevention. In Asia, home to

more than half the world's population, even low prevalence translates into huge numbers of people infected, with profound economic and social implications. China, Indonesia, Malaysia, and Vietnam all have injection-driven HIV epidemics, and have all shown a willingness to adopt some of the measures necessary to halt the spread of HIV among IDUs and their sexual partners. The challenge for many of the hardest-hit countries, however, lies in translating commitments into practice, without sacrificing protection of human rights.



Outside a buprenorphine clinic in Odessa, Ukraine

From the Directors

AIDS, which is responsible for more than 25 million deaths since 1981, has forced advocates and health care providers to reimagine the possible. Universal access to HIV treatment, once regarded as unachievable, is now a goal toward which the world is making slow but significant progress.

The number of people receiving HIV treatment in developing and transitional countries rose by 54 percent between 2005 and 2006. The Global Fund to Fight AIDS, Tuberculosis and Malaria did not exist a decade ago, but today has disbursed more than \$4.72 billion. Unfortunately, these efforts come late and are too little—an estimated 2.9 million individuals died of AIDS in 2006 alone.

For every person who initiates HIV treatment, six more will become infected because the services required to keep them HIV-negative are inadequate. Funds from the Global Fund grants are only as effective as the programs that turn them into services at the country level. Here, as this report shows, much remains to be done. The gap between rhetorical commitment and concrete measures to save lives is particularly evident for injecting drug users (IDUs), who now account for 30 percent of new HIV infections

outside of sub-Saharan Africa. Needle sharing is one of the most effective ways of transmitting HIV, and injection-driven HIV epidemics can accelerate quickly, with prevalence among IDUs going from zero to 50 percent in the span of a few years.

Over three-quarters of the world's 13.2 million injecting drug users live in developing or transitional countries, and only 8 percent of them have access to HIV prevention. This last figure is likely overstated, since in many instances "access to HIV prevention" means nothing more than receiving a pamphlet or being told to use a clean needle without being offered one. Services like needle exchange or prescription of medications to reduce injection of and craving for illicit opiates reach even fewer IDUs, indicating, in the words of UN Secretary General Ban Ki-Moon, "virtual neglect of this most-at-risk population." In his March 2007 progress report on the global response to



Thai and Chinese harm reduction activists at a training in Guangxi, China

HIV/AIDS, the secretary general also said “know your epidemic and your current response.” This report helps answer that call, providing a snapshot of key developments in HIV prevention and treatment for injecting drug users in 2006 and 2007.

The evidence is clear. When drug users have access to sterile needles and affordable treatment, they are able to protect their health and the health of others. Offered proper support, IDUs can adhere to and receive the same benefits from antiretroviral treatment as others with HIV. In Europe, needle exchange programs and treatment with buprenorphine and methadone have limited the spread of HIV and reversed epidemics among IDUs in the United Kingdom, France, Italy, and Spain. Less than 5 percent of new HIV cases in Australia are among IDUs, thanks to harm reduction efforts. Harm reduction is not only highly effective, but cost effective; the Asian Development Bank estimates that prevention programs targeted to IDUs could cost as little as \$47 per person per year. Less

wealthy countries where harm reduction programs are most needed, however, have yet to take HIV prevention and treatment for IDUs to anything approaching national scale—despite successes from Bangladesh to Ukraine in reducing risky behavior like sharing needles, and new models of anti-retroviral treatment delivery in Russia and Malaysia.

Policing practices may also result in drug-related harms that fuel HIV epidemics. Too many countries disregard the evidence and continue to deal with drug use primarily as a criminal justice problem. Policymakers often claim that services such as needle exchange encourage illicit drug use or do not adequately punish those who break the law. While insisting they only support measures that decrease drug use, these lawmakers ignore the fact that programs like needle exchange connect drug users with health providers and open the door to treatment. Some decision-makers maintain that any approaches that do not require abstinence from drug use—including medications

used in substitution treatment—represent a moral failure. This argument ignores the moral costs of failure to provide needle exchange, substitution treatment or overdose prevention, which prevent unnecessary illness and death.

This report focuses on countries where IHRD or its local partners work, and does not provide a complete record of global harm reduction developments. Important harm reduction organizations and networks operated in 2006–2007 across Asia and Latin America without engagement with the Open Society Institute, and a new network for harm reduction was formed in

2007 in the Middle East. Moreover, this report focuses on developing or transitional countries where IDUs constitute the largest share of HIV cases. Other countries in Western Europe, South Asia, and North America are also grappling with serious IDU-related HIV epidemics. Nascent epidemics such as the one in Afghanistan, where increased opium production has been followed by increased injection, are not discussed.

We hope the information here will be useful to all those seeking to scale up prevention, treatment, and human rights protection for IDUs.

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Harm Reduction Developments: International Policy

Injection-driven HIV epidemics are frequently found in nations that rely on foreign assistance to address public health needs. As a result, the inclination and ability of individual countries to support harm reduction are greatly influenced by the policies of multilateral institutions and wealthy nations.

United States

The United States government continues to be the largest donor to HIV/AIDS prevention and treatment and to drug abuse research. In the 2007 fiscal year, the U.S. government provided the Global Fund with approximately one-third of its budget, while the President's Emergency Plan for AIDS Relief (PEPFAR) awarded more than \$2.8 billion to HIV programs in 15 focus countries. The largest bilateral HIV program, PEPFAR, is also one of the most restrictive when it comes to IDUs, with guidelines issued in March 2006 reiterating that U.S. funds may not be used to support needle or syringe exchange. The United States remains the only country in the world to ban federal funding for needle exchange.

The 2006 PEPFAR guidelines do recognize methadone and buprenorphine as effective options "for treatment of heroin dependence," a welcome step for a program that previously had not provided funding for such treatment. The new guidance acknowledges that "heroin injectors who do not enter substance abuse treatment programs are up to six times more likely to become infected with HIV than injectors

who enter and remain in treatment." Counterintuitively, however, the PEPFAR guidelines restrict programs from providing methadone or buprenorphine to HIV-negative clients.

The United States has sought to undermine harm reduction programs at the international level. At the 50th Session of the Commission on Narcotic Drugs in March 2007, U.S. representatives expressed concern that harm reduction practices "assist people in using or abusing drugs," and grouped the provision of sterile syringes with drug legalization and other forms of "normalizing and promoting acceptance of drug enabling behaviors" and "undermining global counter-drug efforts."

Numerous studies, including seven federally funded reviews, have found that syringe exchange reduces HIV risk without increasing drug use. The Institute of Medicine, the preeminent U.S. institution working to assess scientific claims and policies, completed a comprehensive 2006 report on HIV prevention among IDUs in "high risk" countries. The institute found that "immediate action using multiple

approaches” was needed to slow the spread of HIV among IDUs, which it called “an urgent public health challenge.” The institute cited evidence that treatment with methadone and buprenorphine helps decrease individuals’ chances of contracting HIV, and that comprehensive HIV prevention programs that include needle and syringe exchange are associated with a reduction in behaviors leading to HIV infection. The report recommended that countries adopt multifaceted strategies that “should include certain medications to treat opiate addiction, as well as needle and syringe exchange wherever feasible.”

In May 2007, President Bush called for a \$30 billion, five-year reauthorization of PEPFAR that has yet to be passed into law. While the proposal set targets for HIV prevention and treatment, it gave no indication of how or whether the United States might alter support for HIV prevention efforts targeted at IDUs.

European Union

The stance of the United States on HIV prevention for IDUs stood in sharp contrast to that of the European Union, which issued a clear call in July 2007 for increased action. Noting that tremendous expansion of substitution treatment had been successful in preventing HIV, and that needle exchange had also been effective, the EU Presidency urged the group charged with HIV policy to make this treatment more accessible, particularly to prisoners; to improve prevention of hepatitis B and C; and to provide comprehensive needle exchange services “outside and particularly inside prison and free of charge.” The European Commission also announced plans to launch a Civil Society Forum on Drugs. The forum’s aim is to encourage input from civil society on drug-related matters, policy proposals, and on the EU Action Plan on Drugs.

As with other national and international declarations, ongoing attention will be needed to make such declarations meaningful. The European Commission issued an April 2007 assessment of progress since the adoption of a 2003 recommendation “on the prevention and reduction of health-related harm associated with drug dependence.” The report found wide variation in coverage, accessibility, and sustainability of methadone and buprenorphine within the EU. Prisons were identified as a setting where the provision of harm reduction services is particularly needed.

The European Court of Human Rights may also play a role in shaping harm reduction policy. In October 2006, in the case of *Khudobin v. Russia*, the court ruled unanimously in favor of an HIV-positive Russian drug user who was detained for more than one year without trial or adequate medical attention after he agreed to buy 0.05 grams of heroin for an undercover police officer. The judges found that his arrest and detention without medical attention had violated prohibitions against cruel and degrading punishment, the right to liberty and security, the right to speedy determination of the lawfulness of detention, and the right to a fair trial. Similarly, in an October 25, 2007 ruling, the court held in *Yakovenko v. Ukraine* that the failure to provide timely and appropriate medical assistance to a prisoner coinfecting with HIV and tuberculosis “amounted to inhuman and degrading treatment” and violated the European Convention on Human Rights.

The court has agreed to hear *Shelley v. the United Kingdom*, which charges that the UK government violated inmates’ rights by not providing them with clean syringes. A favorable ruling would, in theory, be binding on all the countries that have signed the European Convention on Human Rights, as well as those that seek to join the European Union.

voices from the front

TESTIMONY BY DAVID SATCHER, 16TH U.S. SURGEON GENERAL, TO THE HOUSE GOVERNMENT OVERSIGHT COMMITTEE, JULY 7, 2007

“A major example of a challenge which I faced as surgeon general was around the issue of needle exchange programs. CDC had funded several research programs to evaluate the efficacy of needle and syringe exchange programs in reducing the spread of HIV. [T]he Department had decided to call a press conference to announce the results of the needle exchange studies and that the administration was supporting the use

of federal funding to expand needle exchange programs. However, it was while waiting and preparing for the press conference that we learned that the White House had decided not to support federal funding for needle exchange programs, despite the science, because of a political environment in Washington that would not support it.”

United Nations and Multilateral Efforts

In 2006, UN member states and representatives from civil society convened to review progress on implementing the 2001 Declaration of Commitment made at the UN General Assembly’s Special Session on HIV/AIDS. After protracted negotiations and multiple drafts, member nations, including the United States, agreed upon a political declaration that called for “expanded access to...sterile injection equipment” and “harm-reduction efforts related to drug use.” The document avoided mention of sex workers, men who have sex with men, and injecting drug users, referring only to vulnerable groups, and did not set numerical targets for needle exchange or HIV treatment. A commitment to harm reduction was reiterated at the 2007 meeting of the Program Coordinating Board of UNAIDS, where UNAIDS was requested to work at the national level to help governments scale up HIV prevention among IDUs. The recommendation was endorsed by member states that opposed needle exchange and

substitution treatment, including the United States and Russia.

The World Health Organization (WHO), which added methadone and buprenorphine to its list of essential medicines in 2005, continued to emphasize treatment for IDUs in 2006 and 2007. On December 1, 2006, WHO Europe released a revised clinical protocol on HIV treatment and care for IDUs, noting that “a public health policy that addresses the need to treat both substance dependence and HIV/AIDS improves patient well-being, reduces stigmatization and promotes delivery of comprehensive, ethical medical care.” The agency urged countries with HIV epidemics fueled by injecting drug use to respond immediately to the needs of IDUs with preventive and treatment services “including harm reduction, opioid substitution therapy and equitable access to HAART (Highly Active Anti-Retroviral Therapy).”

The United Nations Office on Drugs and Crime (UNODC), the UN agency charged with responsibility for HIV prevention among IDUs, also increased its commitment to the issue in 2006 and 2007. The

HIV/AIDS Unit, supported by a € 20 million grant from the Netherlands, and another \$36 million from Brazil, both primarily for HIV prevention, is among the fastest growing and best supported units in the agency. HIV prevention in prisons has been a particular focus: in 2006, the unit released “HIV/AIDS Prevention, Care, Treatment, and Support in Prison Settings: A Framework for an Effective National Response,” and followed with a 2007 summary of evidence for action jointly authored with WHO and UNAIDS. The framework states that prisons should provide inmates with “sterile needles and syringes” and offer “no-cost methadone maintenance and other substitution treatments” whenever and wherever these harm reduction measures exist in the outside community. “Where no substitution treatment is available in the outside community,” UNODC recommends, “the prison authorities should add their voice to lobby for changes in policy and legislation to make such treatment nationally available, including within prisons.” Another UNODC effort, TreatNet, now supports 20 centers around the world, including in China, Indonesia, Russia, and Kazakhstan, to develop and document best practices in drug treatment.

An exception to the progress made in the UN system was found at the International Narcotics Control Board (INCB), the 13-member, ostensibly independent body that is staffed and paid for by the United Nations to evaluate compliance with international drug conventions and estimate medical need for legal opiates. Although the INCB has acknowledged the legality of needle exchange and substitution treatment, its 2006 and 2007 reports failed to mention needle exchange even once, despite repeated mentions of the connection between drug use and HIV. Medical treatment for opiate addiction reaches only a small fraction of those in need, yet the board consistently

emphasized the danger of diversion of legal opiates in countries that do offer methadone and buprenorphine rather than the need to make treatment more accessible. The board has also harshly criticized facilities such as safer injection sites or drug consumption rooms that offer IDUs places to inject drugs under medical supervision. Functioning in nine countries, these sites have been shown to reduce overdoses and other complications from injection while increasing links to treatment. Despite findings by UN legal experts that such facilities are acceptable under the conventions, the INCB has labeled them “opium dens,” and singled out countries operating them for public censure. Problems of transparency, accountability, and HIV expertise at the INCB were detailed in a February 2007 report by IHRD and the Canadian HIV/AIDS Legal Network, released with former UN Special Envoy for HIV/AIDS in Africa Stephen Lewis at a widely covered press conference at the UN. The board was also challenged by WHO and some member states at the Commission on Narcotic Drugs meeting the following month.

As the UN approaches the 10th anniversary of the 1998 UN General Assembly Special Session on Drugs, convened under the motto “A Drug Free World—We Can Do It!,” many questions remain about whether assessments of progress will be guided by evidence or ideology. In 2007, the Commission on Narcotic Drugs agreed to delay the high-level meeting to review progress until 2009 to allow more time for “an objective, scientific and balanced” assessment, and to develop a process for NGO feedback and participation in that meeting. A number of governments, including the United States, Egypt, Russia, and India, initially opposed plans for NGO inclusion in the central forum; NGO participation in 2009, however, was finally endorsed.



A Humanitarian Action van provides harm reduction services in St. Petersburg

Donor Support for Harm Reduction

International support is a double-edged sword, at once enabling new harm reduction programs and relieving governments of the responsibility for providing them. Nonetheless, international donors have played a critical role in enabling HIV prevention for IDUs to move forward, and have increased funding to record levels in recent years. Although not a comprehensive list, the following donors made harm reduction a part of their work in 2006–2007.

Global Fund to Fight AIDS, Tuberculosis and Malaria

Global Fund grants frequently include prevention and treatment for IDUs as part of larger efforts, making it difficult to quantify how much is spent on harm reduction. By any measure, though, the Global Fund represents a major shift in international funding for harm reduction, having disbursed more than \$400 million in grants in support of HIV prevention and harm reduction activities to 14 countries with injection-driven epidemics as of October 2007. More than \$280 million has gone to Central and Eastern European countries,

and \$127.5 million has been granted to China, Indonesia, and Iran, with China claiming more than 70 percent of those funds. In many countries, Global Fund grants include not only support for needle exchange or methadone, but programs that include IDUs as a specific population in need of antiretroviral treatment. Programs supported by the Global Fund have included peer outreach and needle exchange in AIDS centers in Kazakhstan, methadone treatment in Moldova, methadone clinics and needle exchange in China, drug user drop-in centers in Thailand, and integration of tuberculosis and drug treatment in Ukraine.



