

Regional Overview

2.2 Eurasia

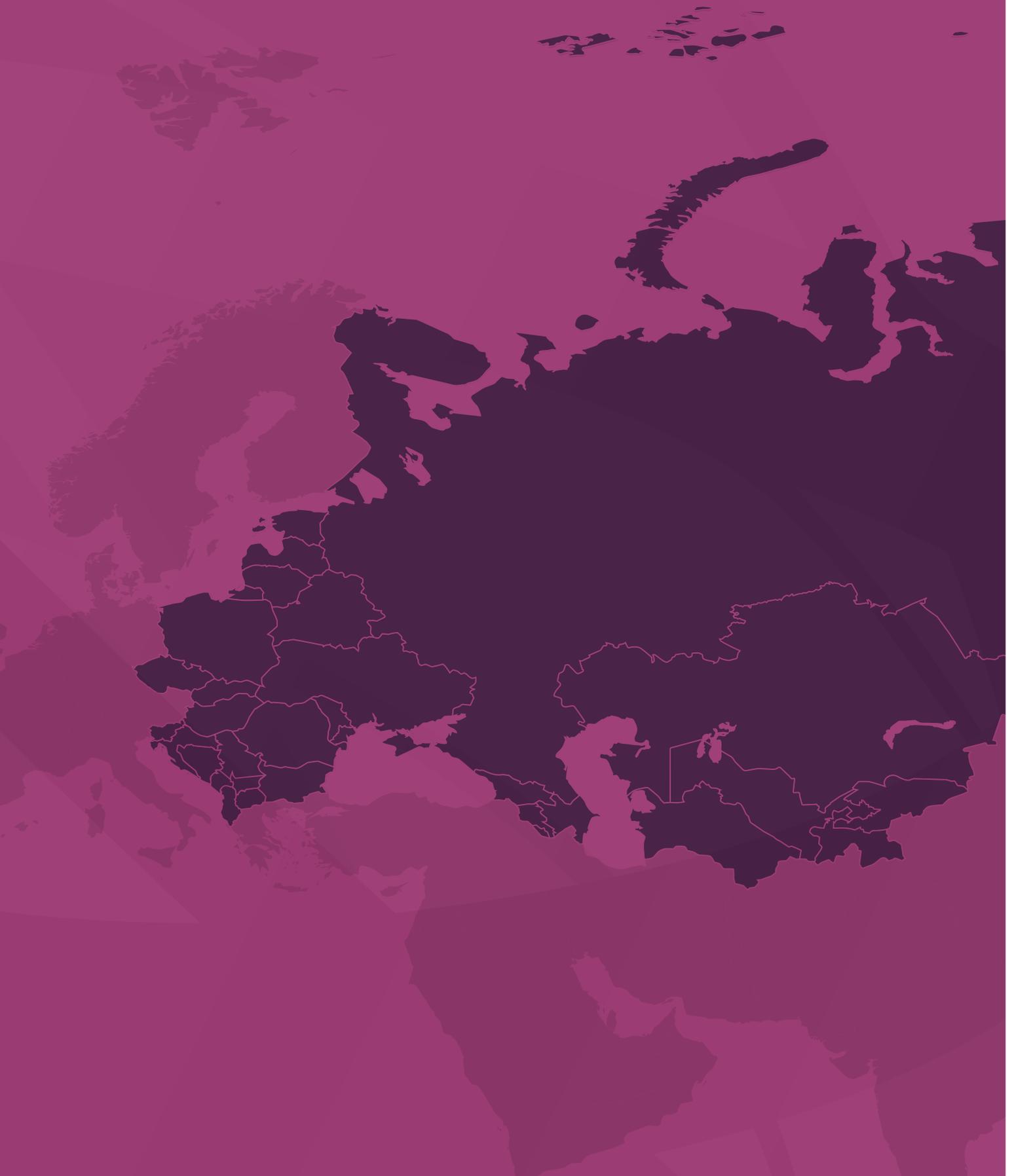


Table 2.2.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Eurasia

Country/territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs(%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs(%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response			
					NSP ^a	OST ^b	Peer-distribution of naloxone	DCRs
Albania	5,132 ^[1]	0.5% ^[1]	28.8% ^[1]	11.5% ^[1]	✓2 ^[2,3]	✓6 ^[2]	x	x
Armenia	13,000 ^[4]	5.4% ^[4]	42.7% ^[4]	nk	✓12 ^[2,3]	✓4 ^[2]	x	x
Azerbaijan	71,283 ^[5]	9.7% ^[4]	62.1% ^[4]	10.4% ^[4]	✓17 ^[4]	✓2 ^[2]	x	x
Belarus	40,500 ^[4]	25.6% ^[4]	58.3% ^[4]	11.2% ^[4]	✓34 ^[2,3]	✓19 ^[6]	x	x
Bosnia and Herzegovina	9,500-15,000 ^[7]	0.3% ^[4]	39.9% ^[4]	0.5% ^[4]	✓5 ^[8]	✓7 ^{[2](M,O)}	x	x
Bulgaria	18,500 ^[4]	1.7-3% ^[9]	57.8-68.5% ^[9]	6.6% ^[4]	x ^[10]	✓31 ^[11]	x	x
Croatia	6,344 ^[12]	0.5% ^[12]	38.3% ^[12]	0.9% ^[4]	✓142 ^[13]	✓1 ^{[3](M,O)}	x	x
Czech Republic	47,000 ^[4]	0.3% ^[4]	18.3% ^[4]	15.1% ^[4]	✓153 ^[13]	✓1 ^{[3](M,B,BN)}	x	x
Estonia	8,500 ^[4]	53.4% ^[4]	79.2% ^[4]	3-22% ^[14]	✓37 ^[13]	✓9 ^{[2](M,B,BN)}	✓1 ^{[14]c}	x
Georgia	52,700 ^[15]	2.3% ^[16]	65-75% ^[16]	7.2% ^[4]	✓22 ^[2]	✓18 ^{[2](M,BN)}	x	x
Hungary	6,707 ^[17]	0.2% ^{[17]d}	49.7