Harm reduction activists meet in Ukraine to discuss community mobilization

Governments are required to include NGOs in the process of grant preparation, and the vast majority of harm reduction services supported by Global Fund grants are provided by NGOs. In instances where harm reduction groups are able to demonstrate that government-controlled mechanisms would not consider their applications fairly, the Global Fund has also supported grants that bypass the government entirely, such as a \$1.3 million grant to a group of NGOs that included the Thai Drug Users Network and a \$15 million grant to the Russian Harm Reduction Network.

The Global Fund's support of tuberculosis prevention and treatment has made it well-positioned to support programs addressing HIV/TB coinfection, a common problem in many countries with IDU-driven epidemics. Reports and applications to the Global Fund—available for free at www.theglobal-fund.org—have become an important source of information on the state of harm reduction, and a way for NGOs to contrast government claims with the experiences of patients on the ground.

International Committee of the Red Cross (ICRC)

ICRC's 2003 publication, *Spreading the Light of Science*, highlighted important research findings and guidelines on harm reduction. Since 2004, ICRC and the Italian Red Cross have moved from program description to implementation. In December 2005, 51 National Red Cross and Red Crescent Societies signed the "Rome Consensus," committing to implementation of sound national drug policies and to strengthening the role of the Red Cross and Red Crescent in harm reduction. While this work takes various forms and is implemented with support from a range of other donors, ICRC work has included needle exchange and campaigns to fight stigma and discrimination against people with HIV in Armenia, Belarus, Croatia, Macedonia, and Russia. Approximately half of the 1,000 IDUs receiving direct services from national societies in Eastern Europe in 2006 also received voluntary HIV testing.

UK Department for International Development (DFID)

DFID released a position paper noting the importance of harm reduction in health, social, economic, and legal spheres in December 2005. DFID funding in regions and countries with high levels of injecting drug use has included support for needle exchange, trainings, HIV prevention and service provision programs, and protection of human rights of IDUs in China, Indonesia, Russia, Ukraine, Vietnam, Central Asia, and the Western Balkans. In Russia, DFID facilitates the implementation of a unified national response with one HIV/AIDS coordinating authority and one monitoring and evaluation system, and provides indirect support to the national networks of people living with HIV and AIDS for networking and advocacy. DFID provides \$1.9 million to a \$26.9 million joint program with the World Bank on HIV/AIDS in Central Asia, and is funding the Central Asian Regional HIV/AIDS Program, a \$10.3 million project over four years (2005–2009) dedicated to expanding harm reduction services in Kyrgyzstan, Tajikistan, and Uzbekistan. DFID's Western Pacific Regional Office in Manila supports harm reduction in China and Vietnam, where work has included expansion of needle exchange, training, and technical assistance. The DFID–Global Fund China HIV and AIDS Program (2006–2011) will scale up interventions to vulnerable groups in seven provinces, with a special emphasis on injecting drug users and sex workers.

In addition to supporting activities in individual countries, DFID funds international advocacy to strengthen harm reduction. In 2006, DFID granted the International Harm Reduction Association £1.4 million (approximately \$2.8 million) over three years to strengthen relationships with regional harm reduction networks and to help support the International Network

of People Who Use Drugs (see section on *Community Mobilization*). DFID also supports the International HIV/AIDS Alliance to advocate for the rights of IDUs, and works to encourage UN bodies in general, and the UNODC in particular, to focus more attention on HIV prevention services for IDUs and prisoners.

Canadian International Development Agency (CIDA)

Through CIDA, Canada supports a comprehensive response to HIV that recognizes the importance of promoting and protecting human rights with a particular emphasis on four key areas: prevention, strengthening health systems, promoting gender equality and women's empowerment, and promoting children's rights. In this context, CIDA and the Open Society Institute signed a contribution agreement in 2006 for a \$2.8 million, three-year project to promote the health and human rights of drug users in Georgia, Russia, and Ukraine. This collaboration responds to the main driver of the HIV/AIDS epidemic in these countries—injecting drug use—by contributing to evidence-based prevention and to the promotion and protection of human rights. The project, which requires that OSI provide a \$1.2 million match, will focus on four areas: access to high-quality treatment for drug dependence; access to HIV prevention and treatment services for women who use drugs; community-based advocacy; and prison-based harm reduction policy and service development. Since 2001, CIDA has also supported an eight-year, \$4.7 million grant to the HIV/AIDS Community Clinics Network in Vietnam. The network of 12 clinics works in four provinces to diagnose and manage sexually transmitted infections among sex workers, and uses peer educators for needle exchange and harm reduction education.

German Agency for Technical Cooperation (GTZ)

GTZ considers itself an implementing agency and provider of technical advisory services rather than a donor, and targets its social development and health programs to vulnerable populations with unequal access to services. HIV prevention for IDUs—a joint strategy of GTZ and the German Federal Ministry for Economic Cooperation and Development (BMZ)—includes support for drug demand reduction (which GTZ defines as drug misuse prevention), drug treatment and rehabilitation, harm reduction, and the promotion of integrated local drug policies. In 2004, GTZ was instrumental in launching the Harm Reduction Knowledge Hub in Vilnius, Lithuania. A partnership between AIDS Foundation East-West, the Eurasian Harm Reduction Network (formerly known as the Central and Eastern European Harm Reduction Network), and the WHO Regional Office for Europe, the knowledge hub provides trainings on subjects including principles and practices of harm reduction, HIV treatment and care for IDUs, outreach and peer approaches, and needle/syringe programming. The hub also provides trainings on drug substitution treatment, harm reduction in prisons, and harm reduction for sex workers.

While its project in Iran—Drug Demand and Harm Reduction in the Islamic Republic of Iran—has ended, GTZ continues to work in harm reduction in several countries, including Ukraine and Vietnam. The German-Ukrainian program on AIDS prevention is working to enhance IDU services through support for capacity building, needle/syringe exchange, and substitution treatment in four regions in the west of the country. GTZ is also working in Ukraine to establish drop-in centers and pilot services specifically tailored to female

IDUs. In Vietnam, GTZ is active in Cao Bang and Son La provinces, strengthening the capacity of NGOs and governmental groups to advocate for, develop, and deliver harm reduction and other services targeted to IDUs.

Dutch Ministry of Foreign Affairs (DMFA)

The DMFA has been the primary funder of the Mainline Foundation, an Amsterdam-based NGO that supports harm reduction at home and abroad, and the Asian Harm Reduction Network (AHRN). Mainline and AHRN work together on “From Margins to Mainline,” an initiative that focuses on the triple nexus of HIV risk, drug use, and poverty, and that works in Cambodia, India, Indonesia, Iran, Malaysia, Nepal, and Pakistan. Particular services supported have included outreach to IDUs in Indonesia, buprenorphine delivery in Nepal, and assistance to the Iranian NGO Persepolis, which offers methadone and needle exchange at community drop-in centers serving homeless and other highly vulnerable IDUs.

Australian Agency for International Development (AusAID)

AusAID’s work on harm reduction has included the \$16 million Asia Regional HIV/AIDS Project (ARHP), which from 2002 to 2007 strengthened the capacity of governments and NGOs to reduce HIV transmission and other drug-related harm among IDUs in Burma, Vietnam, and the Yunnan and Guangxi provinces of southern China. ARHP worked to develop community support for effective HIV prevention among drug users; to spur regional discussion of evidence-based approaches and collaboration; and to improve project management,



Workshop in Indonesia on human rights of drug users

monitoring, and evaluation. ARHP also focused on improving law enforcement practices by supporting the expansion of police curricula to include information on HIV prevention for drug users, and training staff and inmates of prisons and compulsory detention centers.

ARHP was followed in 2007 by the HIV/AIDS Asia Regional Program (HAARP), a \$59 million project to end in 2015, which will expand its focus to include Cambodia, Laos, and the Philippines. AusAID has also launched the \$10 million HIV/AIDS Prevention and Care Program in North East India targeted to IDUs, a \$9.5 million South

Asia regional project entitled “Prevention of Transmission of HIV among Drug Users in South Asian Association for Regional Cooperation Countries,” and its largest project—a \$41 million effort in Indonesia from 2002 to February 2008 on interventions that include those targeted to IDUs in seven provinces. In addition to spearheading methadone availability in Indonesian prisons—a first for a developing country in Asia—the effort has been instrumental in building NGO capacity and developing comprehensive harm reduction services within the government-run *puskesmas*, or public health facilities.



All-Ukrainian Network of People Living with HIV demonstration against substandard AIDS medications purchased by the government

Harm Reduction Developments: Central and Eastern Europe and the Former Soviet Union

UNAIDS, WHO, the European Commission, and other international observers expressed concern in 2006 and 2007 about HIV in Eastern Europe and the former Soviet Union, where the HIV epidemic continued to grow faster than anywhere else in the world.

Despite reports of a “generalizing” epidemic, injecting drug use still accounts for the vast majority of cases: over 80 percent of registered HIV cases in the region in 2006 were IDUs, according to UNAIDS. Ukraine, where 410,000 people were estimated to be living with HIV in 2006, and Russia, with an estimated 940,000 HIV cases, together account for 90 percent of all HIV infections in Eastern Europe and Central Asia, but Central Asian epidemics are growing rapidly. HIV prevalence among IDUs in some cities in the region is 30 percent or higher. Research has found even higher levels of infection—between 70 to 90 percent of

IDUs—with hepatitis C, which can result in liver disease and complicate HIV treatment.

Harm reduction projects for IDUs, despite support from the Global Fund and other international donors, have not grown nearly as rapidly as HIV infections. Though estimates of numbers of IDUs and definitions of what constitutes coverage by a needle exchange program vary widely, services providing sterile injection equipment reach few IDUs at risk by any account. A 2007 Global Fund estimate put overall coverage of harm reduction in Eastern Europe and Central Asia at 9 percent in a best-case scenario, with coverage falling to 2 percent in the Russian Federation.



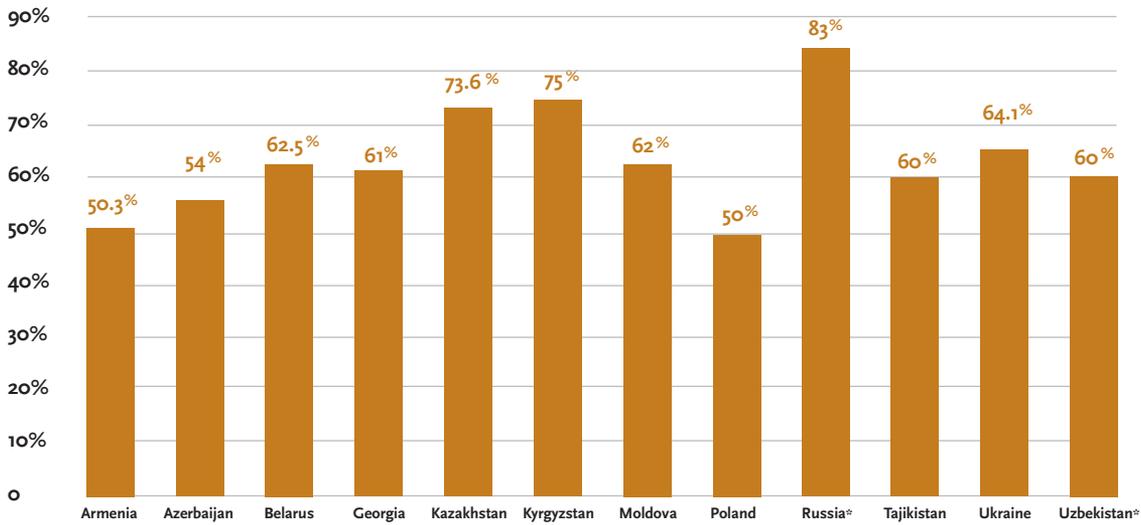
Taking a blood sample at a harm reduction center in St. Petersburg

Given the centrality of injecting drug use to the spread of HIV in the region, treatment for opiate dependence must be the foundation for a public health response. In the former Soviet Union, “narcological clinics” are often the first point of contact with health services for drug users, and offer opportunities to access treatment for HIV, tuberculosis, or other infections. Unfortunately, these opportunities are frequently lost since treatment for drug use (if available at all) remains separate from treatment for HIV/AIDS and other health problems. The best studied and most effective form of treatment for opiate dependence—prescription of buprenorphine or methadone—remained illegal in the Russian Federation as of 2007 and unavailable in Armenia, Kazakhstan, and Tajikistan. Where programs do offer methadone or buprenorphine, it is often in a highly

regulated clinical setting, and IDUs have even less access to these medications than they do to sterile injection equipment.

Laws and practices by police discourage IDUs from accessing harm reduction services. In many countries, police position themselves outside methadone clinics or near needle exchange centers, threatening arrest or demanding bribes. In countries such as Ukraine, where possession of very small amounts of opiates is punishable by imprisonment, or Georgia, where blood tests showing evidence of past drug use makes one liable for punishment, those bringing used needles in for sterile ones may face arrest, fines, or harassment. All countries of the former Soviet Union have laws requiring that drug users apprehended by the police have their names registered on government lists; in some countries, such as Russia and Ukraine, those who present

IDUs as Percent of Total Registered HIV Cases Eastern Europe and Central Asian Countries, 2007



* As of 2006

Sources: National AIDS Centers (Armenia and Azerbaijan as of January 2007). Belarus data from Aliaksandrau A. Belarus Pilot Tramadol Substitution Project, 18th International Conference on the Reduction of Drug-Related Harm. Warsaw: May 2007.

themselves voluntarily for treatment but cannot pay also have their names added to the registries. Registration can carry a range of economic and social consequences, including mandatory medical inspections, and denial of a driver's license, government employment, public housing, or child custody. Former drug users remain on the government registries for years, with removal requiring informal payments or extensive and complicated paperwork.

International agencies, including UNAIDS and UNODC, stressed the importance in 2006–2007 of offering drug users services rather than punishment, and emphasized protection of drug users' human rights as integral to HIV prevention and treatment. In Eastern Europe and the former Soviet Union, however, proposals included moves toward tightening penalties on drug users and reducing alternatives. In 2007, some members of the Russian

Duma proposed a return to compulsory drug treatment; in Georgia, fines for first-time drug offenders were increased to 41 percent of the average annual income.

National support for harm reduction, meanwhile, is scant, offered primarily through "in-kind" donations of space or limited contributions from local government. In all countries of Eastern Europe or the former Soviet Union, the vast majority of funding for harm reduction came from international donors in 2006–2007. The arrival of grants from the Global Fund and bilateral donors has increased government interest in securing their share, often leading to the creation of government-organized NGOs (GONGOs) that now compete with nongovernmental organizations for funds. Drug users, who are frequently distrustful of government entities, are likely to be the losers.

Central Asia

While Central Asian countries vary in socioeconomic status, ethnic composition, and political organization, they face similar challenges in HIV prevention and treatment. The five countries of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan experienced skyrocketing increases in reported drug use and sexually transmitted diseases following independence. All sit on routes for opiates smuggled from Afghanistan, which in 2007 produced more than 90 percent of the world's opiates. While levels of HIV in the five countries have not yet reached the levels of other former Soviet countries, all save Turkmenistan—where accurate information about HIV is not available—reported sharp increases in HIV infections as a result of injecting drug use from the late 1990s onward.

All of the Central Asian states except Turkmenistan are collaborating with international donors to offer antiretroviral drugs and some form of sterile syringe programs. Kyrgyzstan and Uzbekistan both provided methadone or buprenorphine to patients in 2006–2007, though fewer than 200 patients were receiving medication in either country as of mid-2007. Support for harm reduction initiatives is included in Global Fund grants to Kazakhstan (\$22.1 million), Kyrgyzstan (\$17.1 million), Tajikistan (\$2.4 million as of mid-2007), and Uzbekistan (\$24.1 million). DFID has funded the Central Asia Regional HIV and AIDS Program (CARHAP) with a budget of \$10.3 million to be implemented over the four-year period from 2005 to 2009 in Kyrgyzstan, Tajikistan, and Uzbekistan, as well as a \$26.9 million Central Asia AIDS Control Project (CAAP) launched in 2006 in Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan in collaboration with the World Bank. A \$13 million USAID-funded Central Asian Program on AIDS Control and

Intervention Targeting Youth and High-Risk Groups (CAPACITY) project is providing technical assistance to all five Central Asian countries for HIV prevention work with vulnerable groups, and USAID's \$16.5 million Drug Demand Reduction Program led by the Alliance for Open Society International, concluded its fifth year in Kyrgyzstan, Tajikistan, and Uzbekistan in 2007. The UNODC Regional Office developed a range of HIV prevention and drug treatment services for injecting drug users in all five countries. UNODC also started a \$4 million program to improve HIV/AIDS prevention and treatment among drug users and prisoners in Central Asia and Azerbaijan, cofunded by the Organization of the Petroleum Exporting Countries. AIDS Foundation East-West, through a €6.8 million grant from the Dutch Ministry of Foreign Affairs, will work to help integrate TB and HIV treatment. The program will start in early 2008 in Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan.



Antidrug poster in Panjakent, Tajikistan

All of this support, however, has not added up to sufficient coverage of needle exchange programs or expansion of methadone or buprenorphine treatment for IDUs in Central Asia. In Kyrgyzstan, fewer than 25 percent of IDUs are reached by harm reduction services, with less than 1 percent having access to substitution treatment. In Uzbekistan, 2006 estimates indicated that needle exchange reached fewer than 2 percent of IDUs in the country.

Kazakhstan

The number of reported HIV cases in Kazakhstan doubled between 2005 and 2006, as it has every year since 2000, and was 14 percent higher in the first five months of 2007 than in the same period the

previous year. Nearly three-quarters of HIV cases in Kazakhstan are attributable to injecting drug use, and more than 26 NGOs and 22 regional AIDS centers delivered syringe exchange services in Kazakhstan in 2007. Nonetheless, coverage falls well short of need, ranging from a low of 8 percent of IDUs reached as reported by UNAIDS in 2006 to a high of 35 percent according to Global Fund estimates in May 2007.

Despite a pledge to provide methadone in a 2003 Global Fund grant, substitution treatment remained unavailable in Kazakhstan in 2007. After the government failed to implement pilot substitution treatment projects in 2005, the Global Fund proposed withholding \$800,000 of the \$22 million grant, but strong statements in support of substitution treatment by the

director of the national AIDS center and revised government targets (50 people receiving substitution therapy by 2008) prevented this. In October 2007, the Ministry of Health approved plans for methadone treatment, and requested approval from the INCB to import the medication.

Kazakhstan's 2007 application to the Global Fund included yet another pledge to provide substitution treatment to IDUs, though no number was specified. In the same proposal, Kazakhstan sought to scale up antiretroviral treatment to IDUs and other vulnerable groups, and to increase support to nongovernmental organizations with the goal of reaching 60,000 IDUs in the country with HIV prevention. In the lead-up to submitting the proposal, four NGO representatives were elected to the local Country Coordinating Mechanism, and the director of the oldest harm reduction association in Kazakhstan was elected as vice-chair. The grant was approved in November 2007, though whether these changes will translate to greater services for IDUs remains to be seen.

Kyrgyzstan

Kyrgyzstan has the widest array of harm reduction services in Central Asia, which may partly explain the relatively stable number of new HIV cases each year since 2001.

A \$17 million, five-year Global Fund grant supports needle exchange and substitution treatment, including syringe exchange in prisons. Many of these activities have been implemented by the strong community of NGOs, and Global Fund support has been supplemented by a regional DFID program as well as by an initiative jointly created by DFID and the World Bank. By early 2007, the country reported reaching 25 percent of total estimated IDUs (11,243 people) with sterile

injection equipment, and treating 525 patients with methadone, though these numbers reflect cumulative efforts rather than current caseloads. Difficulties with importing and transporting methadone to clinic sites led to decreased doses and dismissal of patients in 2005; by early 2007, with three clinics operating in Bishkek and one in Osh, patient numbers had approached earlier levels. The country's methadone program moved out of the pilot stage by year's end, with clinics opening in Kant, Kara-Balta, and Tokmok, and an additional facility opening in Osh. A fourth clinic in Bishkek is scheduled to open in early 2008. The methadone program is funded by the Global Fund, with technical support provided by WHO, UNODC, and the Soros Foundation–Kyrgyzstan, and seeks to reach 1,500 people by the end of 2009. The program, however, is confronted by obstacles such as legal prohibitions against publicizing methadone, harassment by law enforcement of methadone patients, and IDU misconceptions about treatment.

Needle exchange, funded by the country's Global Fund grant and by CARHAP, has also expanded. Already available through multiple service providers in Bishkek, Chui oblast, Jalalabad, and Osh, in 2007 more needle exchange points opened in Kara-Suu (in Osh oblast), Shopokov (in Chui oblast), and Uzgen. A pilot initiative for pharmacy-based needle exchange, sponsored by AIDS Foundation East-West, has begun in Bishkek through the NGO Sotsium. Kyrgyzstan also remains the only Central Asian Republic to offer syringe exchange in prisons, with programs established in 10 out of 13 prisons, and reportedly covering over 6,500 clients.

After several years of political unrest and changes to officials in the health, penitentiary, and justice sectors, the legal environment for HIV prevention among IDUs also improved in 2007. In June,

Kyrgyzstan's president approved a proposal, supported by parliament and a coalition of advocates for HIV prevention and the rule of law, to "humanize" criminal penalties. Along with abolishing the death penalty, the new law abolishes mandatory imprisonment for possession of small amounts of narcotics. Two prisons already offer drug treatment and allow NGOs to provide follow-up services for newly released prisoners through the Atlantis rehabilitation program.

Parts of Kyrgyzstan use an integrated approach to drug treatment, with the same organizations providing needle exchange and drug-free treatment, in close cooperation with the city's methadone provider. Nonetheless, these services remain limited: a 2007 survey of providers and IDUs by the Soros Foundation–Kyrgyzstan identified drug treatment as the most pressing need facing IDUs.

Tajikistan

Needle and syringe exchange programs continue to function in Tajikistan on a limited basis, with 5,352 drug users reached by 13 "trust points" supported by the Global Fund in 2007. An additional 12 needle exchange points begun by the local Soros foundation are now supported by DFID through the CARHAP project. CARHAP also began needle exchange at 6 new trust points: together, its 18 points serviced over 4,000 IDUs in mid-2007. CARHAP has also supported the country's first mobile programs—one in Dushanbe, and one in the Sogd region. Operating out of minivans, the programs are able to extend services to areas previously out of reach. Methadone treatment, promised in the Global Fund grant, has yet to be implemented, making Tajikistan one of five former Soviet countries (along with Armenia, Russia, Kazakhstan, and Turkmenistan) where

neither methadone nor buprenorphine were available for addiction treatment in 2007.

Although prisoners account for more than 20 percent of Tajikistan's HIV cases, needle exchange in penitentiaries, promised in the Global Fund application of 2004, had not begun at the close of 2007. Recent amnesties prompted by the government's inability to manage its large prison population resulted in the release of 6,700 incarcerated persons in 2006 and 8,000 in 2007.

Other forms of treatment for people who use drugs also lag far behind need. A 2006 assessment found that many narcological clinics lacked even basic medicines to assist drug users with detoxification, and that some 70 percent of narcologists had received no in-service training or continuing education in the last 14 years. Many IDUs, fearing registration by the police or doubtful about the effectiveness of services, have stopped seeking treatment. In 2006, with support from IHRD, the NGO Volunteer began Tajikistan's first overdose prevention project in the mountain region of Khorog. Distributing naloxone, which is injected intramuscularly to reverse opiate overdose, the program worked with the local emergency department, hospitals, and police to achieve a 50 percent decrease in lethal overdoses in a 10-month period.

The slow pace of HIV prevention in Tajikistan has provoked international concern. In November of 2006, the UN Committee on Economic, Social and Cultural Rights released a report on Tajikistan, calling on the government to "establish time-bound targets for extending the provision of free testing services, free treatment for HIV and harm reduction services to all parts of the country." This was the first time a UN human rights treaty body recommended that a government expand its harm reduction programs.

HIV and IDUs in Select Central Asian Countries, June 2007

	Total population	Estimated number of IDUs	Total registered HIV cases	IDUs as share of total registered HIV cases
Kazakhstan	15.2 million	173,699	8,218	73.6%
Kyrgyzstan	5.2 million	44,398	1083	73%
Tajikistan	6.5 million	52,598	872	60%
Uzbekistan	26.6 million	86,795	7,810	60%

Sources: Population: UN Dept. of Economic and Social Affairs, 2006.

IDU numbers: Aceijas C, SR Friedman, HL Cooper, L Wiessing, GV Stimson, and M Hickman. 2006. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. *Sexually Transmitted Infections* 82, iii10-17

HIV data: National AIDS Centers, June 2007. Uzbekistan data as of 2006.

Uzbekistan

Needle exchange, though supported in name by the government, has remained limited in practice in Uzbekistan, with many of the country's 212 needle exchange points lacking sterile injection equipment, trained staff, or both. The country reported in 2006 that 18,421 IDUs had "benefited from harm reduction interventions" as part of the \$24 million grant from the Global Fund. A DFID-supported project is working in Tashkent to strengthen ties between NGOs and government needle exchange, and to develop a pilot program to deliver detoxification, family counseling, and other services to those using needle exchange.

In 2006, Uzbekistan became the first country in the former Soviet Union to offer both buprenorphine and methadone, with buprenorphine programs starting in February and a smaller methadone pilot beginning in December. While originally restricted to HIV-positive patients, entry criteria have been relaxed to include HIV-

negative patients who are offered the choice of ongoing methadone maintenance therapy or buprenorphine as a transition to drug-free status. As of November 2007, there were 90 patients receiving buprenorphine and 37 receiving methadone.

Legal impediments, both for NGOs and for IDUs, hamper harm reduction efforts. IDUs are subject to government registration and compulsory drug treatment that involves prolonged isolation; many are reluctant to come to government clinics to exchange needles. NGOs have been required to register with the government, and to undergo review of their mission. Access to their bank accounts has also been restricted or blocked by the government. Many international NGOs have been closed by the government after court challenges in which they were found to have exceeded their mandate.



Methodone maintenance clinic in Georgia

Georgia

According to Global Fund statistics, 351,000 clean needles were distributed throughout Georgia between January 2006 and February 2007. Needle exchange programs operate out of five centers: two in Tbilisi and one each in Batumi, Zugdidi, and Gori. A June 2007 Global Fund grant report indicates that these programs are serving about 1,112 people.

Since 2003, the Georgian government has decreased funding for drug treatment almost tenfold— from 500,000 GEL (about \$233,000) in 2003 to 50,000 GEL (or about \$28,000) in 2006. Although funds increased for drug treatment in 2007, services remain limited. Georgia launched its methadone program in December 2005, and as of July 2007 was reaching a total of 225 people through three clinics in Tbilisi and Batumi. At least 220 people were on a waiting list for spots in the program.

Positive developments in harm reduction have been offset by the initiation in March 2006 of a “Zero Tolerance” campaign, which is reportedly driving drug users further underground. Individuals can be brought in at will by police on suspicion of

drug use, and the fine for drug possession has been raised to 500 GEL (\$296), an exorbitant amount in a country where the average monthly income is 102 GEL (\$62). The legal change has been accompanied by a thirteen-fold increase in forced drug testing by the police: between January and April of 2007, 12,801 people were tested as compared to 985 for the same period the previous year. Local organizations have begun educating citizens about their rights to refuse testing; in response, the Parliament’s Legal Committee prepared a bill that would make people who refuse testing face the same exorbitant fines as those testing positive. A full parliamentary reading of the measure is expected in early 2008.



Homeless drug users in Warsaw, Poland

Poland

In Poland, only small areas of the country have needle exchange and outreach services for drug users; a number of large cities are among those places with no needle exchange. Fourteen programs in the country distributed 600,000 needles in 2006, with a return rate of roughly 50 percent.

Poland currently has some of the most restrictive antidrug laws in Europe. In 2006, Poles elected a conservative government which ran on a platform of being tough on crime. Strict enforcement of drug laws following the elections has led to prisons overflowing with drug users convicted on minor drug offenses.

The first methadone pilot program was introduced in Poland 16 years ago. For years, the number of drug users receiving treatment at the country's 12 centers has remained virtually unchanged, never exceeding 1,000—or about one in 40 opiate users in the country—despite long waiting lists and the absence of methadone in some cities with large numbers of IDUs. An

additional three centers operate in prisons. A legislative act passed in 2005 allows qualified NGOs, as well as government-run clinics, to administer methadone, and two NGO-administered methadone programs were opened in 2007. Both are based in Warsaw.

Deficiencies in HIV testing and data collection practices make it impossible to accurately assess epidemiological trends in Poland. In 2006, only 13,000 people were tested for HIV at the 20 government-funded, free, and anonymous sites, and 745 HIV cases were reported. Sixty percent of Poland's registered HIV cases are reported as "unknown route of transmission."

Russia

Changes in HIV testing, including sharp decreases in the numbers of IDUs tested and increases in the share of positive test results of “unknown route of transmission,” make it difficult to chart changes in the HIV epidemic in Russia. By any gauge, however, the country has the largest HIV epidemic in the region, with UNAIDS estimating total HIV infections at 940,000 and the head of Russia's Federal AIDS Center estimating the total number of infections to be as high as 1.3 million. The number of new HIV infections in 2006 exceeded those in 2004 and 2005, with infections in the first quarter of 2007 nearly 10 percent greater than those recorded in the same period the previous year. Though still the overwhelming majority of registered HIV cases—about 83 percent of cumulative HIV cases as of March 2006—IDUs represent a decreasing share of the newly diagnosed.

Under international scrutiny as host of the G8 summit and pressure from AIDS advocates, and with new funds available from oil revenues, in 2006 Russian President Vladimir Putin increased the HIV budget by twenty-fold. In 2007 he doubled it to \$289 million, though a report by the Health and Development Ministry noted that only \$7.75 million would be spent on prevention. Putin also announced a \$270 million pledge to the Global Fund, a contribution that equaled the amount the country had received through earlier grants. In April 2006, a law was passed subjecting NGOs to more stringent registration requirements and financial scrutiny, and allowing the government to dissolve organizations whose activities are considered to threaten Russia's sovereignty or deviate from their stated mission.

Russia's financial commitment to HIV has not included measures to ensure that the funds go to those at greatest risk. In 2007, the federal government actually reduced funding for needle exchanges supported within the framework of the national health project—from 15 programs funded in 2006 to only 3 in 2007. This was despite UNAIDS estimates in 2005 that less than 5 percent of IDUs in Russia were reached by syringe exchange programs and Global Fund estimates that only 2 percent of IDUs are reached by its prevention and

harm reduction services. While increased government commitments to AIDS included funding for programs to reach youth and provide treatment, they have not included monies to sustain the harm reduction programs started by the Global Fund. GLOBUS, a consortium of NGOs led by the Open Health Institute, uses Global Fund support for 24 needle exchange programs in 10 regions of the country. Since GLOBUS's inception, 33,030 people had received clean needles as of June 2007.

After the Country Coordinating Mechanism refused a request to support needle exchange in regions not reached by the original Global Fund grant, the Fund awarded an additional \$15 million, five-year grant to the Russian Harm Reduction Network. The group received the first installment in 2006, and has used the grant to help expand needle exchange services in 33 regions, and to promote voluntary counseling and testing, appropriate referral to TB treatment, and capacity building for service providers, IDUs, and organizations of people living with HIV. Five NGOs and Red Cross affiliates will carry out the new needle exchange programs. The first 28 needle exchange programs to receive Global Fund funding through this grant had distributed 923,685 syringes and needles to 15,465 IDUs as of July 2007.

The Global Fund has also supported innovative efforts to ensure that IDUs receive HIV treatment, which have helped overcome longstanding discriminatory practices that excluded IDUs from ARV programs. The GLOBUS project, which trains health care providers and patients on how to increase treatment adherence, had provided treatment to 2,413 people by September 2007. People with HIV and IDUs are regarded as partners, rather than passive recipients of treatment, and serve as peer counselors at each participating AIDS center. Of those receiving treatment through GLOBUS projects, 1,379 or 57 percent had a history of injecting drug use as of September 2007. In some cities, support from IHRD has helped strengthen the links between HIV treatment and harm reduction services, including the formation of drop-in centers, the hiring of adherence counselors who are themselves IDUs, and support to outreach workers who connect needle exchange clients with HIV treatment.

One of the most important tools to prevent HIV among IDUs or to increase their adherence to HIV treatment—provision of methadone or buprenorphine to reduce cravings for and injection of illicit opiates—remained illegal in Russia in 2007. Russian officials, including the director of the National Center on Addictions, Nikolay Ivanets, and the Russian member of the

International Narcotics Control Board, Tatiana Dmitrieva, lobbied hard to maintain the ban, despite findings by WHO, UNAIDS, and UNODC that use of these medications form an essential part of drug dependence treatment and HIV prevention. In March 2006, the journal *Вопросы наркологии (Issues in Narcology)* reprinted a memorandum signed by these and other health care officials entitled “No to Methadone Programs in the Russian Federation,” which was distributed widely to drug treatment professionals in the former Soviet Union. More than 50 drug treatment and HIV experts from around the world responded with an article detailing the memorandum’s numerous errors; however, the journal did not publish the rebuttal. Another attack, “Danger: Methadone,” was published in March 2007 by the Serbsky Institute for Social and Forensic Psychiatry—directed by Dmitrieva—and the Edifying Rehabilitation Center of St. John of Kronshtadt. A Russian language rebuttal, titled “Danger: Pseudonarcology,” was signed by 26 drug addiction experts from Russia and other countries of the former Soviet Union.

While medical treatment for addiction remains limited by law to government clinics, many of these offer only detoxification without psychosocial counseling, personalized treatment plans, or the support for relapse

Russian Narcological Services Through the Eyes of Patients: 10-City Survey, 2007

Percent of respondents who tried to quit at least once:	91%
Percent of respondents who tried to quit more than four times:	64%
<i>Percent who return to drug use after treatment</i>	
Within 1 month of treatment	52%
Within 2 years	96%

Source: Oleynik, S. 2007. Наркологическая служба России глазами пациентов (*Russian narcological services through the eyes of patients*). Moscow/Penza: Russian Harm Reduction Network and Anti-AIDS Charitable Foundation.



Assembling a harm reduction safety kit in St. Petersburg

prevention recognized as best practice. Detoxification regimes often rely on heavy sedation, eliminating any patient engagement from the process. Return to drug use after these costly but ineffectual detoxifications is common. A 2007 study of 988 injecting drug users in 10 Russian cities found that 64 percent of respondents had attempted to stop opiate use five times or more. More than half of the respondents reported resuming drug use within a month after treatment. *Rehabilitation Required*, a 2007 study by researchers at Human Rights Watch, found that Russian drug users were so heavily medicated that they did not remember much of their time spent in treatment, and that fear of having their names added to government lists was a disincentive to treatment.

The most tragic reminder of the dangers of a treatment system that sees its patients as untrustworthy came in December 2006, when 44 young, mostly HIV-positive women and 2 nurses died during a fire at a drug treatment hospital in Moscow. Hospital staff fled after a fire broke out, leaving the patients trapped and screaming behind the ward's barred windows and locked doors.

While drug treatment in Russia remains ineffective and inhumane, advocates scored several victories on the legal front. In Voronezh, activists successfully challenged an ordinance that would have required health care providers to share confidential information on drug users with law enforcement. The European Court on Human Rights issued two rulings (*Vanyan v. Russia* in 2005 and *Khudobin v. Russia* in 2006) finding that the Russian practice of entrapment irreversibly undermines the fairness of justice and violates Article 6 of the Convention on Human Rights and Basic Freedoms. Over 80 percent of Russians convicted for selling drugs and serving long prison terms are arrested in drug sales orchestrated by police. The European Court rulings paved the way for an amendment to Russian federal law that came into force in August 2007 and forbade law enforcement from directly or indirectly soliciting criminal acts. For drug users and their families, the litmus test will be whether Russian courts uphold the amendment by throwing out evidence gathered through what are euphemistically labeled “controlled purchases.”

voices from the front

FIRE IN LOCKED WARD OF A MOSCOW DRUG TREATMENT HOSPITAL KILLS 46

Below is a letter sent to Russia's minister of health and social development, signed by 341 professionals and activists, calling for an investigation of the fire and protesting the state of drug treatment in the Russian Federation.

*English Translation
Original in Russian*

December 18, 2006
Moscow

To M.Yu. Zurabov,
Minister of Health and Social Development of the Russian Federation
On the necessity to revise the concept of drug treatment assistance in the Russian Federation

Dear Mr. Zurabov,

On December 9, 2006, a fire in Moscow's drug treatment hospital no. 17 took the lives of 46 women, including 44 HIV-positive women undergoing narcological treatment and two hospital staff. The Office of the Prosecutor General of the Russian Federation announced the initiation of criminal cases. We support the need for a just and unbiased investigation that should take into consideration all the details and involve people who from their own experience are familiar with the regime and specifics of procedures in the drug treatment hospital no. 17—the clinic's patients or representatives of civil organizations representing interests of people who use drugs.

However, we, activists and professionals working in the areas of drugs and HIV/AIDS in Russia and around the world, agree that whatever the results of the investigation, we shouldn't blame selected individuals, be they patients or personnel of the hospital. We assert that the cause of the tragedy is rooted in the inhumane and ineffective organization of drug treatment in Russia, and is not merely due to the negligence of separate individuals.

For more than a decade, since the early 1990s, drug use has risen consistently in Russia. According to different estimates, 2 to 5 million people who use drugs now live in the country. However, the drug treatment system remains at the same level—both in terms of logistics and material conditions, and, which is much more important, in terms of conceptual approach. The development of the Russian drug treatment system lags dozens of years behind the effective comprehensive models implemented in the world. It still employs approaches that are far from being humane and evidence based. Russia lacks targeted governmental support to different forms of rehabilitation and resocialization of drug users. Most of the rehabilitation programs are business-based and expensive, and are not accessible for the overwhelming majority of drug-dependent citizens. Russian legislation prohibits substitution therapy that is widely and successfully used in all member states of the European Union, in Switzerland, Canada, USA, Australia, Iran, China and many other countries.





Source: NTV, 2006 <http://news.ntv.ru/99452/>

Drug treatment hospital no. 17 after the fire

During the same period—starting in the mid-1990s—Russia’s HIV/AIDS epidemic grew dramatically; and its rates of increase remain some of the highest in the world. At the moment, 350,000 HIV/AIDS cases are registered in Russia. Both UNAIDS and Russian Federal AIDS Center estimate the real number of people living with HIV to be much higher: 940,000 (560,000–1.6 million.). Eighty percent of all HIV cases with known transmission routes are attributed to injecting drug use.

When the Russian Federation sets its own goals for Universal Access to HIV/AIDS prevention and treatment—and when a majority of those in need of ART are people who use drugs—unavailability of modern comprehensive drug treatment including substitution therapy will inevitably lead to failure in achieving these goals and threaten the lives of thousands of young Russians.

We call upon the Ministry of Health and Social Development of the Russian Federation to revise the very foundations of the concept of drug treatment assistance in the country. Patients should not be treated as prison inmates, doctors should not serve as jail-keepers. Respect for patients and modern evidence-based approaches should become the foundations of drug treatment in Russia.

Yours,

Vitaly Djuma
Executive Director
Russian Harm Reduction Network

Gregory Vergus
International Treatment Preparedness Coalition

Ukraine

Ukraine, with the highest HIV prevalence in Europe, also has one of the most developed nongovernmental responses to the epidemic in the former Soviet Union. While estimates of IDUs and definitions of coverage by harm reduction vary, Ukraine achieved a significant expansion of needle exchange services through a \$97.8 million Global Fund grant awarded in 2003. Government inefficiency and accusations of corruption caused the grant to be transferred to a nongovernmental organization, the International HIV/AIDS Alliance, which in July 2007 reported reaching 124,046 IDUs at 645 needle exchange points. Innovations include a 24-hour pharmacy-based exchange in Kiev, as well as a peer-based approach that taps into social networks to draw injectors of *vint*, or homemade amphetamine, to harm reduction projects.

An additional \$151 million, five-year Global Fund grant, given jointly in 2007 to the International HIV/AIDS Alliance and the All Ukrainian Network of People Living with HIV/AIDS, was the largest awarded in the former Soviet Union, and will support increases in HIV prevention and treatment access. These include drop-in centers, outreach by workers able to connect needle exchange clients to ARV, and services working to integrate methadone and buprenorphine treatment, harm reduction, and ARV programs. The grant sets a target of 5,000 additional IDUs on ARV, and is specifically designed to reach patients with “double or triple diagnoses,” including active drug users and those coinfecting with TB. The grant also aims to provide treatment to 500 prisoners by 2011.

After years of inaction, Ukraine has recently made some progress on methadone and buprenorphine treatment. By mid-2007 more than 500 individuals in the capital and eight regions were receiving buprenorphine, though projects reported almost equal numbers on waiting lists, and treatment remained unavailable in many cities. The Ministry of Health’s initial

recommendation that medication be prescribed only to those with HIV and other “socially dangerous diseases,” along with the high price of buprenorphine, made it impossible to reach the goal of 3,000 patients on treatment by 2007. In November 2006, the government started the process of registering methadone, a far cheaper medication; relaxed buprenorphine criteria to include HIV-negative patients; and agreed to commit its own funds to support 300 HIV-positive patients receiving buprenorphine. Under pressure from the All Ukrainian Network of PLWHA, other local advocates, and the Global Fund, the minister of health and the deputy prime minister for humanitarian issues signed orders in 2007 authorizing methadone distribution and allowing methadone and buprenorphine to be provided at HIV and tuberculosis treatment centers. Authorities have also completed the forms needed to secure permissions for importing methadone.

Global Fund targets call for provision of methadone or buprenorphine to up to 11,000 IDUs by 2011, and 3,500 patients were expected to receive methadone in 2007.

voices from the front

MY SENSE OF DIGNITY CANNOT BE CRUSHED

Ukrainian harm reduction advocate Ol'ga Belyaeva, wrote the following in response to a request for biographical information for the Women Deliver conference held in London in October 2007.

I used drugs for a long time (18 years), and I worked for a long time (16 years). During this time the people I worked with related to me in many ways; they respected me, they wanted to be my friend, they invited me to parties. But only until they found out that I was a drug user. I was ashamed of myself, and ashamed for my mother and my son. When I woke up each day I didn't know where I would find myself in the evening: in prison (because above all the police hate people who use drugs); or in the grave (because the drugs I bought were bad). As a woman, most of all I had to endure people's attitudes: doctors refused to treat me, and forced me to have abortions. Lawyers did not wish to defend me; even a drug treatment expert called me rubbish and shut me out of the rehabilitation center where I wished to be treated.

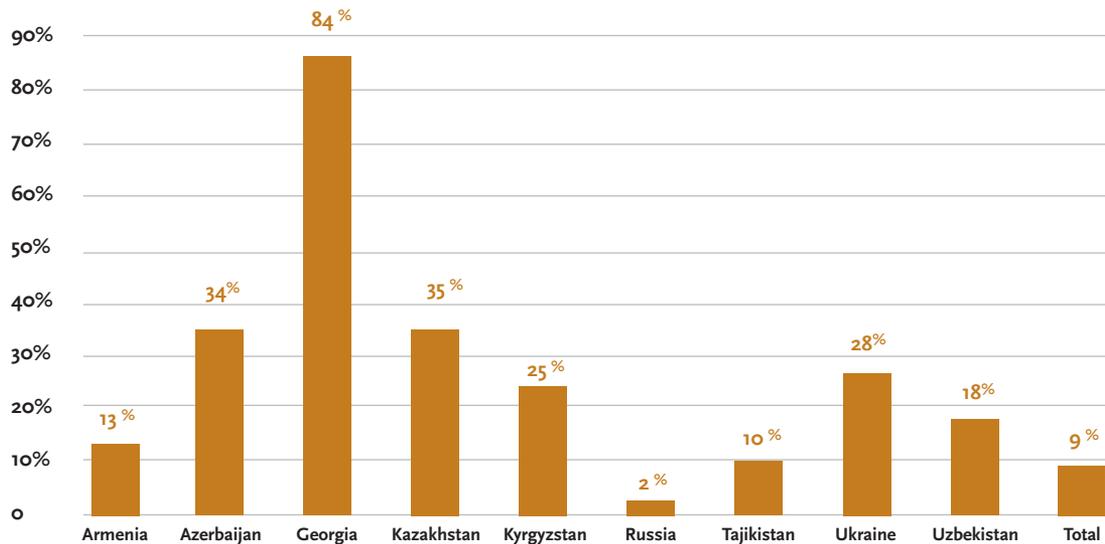
Seven years ago I realized that my sense of dignity cannot be crushed. Fighting for freedom has only strengthened and tempered it. I decided to work openly to tell the world about this part of life, in order to have the opportunity to help other people.

I am now the leader of Virtus, Dnipropetrovsk's drug user group. Ninety percent of the employees at Virtus have used drugs, and many are living with HIV. Doctors and students help us: we have over 200 volunteers. For us, the example of countries where users have united to protect their rights and interests is important. My work aims to improve the quality of life of drug users, change the attitude of society and the medical establishment toward them, and educate people about the importance of the idea of "Nothing about us without us," so that all users have an opportunity to receive substitution treatment; so that women have a free choice about giving birth or having an abortion; so that women can have the power and support to escape domestic violence; and so that all users will know who they can turn to for help.

Virtus supports, develops, advocates for, and implements programs aimed at solving problems in the areas of drug addiction, HIV/AIDS, tuberculosis, public health services, and social isolation. We work on the basis of humanism, tolerance, partnership, and respect for human rights. Our long-term goal is the establishment of civilized, mature relationships between the most vulnerable social groups and the state.

We recently celebrated our sixth anniversary and discussed our achievements. Thanks to our work concerning drug addicts and PLWH, there is a substitution treatment program in the Dnipropetrovsk region now, as well as ARV treatment. During its lifetime, Virtus has helped and supported 768 people living with HIV and more than 2000 active drug users. The most important thing is that during this time hundreds of people who felt lonely and useless have discovered their talents, received treatment, and found jobs, families, and friends. But there remain many more people suffering from callousness and heartlessness. We have a lot of work ahead of us.

Percent of IDUs Reached by HIV Prevention Services* Eastern European and Central Asian Countries, 2006



* Measures provision of all services, including information and referrals. No country is reaching even half of its IDUs with clean needles or methadone/buprenorphine.

Sources: Weber, U. 2007. "Harm Reduction is Established in Eastern Europe." 18th International Conference on the Reduction of Drug Related Harm. Warsaw: May 2007.

However, that target fell far short with no patients receiving methadone by the end of 2007. Methadone and buprenorphine treatment remains unavailable at in-patient hospital wards, forcing clients who need treatment for AIDS or tuberculosis to forego the most effective treatment for opiate dependence. A 2007 Ministry of Health order allows the provision of substitution treatment in up to 10 AIDS or TB clinics, though such provision has yet to begin.

Uneasy relations between public health and law enforcement efforts pose an additional obstacle for HIV prevention or treatment for IDUs. Participants in a patient support group at a buprenorphine clinic in Odessa in April 2007 all spoke of police harassment, and needle exchange points regularly complain of police activity targeting their clients. Harm reduction projects report that police use the threat of painful withdrawal symptoms to coerce confessions from IDUs, including for unsolved crimes.

A project by the International HIV/AIDS Alliance is working to train police not to take away ARVs from IDUs. In the past, officers have insisted that the medications were illicit drugs and confiscated them.

Those who are imprisoned are forced into high-risk environments where drug use continues and where sharing of needles—some sharpened with glass by desperate inmates—is common. In its Concluding Observation on Ukraine in November 2006, the United Nations' Human Rights Committee decried prison conditions, expressing concerns about "the high incidence of HIV/AIDS and tuberculosis among detainees...and the absence of specialized care for pre-trial detainees." According to the Ukrainian AIDS Center, HIV prevalence among those incarcerated rose from 9 percent in 2003 to 14 percent in mid-2006, and other studies have reported even higher prevalence rates at select prisons.

country briefs

EASTERN EUROPE AND THE FORMER SOVIET UNION

Armenia

In Armenia, IDUs accounted for 50 percent of all registered HIV cases as of June 2007. Needle exchange services reach 1,178 of the country's estimated 8,800 IDUs. Programs funded under the \$7.24 million Global Fund grant report that half of the IDUs targeted in Gumri, Kapan, and Yerevan are being reached with HIV prevention and needle exchange services. As of June 2007, 59 people were receiving ARV; 24 are former injecting drug users and 4 are active users. Of the 15 prisoners diagnosed with HIV as of 2007, 3 receive ARV. Methadone remained unavailable in 2007, though advocates have begun the process of legal reform that would permit the delivery of substitution treatment.

Azerbaijan

With a 2005 Global Fund grant for \$10.3 million and support from the OSI Assistance Foundation–Azerbaijan, needle exchange programs have expanded from 2 to 12 locations in Baku, Ganja, Lenkoran, and Nakhchivan in 2006. Five more needle exchange points are scheduled to open at the end of 2007 regionally. UNAIDS estimates that needle exchange, however, reached fewer than 10 percent of IDUs as of December 2006. Though a methadone pilot program began in 2004, the number of patients on substitution treatment was only 93 in September 2007. ARV did not start in Azerbaijan until late 2006. While 54 percent of cumulative HIV cases were among current or former IDUs, in 2006 and 2007 over 71 percent of new HIV cases were due to injection drug use. Infection rates among IDUs in Baku and Lenkoran are 24 percent and 19 percent, respectively.

Belarus

As of January 2007 there were 8,120 cases of HIV registered in Belarus, 62 percent of them among IDUs. More than 80 percent of registered IDUs are hepatitis C infected, and almost 20 percent are HIV-positive. With Global Fund monies, the NGO Positive Movement is implementing harm reduction services, including needle exchange. Less than 17 percent of IDUs were being reached by HIV prevention programs in late 2006. A methadone project to be financed through the same Global Fund grant was initially slated for launch in 2005. After discontinuation of a pilot project, methadone treatment recommenced in September 2007. Belarus experienced a disruption in the supply of ARV in 2007, prompting PLWHA and activists to write a letter of protest and demand better planning to prevent the problem from recurring.

Lithuania

In Lithuania, IDUs made up 76 percent of total HIV cases in 2007. Concerted media and policy work by a coalition of patients, physicians, NGOs, and government experts, and commitment from the Ministry of Health, resulted in new standards and regulations for needle exchange and methadone and buprenorphine provision. The new needle exchange standards, passed in 2006, call for mobile and stationary sites, sterile injection equipment, wound dressing, safer sex education and supplies, and counseling and education, including referral to legal and medical support for drug users and families. In 2007, Lithuania added buprenorphine to the list of medications approved for drug treatment, removed the requirement that patients must document two unsuccessful attempts to stop opiate use by other means, allowed licensed

mental health clinics to provide treatment without a special order from the Ministry of Health, increased the number of days for which “take home” doses are permitted, mandated that all medication be provided free of charge, and instituted a national monitoring system. Lithuanian treatment program regulations will conform most closely to best practices of WHO and UNODC, which both provided evidence and worked actively to help sway the national debate.

Moldova

In 2006, UNAIDS estimated that 29,000 people were living with HIV in Moldova, with 62 percent of registered cases attributed to injecting drug use. Global Fund estimates show that by late 2006 around 26 percent of IDUs were reached by harm reduction services, which include needle exchange to 11,294 drug users, including prisoners, and methadone to 73 IDUs, including prisoners. Moldova is the only country in the former Soviet Union where methadone maintenance is available in penitentiaries. The country's 2006 application for a new Global Fund grant of nearly \$16 million was judged among the strongest submitted and approved. Funds awarded under that grant support scale-up of services by shifting harm reduction delivery from NGOs to government facilities, and will expand methadone availability to the breakaway region of Transnistria. In August 2007, bureaucratic delays caused a month-long interruption of methadone supply in Moldova. Patients were forced to reduce their dose, receive inpatient treatment with tramadol, a medication unsuitable for ongoing treatment of opiate addiction, or go to the street in search of illicit drugs.



Kunming Municipal Compulsory Rehabilitation Center, Yunnan Province, China

Harm Reduction Developments: Asia

Over one-fifth of all people living with HIV and approximately half of the world's estimated number of injecting drug users reside in Asia. According to UNAIDS, injecting drug users now account for almost half of new HIV infections in Asia.

Despite over a decade of studies showing high prevalence among injecting drug users, UNAIDS reported that less than 10 percent of the continent's estimated 6 million injecting drug users had access to prevention services in 2007. The UNAIDS Asia Pacific regional director has urged countries to prioritize efforts targeted at IDUs, advocating that 80 percent of this population be reached by 2010 with "comprehensive interventions, including needle exchange and medication-assisted addiction treatment." While overall HIV prevalence in Asian countries does not exceed the 1 percent of the population regarded as a threshold for a generalized epidemic, regions within them are experiencing large and concentrated HIV epidemics among IDUs. In parts of Southwest China, the northeast states of India, and Indonesia, prevalence among IDUs ranges from 50 to 70 percent, signaling an urgent need for expansion of harm

reduction activities. In Thailand, successful efforts to reduce sexual transmission have received much favorable attention in the past decade. HIV prevalence among IDUs, however, estimated at 43 percent in 1988, has stayed at similar levels for nearly 20 years, highlighting government failure to adopt effective harm reduction measures.

National efforts to stem the HIV epidemic among IDUs in Asia have been the source of both frustration and hope. Vietnam passed an AIDS law in June 2006 that provides the legal foundation for greatly expanded harm reduction efforts, but as of November 2007, had yet to open its first methadone clinic. After several years of pilot programs, China and Malaysia are both in the midst of rapid scale-up of harm reduction services. Yet both countries continue to pursue punitive law enforcement strategies that make it more difficult to reach IDUs with health services.

China

Unlike many other countries, China's dual epidemics of HIV and injecting drug use began in rural areas, moving through the country along heroin trade routes originating in Vietnam and Burma. China's first indigenous AIDS cases were detected nearly 20 years ago in the southwest border city of Ruili. By early 2005, the Ministry of Public Security had registered 1.16 million drug users—70 percent of whom were believed to be heroin users—with experts estimating actual numbers up to five times as high.

Outpacing both plasma donation and sexual transmission, injecting drug use accounted for 44 percent of the estimated 650,000 individuals infected with the virus in December 2005. Nearly 90 percent of HIV among IDUs was concentrated in seven provinces, where HIV infection rates among IDUs are commonly 20 percent or higher. In certain communities, such as Yili City in Xinjiang province, as many as 89 percent of IDUs are already HIV-positive.

A national response once characterized by obfuscation and victim blaming has turned to dramatic government commitment to harm reduction. The Chinese Action Plan for Controlling AIDS from 2006 to 2010 promises to cover 70 percent of city dwellers and 50 percent of country dwellers with harm reduction services by 2010, including plans to open 1,500 methadone clinics and 1,400 needle exchange sites by the end of 2008. The number of needle exchange sites increased from 93 at the start of 2006 to 729 sites and 40,000 drug users by early 2007. The sites, which are funded by the Chinese government, the Global Fund, AusAID, and DFID, are slated to expand

services to 70,000 users by the end of 2008. However, some government sites operate in a perfunctory manner, exchanging a limited number of needles in environments described by IDUs as “hostile.” While certain provinces have legalized needle and syringe exchange programs, the national China AIDS Regulation issued in March 2006 included no explicit mention of needle exchange. Due to its unclear legal status, many government officials see needle exchange as an intervention best suited to rural areas where methadone clinics are hard to implement.

Methadone maintenance, unavailable anywhere in China in 2003, is now the heart of the national response to HIV among IDUs, and China's scale-up has been the most rapid in any developing or transitional country. As of late March 2007, 320 clinics were providing treatment to an estimated 36,000 patients on a daily basis, with plans to reach 300,000 individuals by the end of 2008. At the same time, many clinics were only about a third full in 2007, and patient retention was about 60 percent. Obstacles to further expansion of methadone include low

voices from the front

THE BEIJING OLYMPICS, 2008

“The police in 2007 will shift our efforts from focusing on establishments where drug use occurs to the drug users themselves, and we won’t eliminate the possibility that before the 2008 Olympics all drug users in the community will enter compulsory detoxification.”

—Fu Zhenghua, deputy director of the Beijing City Public Security Bureau

dosages, lack of “take home” doses, limited hours of clinic operation, and lack of relationships between methadone clinics and other service providers. While less demanding than at the outset, entry requirements still keep many people from accessing the services—especially migrants and others who may lack required documents.

The government piloted a number of improvements in methadone delivery in 2007, including an ID card that could in the future allow access to methadone at any clinic in the country, model “platform” sites with links to a range of other services, mobile methadone provision, and waivers of residency requirements. Clinics are expected to meet performance targets, including patient enrollment and retention of HIV-positive patients.

Perhaps the largest single challenge to China’s plans to increase service to drug users is the expansion of “crackdown” tactics on the part of the Ministry of Public Security. In 2004, 273,000 drug users were detained by public security personnel in arrests made on streets, in raids on people’s homes, and other coordinated activities. Arrested drug users are generally sent to compulsory detoxification centers or to “reeducation through labor” centers. The compulsory detoxification centers keep

users in often overcrowded and unsanitary conditions for between six months and one year and in some cases do not allow residents access even to short-course medication to ease withdrawal symptoms. Reeducation through labor camps, where drug users can spend up to two years if they have a record of prior drug use, force individuals to work up to 16-hour days in difficult conditions.

Signs indicate that support for the criminalization of drug use approach may be increasing in China. The national government is in the process of investing 100 million yuan (\$12.4 million) to expand the capacity of compulsory detoxification centers to hold newly arrested users by 2008. Yunnan province, for example, hopes to double the number of beds in its detoxification centers, from 34,000 in 2005 to 68,000 by 2008. In preparation for the Olympics, Beijing police have trained 10,000 local community “antidrug volunteers,” promised rewards of up to \$1,280 for tips related to the “solving of drug cases,” and announced a “Wind and Thunder” campaign to impose mandatory urine tests on all registered drug users. One official in Beijing has proposed that every registered drug user be taken off the streets during the Olympics.



A clinic worker at a methadone maintenance program in Jakarta, Indonesia

Indonesia

Home to more Muslims than any other country and the fourth most populous country in the world, Indonesia has one of Asia's fastest growing HIV epidemics. Indonesian officials have mounted a public health response—embracing harm reduction in 2004 in the Sentani Commitment to Fight HIV/AIDS, and later revising it to endorse needle exchange and methadone explicitly.

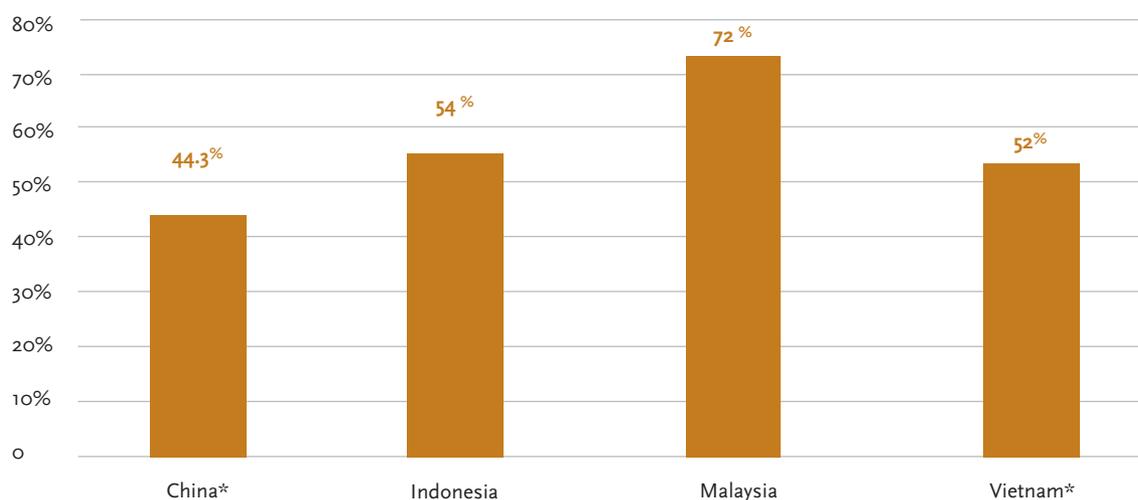
Harm reduction has been implemented primarily through NGOs, many of them comprised of drug users and belonging to the 50-member network JANGKAR. The Global Fund in 2005 awarded over \$62 million to the Ministry of Health's Center for Disease Control. As Indonesia prepares to scale up efforts, the government health system is becoming an increasingly important player, particularly via the *puskesmas*, or community public health centers, run by provincial or city governments.

At the end of 2006, there were 115 sites providing needle exchange. Of these, 41 were NGOs and 74 were *puskesmas*. By October 2007, each month 7,000 IDUs were visiting 75 *puskesmas* that collected more than 60,000 syringes. The Indonesian HIV/AIDS Prevention and Care Project, a partnership between AusAID and the Indonesian government, supports many of these efforts with an agreement that the government will assume the costs of services

in the future. The city of Bandung in West Java has launched its own health center-based needle and syringe programs at nine locations. Increasingly, NGOs and public health centers are moving toward offering IDUs a more comprehensive prevention package. The National Commission on AIDS plans for 75 public health centers to provide care, support, and treatment to IDUs by 2010, and 11 centers have already been trained to carry out voluntary counseling and testing and provide ARV.

Prior to 2003, drug treatment mostly consisted of detoxification and rehabilitation in drug-free clinics, operated by NGOs, mental hospitals, or therapeutic communities. Buprenorphine was available through certified doctors, but the price made it unobtainable for most. The first two pilot projects with methadone were implemented in 2003 by WHO, the Ministry of Health, and AusAID. At the end of 2005, the projects were serving a total of 300 drug users. After visiting

IDUs as Percentage of Total Registered HIV Cases Select Asian Countries, 2006



* Data as of December 2005

Sources: China Ministry of Health, 2006 update; Indonesian Ministry of Health, September 2006; Infectious Diseases Unit, University of Malaya Medical Center, June 2007; Vietnam Ministry of Health, December 2005.

a clinic on Anti-Drug Day in June 2005, President Susilo Bambang Yudoyono announced that the government would support a widespread expansion of methadone maintenance programs. Methadone became increasingly available thereafter and by the end of 2006 approximately 1,000 people were receiving treatment at one of seven clinics. In July 2006, the government's National Commission on AIDS declared one of its goals "to prevent having one million infected by HIV," and has set a target of reaching 50,000 drug users with methadone by 2010. Indonesia, a producer of antiretroviral drugs, is one of the few countries in Asia that does not formally exclude active drug users from treatment with ARV.

Use or possession of drugs in Indonesia is a criminal offense and trafficking sometimes carries the death penalty. While

religious leaders have presented little opposition to harm reduction, underpaid police in a country with a recent history of military dictatorship have been more resistant. Law enforcement officials continue to drive IDUs underground, discouraging them from seeking treatment or clean needles.

Government support for HIV prevention and treatment targeted to IDUs extends to drug users in prison. In 2005, Indonesia developed its National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centers, paving the way for Indonesia to become the first country in Asia to provide methadone to prisoners. This began in Bali, and the National Commission on AIDS has called for harm reduction programs to be established in 95 of the country's 396 prisons by 2010.

Malaysia

Malaysia has grappled with the twin epidemics of drug use and HIV by using both law enforcement and public health measures. The government is committed to the goal of a “drug-free Malaysia” by 2015, and has pursued a vigorous antidrug campaign including forced drug testing at roadblocks, factories, and schools, registration of offenders, flogging and/or imprisonment of those convicted of possession of illicit substances, and prolonged compulsory institutionalization of those with a history of illicit drug use.

Under the Ministry of Internal Security, those who tested positive for past use of illicit substances were sent to boot camp-style treatment facilities offering military-style discipline and often little else. More than half of the 22,811 drug users registered by police in 2006 were repeat offenders, testifying both to the failure of the “break-them-down” approach to drug treatment and to the immense difficulty of achieving the government’s goal of ridding Malaysia of illicit drugs.

Responsibility for drug treatment was shifted to the Ministry of Health in 2006, and Malaysia’s National Strategic Plan on HIV/AIDS for 2006–2010 includes calls for methadone and buprenorphine, needle exchange, and free ARV. Support for a national harm reduction program has come from the prime minister and has gone beyond just a rhetorical commitment: after spending about RM 40 million (\$11.5 million) a year on HIV/AIDS, the government more than doubled its contribution, pledging RM 500 million over five years for harm reduction.

Methadone has been scaled up continuously since its introduction in 2005, with programs reaching over 3,000 patients by 2007. Previously, only one company

distributed methadone in Malaysia, resulting in one of the highest retail prices in the world. In 2007, the cost was lowered from \$10 to \$0.80 per 40 milligrams. Increasing the number and availability of qualified medical practitioners and counselors has proved more difficult. Following a UNODC-sponsored study visit to Iran in 2007, prison authorities began discussion of provision of methadone in penal institutions.

Needle exchange began in February 2006 with pilot projects in Johor Baharu, Kuala Lumpur, and Penang targeted to reach 1,200 drug users. By February 2007, the projects served 1,701 IDUs and were expanded to Alor Star, Kuantan, and Kota Baharu by the end of 2007, making sterile injection equipment available to an additional 3,600 IDUs. The minister of health has said that 20,000 IDUs should be reached by needle and syringe exchange by 2010. Pharmacies in Kuala Lumpur are also slated to begin participation. Since needle exchange, like condom distribution campaigns, has been met with some opposition from the Malay Muslim public, all programs are carried out by NGOs. As with methadone projects, the demand for trained outreach workers in needle exchange programs outstrips availability.



Thai activists in a moment of celebration at a harm reduction training in Bangkok

Thailand

While the majority of its HIV cases are not among injecting drug users, Thailand's HIV epidemic among IDUs has continued to grow. According to UNAIDS, 3 to 10 percent of IDUs were estimated to be newly infected with HIV, and prevalence is approximately 45 percent or higher in some areas of the country. Yet Thailand has no harm reduction policy, no government-sanctioned needle exchange, and no methadone maintenance policy.

Community organizations played a strong role in implementing comprehensive harm reduction in 2006–2007. Under a multiyear, \$1.3 million Global Fund grant to the Raks Thai Foundation, directed specifically toward HIV prevention and care for IDUs, the Thai Drug Users Network (TDN) ran three drop-in centers in northern, southern, and central Thailand that included provision of clean injecting equipment and referrals to government health care services including ARV, while providing a “safe space” for users.

While methadone is available in Thailand, it is provided free of charge only in Bangkok by the Bangkok Metropolitan Authority. In spite of Thailand's policy of viewing people who use drugs “as patients, not criminals,” methadone in most other clinics is provided on a short-term basis as “taper detoxification.” Clients must “fail” this program of graduated detoxification,

over 90 or 180 days, three times before being eligible for longer-term maintenance.

In 2003, the Thai Drug Users' Network, Thai AIDS Treatment Action Group (TTAG), and others staged numerous public protests against the violent war on drugs, which included mass arrests, internment of 50,000 alleged drug users in military-run treatment camps, and the execution of more than 2,500 people in what appeared to be professional assassinations. At the request of human rights groups and the permanent secretary for justice, a special committee—the Department of Special Investigations—was given the green light by Prime Minister Surayud Chulanont in 2007 to conduct investigations into some of the killings. TTAG also collaborated with Human Rights Watch in 2007 to document barriers to access to ARV and harm reduction services for IDUs.

Vietnam

HIV prevalence among adults in Vietnam is among the highest in Asia, with IDUs particularly affected and several areas now experiencing generalized epidemics (more than 1 percent HIV prevalence among all adults). Among IDUs in some cities, HIV prevalence is as high as 67 percent. The Vietnamese government has pursued approaches emphasizing both public health and law enforcement in its effort to address the epidemics of HIV and injecting drug use, at times with conflicting results.

Vietnam's Law on HIV/AIDS Prevention and Control, which came into effect in January 2007, calls for the implementation of harm reduction, including promotion of clean needles and syringes and condoms, and medically assisted addiction treatment. Needle exchange was accepted more easily than methadone treatment, though IDU access to needles and syringes fluctuates with police crackdowns and many IDUs are reportedly reluctant to exchange used needles and syringes because of fear of arrest. The Asian Development Bank has given \$20 million to the government of Vietnam to reduce risk behavior, including needle sharing, among youth over a five-year period. Other international donors funding needle exchange include DFID, AusAID, and the Ford Foundation, which supports a Cross-Border HIV Prevention Project for IDUs and women at risk in Vietnam and China. The project provides vouchers for new needles, redeemable at pharmacies, and employs peer outreach workers to distribute sterile injection equipment. A 2006 study in two districts of Hanoi found that pharmacies were able to distribute twice as many syringes as peer educators working for district needle and syringe exchange programs. Overall access to needles and syringes, however, remains limited. A 2007 study of seven provinces found that 90 percent of IDUs had no access to sterile injection equipment in the previous six months.

After study tours to the United States, China, and Hong Kong, the government of Vietnam agreed to launch substitution

treatment. Methadone was scheduled to be made available initially in Ho Chi Minh City and Hai Phong through pilot projects funded by PEPFAR and DFID. As of November 2007, no patients had yet received medication.

The government's once vigorous campaign against "social evils," including drug use, is somewhat less vigorous now, although police crackdowns and the commitment of thousands to centers for drug rehabilitation continue. An estimated 50,000 Vietnamese are held in these facilities, known as o6 centers, including approximately 30,000 in Ho Chi Minh City, where drug users are held for five years. Camps vary widely in their conditions, though most provide mainly detoxification, "moral education," and work programs. Ho Chi Minh City has now built an industrial zone specifically to employ current and former o6 center residents. While the government calls this rehabilitation, human rights groups have described it as forced labor. In many centers, residents are tested for HIV but not informed of the results or offered counseling or ARV, despite average HIV prevalence of 50 percent. Those who become seriously ill may be released, some to former o6 centers converted to palliative care facilities. Based in part on research showing that large-scale commitment of drug users to lengthy terms in o6 centers is not a cost-effective means of combating drug abuse or HIV, the government is currently reviewing the approach.



Demonstration in Indonesia calling for an end to stigmatization and incarceration for people who use drugs

Overviews: Key Issues in Harm Reduction

Previous studies have shown that as a result of being committed to reach a certain number of IDUs in a specified time frame, some harm reduction projects have been less free to evaluate the quality of their treatment. Reaching IDUs “where they are”—both physically and in terms of their personal efforts to manage the consequences of their drug use—requires special attention to ensure that services are not interrupted by incarceration, government inaction, or preconceived notions of what makes a “good” patient and who is unreachable.

Harm reduction is best conceived not as a set of programs, but as a criterion for making choices about how to reduce the adverse effects of drug use and the war on drugs. Even for those whose focus is service delivery, special attention is required to develop innovative, more effective models of care, to ensure that structural barriers to access are removed, and to maintain commitment to

involving those most directly affected.

The following overviews focus on four areas where greater attention is needed to ensure funding, political and financial commitment, and quality of services: community mobilization, antiretroviral treatment for IDUs, harm reduction in prisons, and methadone and buprenorphine treatment.

Community Mobilization: Organizations of People Who Use Drugs and People with HIV

One of the enduring lessons of the HIV epidemic—and one that extends well beyond HIV—is that the expertise and engagement of those affected is critical to effective treatment and prevention. In many countries with injection-driven HIV epidemics, those most affected by HIV are so-called “hidden” or “hard to reach” populations, such as people who use drugs, sex workers, prisoners, and migrants. “Hidden” and “hard to reach,” however, are terms used by outsiders.

At the heart of harm reduction is the belief that drug users are not the problem, but the solution. Drug users and sex workers know their own networks, understand local drug scenes and the risks involved, and consequently are often their own best advocates. Programs staffed by people with an experience of drug use and informed by users’ needs are more successful at reaching out to IDUs and supporting their efforts to be healthier.

People who use drugs banded together in 2006 and 2007 to raise their voices on issues including accessible and effective drug treatment, access to sterile injection equipment, HIV and hepatitis treatment, and drug policy reform. Activists and community groups have increasingly asserted themselves by staging protests, holding international congresses, negotiating as experts with state authorities, participating in media events, and winning new funding to support their work. A senior UNAIDS official announced in 2006 that stronger partnerships between governments and NGOs with drug user activists, including “a real flow of resources to drug user networks,” should be a core component of any effective response to IDU-related HIV. That vision, while closer to reality at the outset of 2008 than ever before, has yet to be fully realized.

Gaining Donor Support

A number of international donors supported drug user groups for the first time in 2006–2007. A Global Fund grant in Romania and UNODC support in Lithuania have helped strengthen peer-based harm reduction services in those two countries. In Russia, the Global Fund’s grant to the Russian Harm Reduction Network includes a significant component to increase the capacity of people who use drugs to engage in advocacy, promote their human rights, and monitor and evaluate programs. The Canadian International Development Agency contributed more than \$350,000 to support drug user and PLWHA community organizing in Georgia, Russia, and Ukraine through a joint program with the Open Society Institute. IHRD and the International HIV/AIDS Alliance have funded technical assistance to and networking by drug user activists, and are working to support the development of criteria for greater and more meaningful involvement of people who use drugs. National activists are better able to draw on other countries’ experiences thanks to the newly established International Network of People Who Use Drugs, which has received funding from DFID through a grant to the International Harm Reduction Association.



An overdose prevention and treatment training in Kiev, Ukraine

Forming an International Network

In April 2006, more than 100 activists from dozens of drug user groups attended the 1st International Drug Users Congress in Vancouver, Canada. Congress participants issued a declaration amounting to a “bill of rights” that included universal access to harm reduction measures and an end to the marginalization, discrimination, and violence that drug users face. The declaration helped lay the groundwork for INPUD, which was established in 2007 in time for the 2nd International Drug Users Congress in Warsaw, Poland. The slogan in Warsaw, adopted from the people with disabilities movement, was “Nothing about us without us”—the title of a report by the Canadian HIV/AIDS Legal Network on more extensive and meaningful involvement of people who use drugs in policymaking and service development. Congress participants worked to draft a manifesto to accompany the international edition of the Canadian report, which will be released in 2008.

Public Awareness and Legal Reform in Bulgaria

In Sofia, the NGO Hope was born out of a patients’ peer support group at the city’s methadone clinic and has become a leading advocate for the country’s drug users. In 2006, Hope worked with Initiative for Health, the Bulgarian Helsinki Committee, and other allied NGOs to organize roundtables, media events, and demonstrations to highlight the effects of a Bulgarian drug law that was among the most repressive in the EU. In October, the law was changed to allow individuals charged with possession to pay a fine rather than serve the 3 to 15 years in prison previously mandated. While still far from what activists seek—the fine is approximately 1,000 BGN (\$694), or more than three times the average monthly salary—the new law represents a step forward. Hope also publicized the needs of drug users in Bulgaria through a series of television documentaries highlighting the expense and corruption of private drug



Young activists form a human AIDS ribbon during a demonstration in Balakovo, Russia

treatment programs. After four such documentaries, the head of addiction services in the country was replaced. Hope is currently working to improve the availability of affordable treatments for hepatitis C and drug addiction, and collaborates with the Bulgarian Helsinki Committee to document police abuses against drug users and launch strategic litigation. In 2007, the organization's chairman was invited to become a member of the Country Coordinating Mechanism for the Global Fund.

Organizing for Change in Ukraine

Activists from more than a dozen Ukrainian drug user organizations staged a demonstration during the opening of the 2nd annual national harm reduction conference in Kiev in March 2007. Covering their mouths with white scarves, they held up a

banner that read, "Why don't you hear us?" One by one, 12 activists removed their scarves to read a statement, urging greater access to treatment for HIV, hepatitis, and drug dependence, and asking that human rights protections be upheld. They also demanded drug user community involvement in policymaking and service development. The demonstration was the first joint action of drug user activists at the national level, and received television news coverage on local and national stations. Participants from the government and representatives from NGOs and bilateral and multilateral agencies such as the UN alluded to activists' demands repeatedly throughout the conference and underlined the importance of their participation in all aspects of harm reduction. Activists also spoke at a number of sessions and ran a training series; seven of them

were invited to present the conference declaration and give the closing statement.

In 2006, a new national network of current and former drug users formed in Ukraine under the name Spilnota, or “Community.” Uniting some 20 groups from around the country, Spilnota is rooted in a 12-step model of mutual support, and seeks to develop and coordinate local and national efforts to reform criminal drug laws, protect drug users’ human rights, and increase access to HIV, TB, and drug dependence treatment in prisons and the community.

Monitoring HIV Treatment in Russia

In November 2006, the Russian Ministry of Health proposed a new standard for HIV treatment that replaced previously approved, inexpensive first-line ARV with more expensive drugs designed for patients who have developed resistance after years of treatment. The revised standard raised suspicions of corruption and alarm about the numbers of people who would lose ARV or be required to change drug regimens. Mikhail Rukavishnikov, chairman of the Community of People Living with HIV, declared that the changes would result in “mass death,” and activists estimated that the change in ARV would set the state back by more than \$30 million. After a media campaign, delivery of protest letters signed by activists across Europe, and attention from Mikhail Grishankov, the head of the Duma’s anticorruption committee, a criminal investigation was begun. In January 2007 the health minister revoked the new standard.

The Russian activist group FrontAIDS—noted for its high profile demonstrations calling for greater access and better quality treatment for drug users and people living with HIV—formalized its efforts by registering as an NGO and

launching a project to document the experiences of people seeking treatment for HIV, tuberculosis, hepatitis, and drug dependence. A documentary film about FrontAIDS civil disobedience actions won the International Harm Reduction Conference’s film award in 2007.

Pressing for Treatment Rather than Punishment in Indonesia

Nationwide activism by current and former drug users and nongovernmental organizations marked the International Day against Drug Abuse and Illicit Drug Trafficking in Indonesia on June 26, 2007. In Jakarta, approximately 200 activists arrived at the national parliament house on four buses from all corners of the city and two other provinces. Covering their buses with banners and broadcasting their demand for an end to the incarceration of drug users who need treatment rather than jail time, participants engaged in the symbolic release of drug users from three cages at the government’s gates. Representatives from STIGMA, an NGO providing harm reduction services and organizing community activists, were invited to talk to government officials and a meeting with national legislators was scheduled. The organizers were featured on an hour-long radio talk show broadcast on 50 stations.

The Jakarta action was part of a national effort under the auspices of the Indonesia Drug Users Solidarity Association, which was founded in 2006 following the Vancouver International Harm Reduction Conference. Actions by users groups and harm reduction activists in Banten, Bali, Jakarta, Bandung, and elsewhere received local and national press attention, with activists speaking out for the scale-up of methadone clinics, more rehabilitative alternatives to jail time, and an end to the criminalization of drug users.



Conducting an HIV test at a harm reduction center in St. Petersburg

Antiretroviral Treatment (ARV) for IDUs

In nearly every region of the world, injecting drug users have inequitable access to ARV. Most countries neither establish targets for HIV treatment to IDUs nor keep statistics on the number of IDUs receiving ARV. Data on active drug users receiving treatment is even rarer.

Best estimates suggest that though IDUs are 30 percent of new HIV cases outside of Africa, they are fewer than 10 percent of those receiving ARV. This gap persists despite evidence that IDUs offered proper supports can achieve the same adherence to and benefits from ARV as other patients. In its December 2006 clinical protocol on HIV treatment and care for IDUs, WHO Europe underlined the importance of substitution treatment and peer support in ARV adherence and unequivocally stated that drug use should never be a criterion for excluding an individual from treatment.

Of the 36,000 IDUs in low- and middle-income countries receiving ARV by the end of 2005, 30,000 were in Brazil, with the remaining 6,000 dispersed over 45 countries. According to a 2006 study in Eastern Europe and Central Asia, IDUs comprised more than 80 percent of HIV cases but only 14 percent of the total number of people receiving ARV. In countries like China, Malaysia, and Russia, where injecting drug users now account for the largest share of HIV cases, 5 percent or less of HIV-positive IDUs have access to ARV. Even in Western countries where ARV is widely available, people with a history of injecting drug use are frequently underrepresented in treatment or begin receiving ARV at more advanced stages of infection.

The lack of attention and priorities for bringing ARV to HIV-positive IDUs carries particularly devastating consequences for

regions with injection-driven HIV epidemics. A 2006 study estimated that in St. Petersburg, ARV targeted to IDUs could avert three times more HIV infections than treatment targeted to non-drug users. Even where there is commitment to treating IDUs, barriers limit access to ARV.

Barriers to Access

Discrimination

Active drug users, often considered by physicians to be unreliable patients, are caught in a double bind. If they disclose their drug use to providers, they may be denied treatment. If they do not disclose their drug use, they will not get important tests (such as screening for hepatitis B and C) or treatment adherence support, and may be labeled as dishonest if their drug use is later revealed.

Cost

Even when ARV is free, patients are often responsible for the costs of various tests—some of them prerequisites for treatment—or are charged for check-ups and treatment of opportunistic infections. These costs impede access for IDUs who are unemployed, homeless, or cut off from family support.

- Under Chinese policy, ARV is free. Outside of Henan Province and wealthier Chinese cities like Beijing, Guangzhou, and Shanghai, however, patients are typically charged user

fees for diagnostic tests such as CD4 or liver function tests.

- In Ukraine, IDUs report that they must pay “informal” fees for tests that are supposed to be provided free.

Lack of integrated care and trained providers

IDUs must often engage with multiple, specialized systems that each claim authority to register, monitor, or medicate. Comprehensive services that deliver HIV prevention and treatment in conjunction with harm reduction increase adherence to both ARV and substitution treatment but are only rarely available.

- In Ukraine, buprenorphine treatment is not available in hospitals. Patients receiving treatment for serious HIV-related illnesses must thus give up the most important tool for treating their addiction.
- Across the former Soviet Union, HIV clinics have little expertise in drug addiction treatment, and are not authorized to provide it. Some AIDS centers have signs with such slogans as “if you are intoxicated today, please come back tomorrow.” For active opiate users, this means no HIV treatment at all.
- In Vietnam, more than 50,000 drug users are in rehabilitation centers, some for as long as five years. While HIV prevalence is as high as 50 percent and HIV tests are mandatory, HIV treatment is usually unavailable.
- Malaysian hospitals provide free ARV, but too few hospitals participate in the program and those that do have not been very successful at recruiting patients.

- In Thailand, IDUs are explicitly entitled to ARV. In practice, however, many doctors refuse to treat drug users.
- In Ditan hospital in Beijing, known for ARV treatment, doctors reported in August 2007 that to their knowledge, few if any of the approximately 400 patients receiving HIV treatment had a history of drug use. Physicians claim that IDUs lack motivation to seek treatment.

Signs of Progress and Innovative Approaches

At least five developing/transitional countries with significant HIV epidemics concentrated among injecting drug users—China, Malaysia, Russia, Ukraine, and Vietnam—have written action plans specifically targeting IDUs for treatment.

- In Russia, NGOs have used Global Fund support to develop a practical model of ARV delivery that involves peer counselors with HIV and links to harm reduction services. The program includes a special component to help strengthen adherence to medical treatment based on the Jumpstart project at Columbia Medical Center in New York. As of 2006, it had a retention rate of 95 percent.
- In Malaysia, the government is training family physicians to administer and provide counseling on antiretrovirals so that the country can reach 10,000 people, including IDUs, with locally produced ARV by 2010.
- In Ukraine, drop-in centers and harm reduction projects are working to link clients to ARV, TB, and buprenorphine treatment.

voices from the front

IT WAS A WAR FOR OUR LIVES

The following is an excerpt from the plenary speech at the XVI International AIDS Conference delivered in Toronto on August 16, 2006. Sasha Volgina is an activist with the FrontAIDS movement and cofounder of Svecha (Candle), a PLWHA self-support group in St. Petersburg, Russia.

In Russia eight out of ten HIV cases are due to injection drug use, and this is how I myself was infected. When I tested positive seven years ago, all I knew was that I would die soon. I only found out that treatment existed three years later, but most of the people living with HIV and AIDS in my country still don't know that treatment exists...I used to be the only person I knew that was positive. In recent years all of my friends have tested positive too.

When my friends and I learned that HIV treatment existed, we had hope for the future. We were going to live, not die. We thought that if treatment existed we would get it when we needed it; we never imagined that it could be otherwise. But when we started to work at hospitals helping HIV patients, we saw that the reality was very different; people were dying...Doctors developed commissions to decide who deserved to live, and who would die. People were labeled socially unproductive and denied treatment. Something had to change. We started to have demonstrations, speak to the media, and show the world that we existed; but still people felt that we were guilty and we didn't deserve treatment.

They say that silence equals death. We were not silent, we were screaming, but nothing changed. We had legal actions, we risked being sent to prison, but it was time to take that risk. We had nothing to lose. We called ourselves FrontAIDS because it was a war for our lives.

After years of our protests and political actions the Russian government increased funding for AIDS. High level officials, including the president, recently recognized the problem and expressed political commitment to increase access to treatment.

The government admitted that drug users have the right to live, but antiretrovirals are still not available to everyone, and there is a lot of work ahead. Problems started with procurement; there have been treatment interruptions because AIDS centers run out of drugs; technical support and planning focused on delivery is needed. The system should become transparent to avoid corruption. Some have said that drug users shouldn't be given ARVs because they won't adhere, but it is Russia that must adhere to treatment by ensuring sustainability in medicine supplies.

Many patients still don't know that treatment is available. Drug users are isolated—even if they know that treatment exists they have many fears and myths about it. They have learned to avoid all state institutions. Pharmacies where you can't find a syringe, but you can always find a police patrol at the entrance. State run detox centers where the best developed referral system is referral to the police. The lack of effective treatment of drug addiction causes problems for adherence for drug users. Substitution treatment is illegal... There is almost no access to drug free rehabilitation. The only drug free addiction centers are religious programs and government sponsored detox; but to get into the government sponsored detox programs you have to be officially registered as a drug user, and then police, employers, and others discriminate against you...Russia must legalize methadone and buprenorphine immediately to help prevent and treat HIV. Until Russia legalizes substitution treatment, ensures a steady supply of ARVs, develops integrated social support programs, and ends stigma and discrimination against people living with HIV/AIDS and vulnerable groups, access to antiretrovirals will be nothing more than an empty promise. The system of providing access to treatment in Russia is still sick, and itself in need of treatment.



Kerobokan Prison in Bali, Indonesia, offers methadone

Harm Reduction in Prisons

Most developing and transitional countries with injection-driven HIV epidemics have responded to growing drug use by tightening legal controls, punishing possession of even small amounts of drugs with incarceration or forced institutionalization.

Efforts to control IDUs through incarceration often fuel HIV, hepatitis C, and sexually transmitted infections, placing IDUs in environments where drug use, unprotected sex, and other risk behaviors are common, and where means of HIV prevention or treatment are unavailable. The lack of sterile injection equipment is the norm in prisons in the developing world, leaving IDUs to share or rent needles that are homemade, contaminated, or even rusty with overuse. HIV prevalence among prisoners exceeds 10 percent in 20 out of 75 developing and transitional countries that record and are willing to share this information.

The two countries in the former Soviet Union with the largest HIV epidemics—Russia and Ukraine—also have some of the continent’s highest incarceration rates. Russia incarcerates a higher percentage of its population than any country except the United States. In many countries, significant proportions of inmates are serving time for drug-related offenses. In Thailand, for instance, over three-quarters of inmates were convicted for drug-related offenses in 2006.

Prison officials often deny that drug use continues or is initiated under their watch, yet no country in the world has ever managed to prevent drug use in its prisons. This is true for the special facilities constructed for drug users in Indonesia as well for general facilities where IDUs comprise a significant

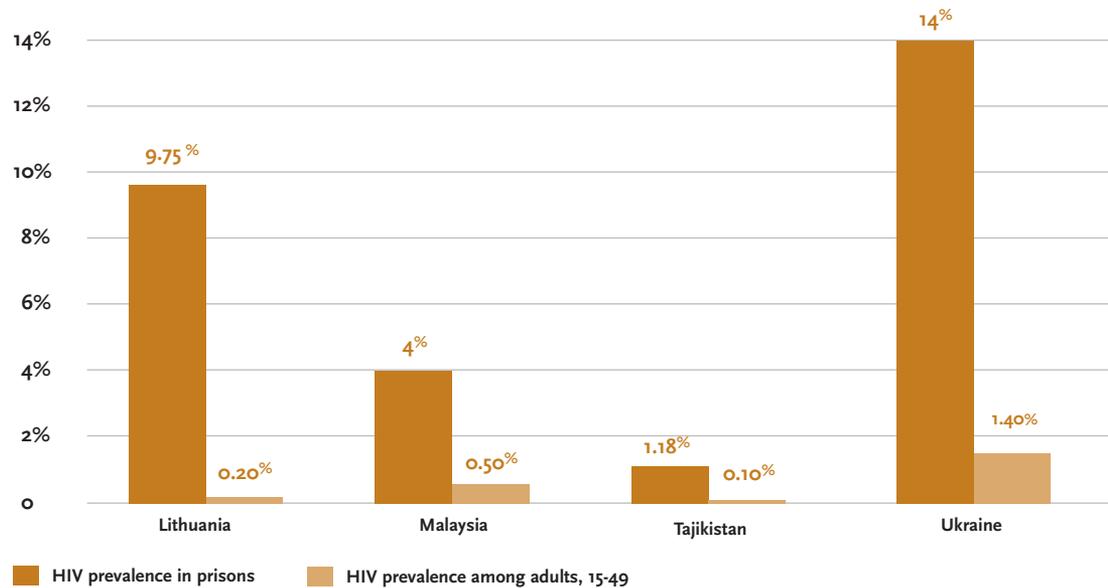
proportion of those incarcerated in countries like Russia, Ukraine, or Tajikistan.

- While IDUs comprise 1.6 percent or less of the general population in Russia, Ukraine, and Vietnam, their proportion of the prison population in those countries is, on average, 10 times greater.
- In Russia, prisoners have reported that a single syringe may serve a whole wing of 40 cells, be used by as many as 200 individuals, or be passed through the chain link fence that separates HIV-positive inmates from those who are uninfected.
- In Ukraine, HIV prevalence among prisoners at seven facilities ranged from 16 to 32 percent in 2004, and hepatitis C among prisoners in two regions ranged from 75 to 91 percent. A recent study in Russia found that those who have been in prison are twice as likely to be infected with HIV.

Mandatory HIV testing—without counseling or HIV treatment—is conducted at prisons in many countries. In Uzbekistan, 520 prisoners tested HIV-positive in 2006—at least 40 of whom have since died—and Kazakhstan registered 443 HIV cases among prisoners in the first eight months of 2007. Many segregate HIV-positive prisoners, giving HIV-negative inmates a false sense of security about sharing needles

HIV Prevalence in Prisons vs. General Population

Select Countries, 2006



Sources: HIV in prisons: UNODC (Lithuania, Malaysia, Tajikistan, 2007), Ukrainian AIDS Center (2006). Total prisoners in Tajikistan from International Centre for Prison Studies, 2006.
HIV prevalence among adults: UNAIDS, 2006.

and syringes. In Malaysia, HIV-positive prisoners occupy a separate block but share close quarters with those who are coinfecting with TB.

Evaluations of prison-based needle and syringe exchange programs have demonstrated numerous positive effects, including reduced syringe-sharing, near elimination of HIV and hepatitis C transmission via injection, decreased heroin overdoses, greater numbers accessing drug dependence treatment, and no reported increase in drug use or injecting. WHO, UNAIDS, and UNODC have all recommended that needle and syringe exchange, methadone or buprenorphine, ARV, and condoms—accompanied by HIV prevention education—be made available to prisoners wherever they are available to the community at large.

Meanwhile, prison-based methadone programs are associated with a drop in drug-seeking behavior while in prison; reduced injecting; and lower reincarceration rates. Compared with prisoners enrolled in detoxification programs, inmates on

methadone are more likely upon release to enter and remain in drug treatment programs. They are also less likely to overdose after release.

Cause for Concern

- In Ukraine, physicians at large prisons (1,000 inmates or more) report that 10 to 15 people are dying of AIDS-related causes every month. Treatment with ARV is largely unavailable.
- Both Moldova and Poland have made methadone available to small numbers of prisoners in the recent past, but neither country has fully embraced or even sustained the measure. In Moldova, prisoners are sometimes required to cease taking methadone after six months, at which point, while going into withdrawal, they are asked if they are “cured” and ready to stop treatment altogether.



Team-building exercise during harm reduction training for Russian police officers

- Kyrgyzstan received a grant from the European Union in June 2006 to develop methadone maintenance programs for pilot prisons. As of late 2007, these pilots had not yet commenced.

Cause for Hope

- Ukraine's national strategy for HIV control in prisons for 2007 calls for 60 percent of prisoners to be reached by needle exchange by 2010. The state penitentiary system signed memoranda of understanding to implement needle exchange in two facilities—prison colony 53 in Mykolaiv Oblast and colony 48 in Lviv Oblast—though as of November 2007 the programs had yet to begin.
- Needle and syringe exchange programs exist in at least some penal institutions in Armenia, Belarus, Iran, Kyrgyzstan, and Moldova, all of which are developing countries with injection-driven HIV epidemics.
- Iranian clinics were providing methadone maintenance therapy

to 55 percent of prisoners in need as of January 2007, with plans to cover 80–99 percent within a year. In addition to receiving clean needles, syringes and methadone, some prisoners also have access to ARV.

- Malaysian officials, after visiting Iran, have decided to initiate methadone treatment in prisons, with patients expected to receive medication in 2008.
- The Kerobokan prison facility in Bali, Indonesia, which provides inmates with methadone as well as bleach, condoms, and ARV, has been adopted as a model by three prisons and is to be replicated in a total of 15 prisons by the end of 2008.

Prison health is public health. Besides making harm reduction services available, other important measures for preventing HIV transmission in prisons include scaling up access to ARV, strengthening links to community services to ensure continuity of care, alleviating overcrowding, and improving the working conditions of staff as well as the living conditions of inmates.

Harm Reduction in Prisons

Developing/Transitional Countries with Injection-Driven HIV Epidemics, 2007

Central and Eastern Europe and the former Soviet Union

	Needle exchange in prisons	Substitution treatment in prisons
Armenia	yes	no
Azerbaijan	no	no
Belarus	yes (one prison)	no
Estonia	no	no
Georgia	no	no
Kazakhstan	no	no
Kyrgyzstan	yes	no
Latvia	no	no
Lithuania	no	no
Moldova	yes	yes (22 patients)
Poland	no	yes (7 prisons, for patients on treatment before incarceration)
Russia	no	no
Tajikistan	no	no
Turkmenistan	no	no
Ukraine	no (approved)	no
Uzbekistan	no	no

Asia

	Needle exchange in prisons	Substitution treatment in prisons
China	no	no
Indonesia	no	yes
Iran	yes	yes
Malaysia	no	no (approved)
Vietnam	no	no

voices from the front

THE ONLY COMMODITY IN SHORT SUPPLY WAS SYRINGES

The following is the story of “Alexander G.” translated from Lyubov’ Nebrenchina’s forthcoming report: Наркополитика в России: судьбы репрессированных потребителей наркотиков (Drug policy in Russia: The fate of repressed drug users). Moscow: Kolodets.

In prison we had two terms: “freedom road” and “big road.” A “big road” connects the prison buildings. A rope is shot from the window of one building to the window of another. This rope is used to transport letters, notes sealed in plastic, or anything you want. Even bottles with *samogon* [homemade alcohol] are transported this way. A “freedom road” is the same rope (we had to weave it for a long time), but it must land outside the prison—in the freedom zone. At first, you need to make a wooden arrow... The arrow is attached to a rope and shot at a certain point outside the prison where a person is already waiting. It is not a secret that in every cell there are mobile phones and about 10 to 20 phone cards—everybody has their own. You can rent a phone for an hour and talk with home or make arrangements about delivering heroin. On the other side a parcel is attached to the arrow and then the rope is pulled by hand back to the prison. You could get anything you wanted—everything that could be slipped between the bars. In fact, we could even pull apart the bars (we had crow-bars and forcers) so that even three liter glass jar could be thrust through them. The only commodity that was in short supply was syringes. There were shakedowns. Once a week about 10 people in masks break into the cell. They flog everyone and kick them out. Then they start ransacking cloth sacks and mattresses. Usually they find a couple of mobile phones which we later buy back from the administration. They would confiscate them and about two hours later come and offer to sell a mobile phone for 500 rubles ransom. Of course, we would pay. They found syringes too. This commodity was worth its weight in gold. It was extremely difficult to get them in the prison.

The minute I mentioned that syringes should be boiled the jailer dissuaded me. “Don’t push this,” he said. “Nobody is doing it here. This is a minor thing which could emphasize your negative attitude.” In my cell there were HIV-positive prisoners. My sentence was the shortest one. Imagine an 18-year-old person with HIV who was sentenced to 22 years. He was sitting there and crying, “I will die in prison,” and here I was with my idea of boiling syringes.

Methadone and Buprenorphine Treatment

Prescription of methadone or buprenorphine for the treatment of opiate dependence, often known as substitution treatment, is common practice in Europe, the United States, and Australia. As of 2005, more than 800,000 of an estimated 2.7 million IDUs in Europe and the United States had access to these medications, which are among the best researched means of treating addiction and preventing HIV infections among IDUs.

Meanwhile, in developing/transitional countries with injection-driven epidemics, methadone and buprenorphine treatment is available to only 2 percent of the people who need it. Of the estimated 6.5 million IDUs in the countries discussed in this report, only about 130,000 have access to methadone or buprenorphine. Most of the buprenorphine clients—20,000—are private patients paying for services in Malaysia. Iran and China, with 96,000 methadone patients, account for over 90 percent of IDUs receiving that medication.

The addition of methadone and buprenorphine to WHO's Model List of Essential Medicines in 2005 was an important symbolic step. In practice, many countries continued to consider substitution treatment as much an issue of law enforcement as of public health. Unlike other patients being treated for chronic medical conditions, methadone and buprenorphine patients are often subjected to mandatory urine tests and dose reduction as a form of punishment, and are forced to discontinue treatment and undergo painful withdrawal before starting again.

Barriers to Treatment Access

Opposition from law enforcement

- In 2007, all patients in a buprenorphine support group in Odessa, Ukraine, reported experiencing police harassment. "We have changed," one patient noted. "The police have not."

- In Russia, a physician who posted information about methadone on his website was threatened with prosecution for promotion of illegal drugs.
- In Kazakhstan and Ukraine, opposition from the Ministry of Interior has delayed implementation of methadone programs for years.
- In Kyrgyzstan, police threaten methadone patients with arrest or demand bribes.

Stringent entry criteria

- In Georgia, patients applying to methadone programs must document that they have previously participated in a drug-free treatment program. Drug-free treatment, however, is expensive and in short supply, and patients who undergo it are added to government registries, which can lead to discrimination and harassment.
- In China, methadone is often offered only to those who have passed through two six-month terms of highly punitive compulsory detoxification, or "reeducation through labor." Only those with residence permits issued by police are eligible—and these are routinely denied to migrants or others.

Irregular supply

- In Moldova, methadone patients were suddenly informed in August 2007 that there was no more



Dispensing methadone at a clinic in Krakow, Poland

medication available. It was a month before treatment resumed.

- In Kyrgyzstan, fears of supply interruption in 2005 caused doctors to sharply reduce doses and urge patients to stop treatment. The size of the country's methadone programs fell by half.
- In Azerbaijan, a 2005 supply interruption forced the closure of the program, and sent patients to the streets.
- Uzbekistan ran out of methadone in June 2007. Patients were told to switch to buprenorphine.

Perpetual pilot status

Whether as a result of donor policy or local political discomfort, many buprenorphine or methadone programs languish as pilots while government authorities evaluate their viability. Even when proven effective, pilot programs are frequently never scaled up.

- In Hai Phong, Vietnam, a pilot program promised for nearly two years had yet to begin as of November 2007.
- In Poland, fewer than 1,000 people receive methadone despite 16 years of experience with the medication. Most clinics have waiting lists and large numbers of IDUs are in need in cities where no treatment exists.
- Ukraine authorized the use of methadone in 2006 and planned to reach 3,500 IDUs by late 2007. As of November 2007, the first patient had yet to receive the medication.
- Kazakhstan and Tajikistan both received Global Fund grants with the promise that they would start pilot methadone projects. As of November 2007, neither had begun.

Signs of Progress

Despite these barriers, there are a number of signs of progress in increasing access to treatment, including the following:

- In Albania, the first methadone maintenance therapy program was opened in 2005 by a nongovernmental organization, Aksion Plus, in close collaboration with the Institute of Public Health. A 2007 evaluation by WHO found that 95 percent of the clients reduced their use of illegal drugs and the majority reported significant changes in their health and social conditions.
- Iran's substitution treatment program, begun in 2002, has demonstrated impressive growth: by 2006, government programs were reaching 15,000 drug users with either methadone or buprenorphine.
- Malaysia launched a one-year pilot methadone project in 2005 which it quickly expanded to reach more than 2,500 clients in 2006; by early 2008 the Ministry of Health expects to cover 5,000 IDUs through more than 50 centers nationwide. If Malaysia achieves this, it will be a third of the way to reaching its 2010 target of 15,000 IDUs on methadone.
- By 2007, China was reaching 36,000 IDUs, up from 27,000 in late 2006. The number of sites offering methadone was projected to increase in 2007 from 195 to over 500 clinics, with the aim of establishing substitution treatment sites in every community with 500 or more drug users. The goal is to provide substitution treatment to 300,000 drug users through 1,500 clinics by the end of 2008.

voices from the front

ONE MOTHER'S EXPERIENCE WITH BUPRENORPHINE TREATMENT

The following is a speech given by Irina Sukhoparova at a press conference organized by the International Center for Advancement of Addiction Treatment (ICAAT) in Salzburg in October 2006.

There is an old French film *A Chacun Son Enfer*—everyone faces his own hell. We can paraphrase it by saying that every family of a drug addict faces its own hell.

My family spent 10 years in this hell, before the substitution treatment (ST) program helped us escape.

My daughter—who is 28 now—used heavy drugs for 10 years. We made many attempts to get her into treatment; she spent time in Christian rehabilitation centers on a number of occasions, but failed to achieve a lasting remission.

The situation was made worse by the fact that many people in Ukraine grow opium poppy for drugs. Rural residents found that growing poppy is much easier and more profitable than growing potatoes or other produce. Some of those who sell poppy straw are respectable people, such as teachers and clergy. Each year, as poppy heads begin to mature, drug users go to the countryside and steal poppy from the peasants. They call this period “the season” in their slang. My daughter participated in such raids of poppy fields for several consecutive years, and at the end of each summer she had to go into detox, having reached an enormous dose. She degraded even more each year, and whenever she lacked money for drugs, she sold her possessions or committed petty theft.

Now it seems like a nightmare, because it has been a year since my daughter and her husband are in the ST program. Now my daughter lives a normal life, she stays away from her former friends, reads books, watches television, and has recently found a job. She handles money as part of her job; she is very proud of being trusted with money, and she is very responsible in her work. Substitution treatment is like an oxygen tube for our family—we got it and we were allowed to breathe. But we are still afraid that someone may squeeze the tube and say, “now fend for yourselves as you wish.”

I believe that in Ukraine with its prevalence of drug use, tuberculosis and HIV/AIDS, ST is a necessity, and it should not be limited to pilot projects, but should be accessible to all those who need this treatment.

Mass media coverage of drug use and treatment methods, including ST, is controversial. Journalists, rather than doctors, describe what ST is about, and they distort the meaning of ST completely. I believe they should publish more life stories of actual people helped by ST—if not to get rid of their dependence, then at least to restore their normal human image, like my daughter and my son-in-law—or stories of those whom ST may help. For instance, a young woman I know who spent four months in a Christian rehabilitation center together with my daughter. She started using drugs at 15, and she is 25 now. Her mom has been going to the Protestant Charismatic Church for seven years—she has been praying for her daughter without rising from her knees. During this time, her daughter served three years in prison, became HIV-positive, and now sells sex to get money for drugs. I believe that her own and her mom's life could change for the better in a major way, if only this drug-dependent girl could access ST.

Of course, in addition to ST programs, more rehabilitation centers must be set up, free of charge as well as fee-based, so that drug users wishing to give up drugs could access qualified services.

We all know, however, that even the best rehabilitation centers have fairly low remission rates, and that rehabilitation centers in Ukraine are tragically lacking. Therefore, as long as there is a slightest possibility of saving thousands of young people from HIV, overdoses, and prison by giving them access to ST programs, doing so is plain common sense.

Methadone and Buprenorphine Availability

Central/Eastern European and Former Soviet Union Countries with Injection-Driven HIV Epidemics, 2007

	Estimated number of IDUs	Total number of patients on methadone	Total number of patients on buprenorphine	Percent of IDUs receiving treatment
Armenia	8,800	0	0	0%
Azerbaijan	19,335	93	0	0.43%
Belarus	45,842	15	0	0.03%
Estonia	19,877	530	165	3.50%
Georgia	12,420	225	0	1.81%
Kazakhstan	173,699	0	0	0%
Kyrgyzstan	44,398	194	0	0.44%
Latvia	18,725	50	0	0.27%
Lithuania	8,500	436	0	5.13%
Moldova	42,955	36	0	0.08%
Poland	96,514	720	0	0.75%
Russia	2,250,000	0	0	0%
Tajikistan	52,598	0	0	0%
Ukraine	400,000	0	522	0.13%
Uzbekistan	86,795	37	90	0.14%
Total CEE/FSU	3,280,458	2,299	808	0.9%

Sources:

IDU numbers: Aceijas C, SR Friedman, H. Cooper, L Wiessing, GV Stimson, and M Hickman. 2006. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. *Sexually Transmitted Infections* 82, iii 10-17.

Methadone and buprenorphine estimates: Central and Eastern European Harm Reduction Network report and IHRD communication with health officials, donors, and in-country correspondents.



A methadone maintenance program in Azerbaijan

Methadone and Buprenorphine Availability Asian Countries with Injection-Driven HIV Epidemics, 2007

	Estimated number of IDUs	Total number of patients on methadone	Total number of patients on buprenorphine	Percent of IDUs receiving treatment
China	1,928,200	*36,000	○	1.87%
Indonesia	561,925	1,500	○	0.26%
Iran	185,000	60,000	**6,500	36%
Malaysia	195,000	3,000	***20,000	11.79%
Vietnam	113,000	○	○	○ %
Total Asia	2,983,125	100,500	26,500	4.26%

* China: patients in the national methadone maintenance program as reported by the Ministry of Health through 2006.

** Iran: 5,000-8,000 patients estimated to receive buprenorphine; private physician prescription makes exact figure inaccessible.

*** Malaysia: 20,000 on buprenorphine are paying private physicians for prescriptions.

Sources:

IDU numbers: Aceijas C, SR Friedman, H. Cooper, L Wiessing, GV Stimson, and M Hickman. 2006. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. *Sexually Transmitted Infections* 82, iii 10-17.

Methadone and buprenorphine estimates: IHRD communication with health officials, donors, and in-country correspondents.



Harm reduction center in St. Petersburg, Russia

Looking Ahead

As IHRD and others striving to expand access to harm reduction services look ahead, several issues will require increased investigation and action in the coming years.

Women and Harm Reduction

Authorities who once appeared “asleep at the wheel” when HIV was concentrated among IDUs are being jolted awake by the increasing numbers of HIV-infected women and the alarm of a “generalized” epidemic. Outside of Africa, many of these HIV-positive women are the wives and sexual partners of male IDUs, but significant numbers are injecting drug users themselves. Especially in Asia and Eastern Europe, there have been rapid increases in the proportion of IDUs who are female. It is estimated that 20 percent of drug users in Eastern Europe and Central Asia and 40 percent in parts of China are women. In Yunnan, a recent study found women drug users had higher rates of HIV infection than male drug users. The vast majority of research on female drug users has been done in North America, Western Europe, and Australia. In developing and

transitional countries—even where HIV is spreading rapidly through injecting drug use—little is known about drug use among women.

Female IDUs are undercounted, understudied, and doubly marginalized by their status as women and drug users. Their needs have gone largely unaddressed. Sex workers have received attention, though largely in terms of their potential to serve as a “bridge” for HIV to cross over into the general population. But women drug users, including sex workers, require information and services that go beyond their role in transmitting HIV to others. Harm reduction programs like the one in Dushanbe, Tajikistan, that reported an increase in female clients from 4 percent in 2001 to 30 percent in 2006, do not necessarily have the training to deal with women’s specific needs.

Sexual Health and Harm Reduction

The broadening of HIV epidemics formerly concentrated among IDUs underscores the importance of including sexual health education and condoms in harm reduction programs. It is also a reminder that failure to offer effective HIV prevention for IDUs has a grave impact not just on people who inject drugs, but also their partners and children. While IDU epidemics are generalizing, they remain concentrated in communities highly affected by drug use. It remains to be seen whether policymakers will use reports of generalizing HIV infections to turn away from the needs of such communities, or to reinvigorate programs serving IDUs and their social networks.

African IDU Epidemics

IDUs in Kenya are estimated to number 30,000 and HIV prevalence among those tested in Nairobi is 53 percent, with similar levels expected in neighboring Tanzania, where one in three drug users in the capital report use of non-sterile injection equipment. Other countries reporting injecting drug use on the rise are Mauritius, which is ranked third in the world in per capita opiate use; Nigeria, where 11 percent of IDUs say they have shared syringes “in the last six months”; and South Africa. With the exception of a new pilot program in Mauritius, needle exchange and methadone treatment programs do not exist in Africa. PEPFAR support for programs in Africa does not include the provision of clean needles, a crucial step in establishing a relationship with clients. In Africa, UN Secretary General Ban Ki-Moon’s call for policymakers

and health officials to “know their epidemic” will mean knowing more about how to address these small but concentrated epidemics among IDUs.

Evidence-Based and Humane Drug Treatment

An urgent need for drug users—whether male or female, living in Lagos or Lithuania—is the establishment of international drug treatment standards. Too often drug users are subjected to ineffective, inhumane, and punitive forms of treatment consisting of little more than medicated withdrawal or prolonged incarceration in the name of health. Without substitution therapy or psychological support, they quickly relapse and are branded failures. Others pay large fees for unproven or abusive treatments, including flogging or partial lobotomy. Drug users should and must have access to treatment that is voluntary, affordable, high-quality, low-threshold, and gender-sensitive. For those faced with the threat of HIV, hepatitis, and other health issues, the stakes are high; the standards also should be. Multilateral institutions and national governments must offer greater guidance for human rights–friendly, effective treatment.

As the twin epidemics of HIV and injecting drug use spread to every corner of an ever more connected world, the words of Martin Luther King, Jr., seem particularly apt: “We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects me directly, affects all indirectly.”

The Open Society Institute works to build vibrant and tolerant democracies whose governments are accountable to their citizens. To achieve its mission, OSI seeks to shape public policies that assure greater fairness in political, legal, and economic systems and safeguard fundamental rights. On a local level, OSI implements a range of initiatives to advance justice, education, public health, and independent media. At the same time, OSI builds alliances across borders and continents on issues such as corruption and freedom of information. OSI places a high priority on protecting and improving the lives of marginalized people and communities.

Investor and philanthropist George Soros in 1993 created OSI as a private operating and grantmaking foundation to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help countries make the transition from communism. OSI has expanded the activities of the Soros foundations network to encompass the United States and more than 60 countries in Europe, Asia, Africa, and Latin America. Each Soros foundation relies on the expertise of boards composed of eminent citizens who determine individual agendas based on local priorities.

www.soros.org

International Harm Reduction Development Program (IHRD)

Founded in 1995, the International Harm Reduction Development Program (IHRD), a project of the Public Health Program 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 programs in Central and Eastern Europe, the former Soviet Union, and Asia, bases its activities on the philosophy 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 of needle exchange, opiate substitution treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the political participation of people who use drugs and those living with HIV. www.soros.org/harm-reduction



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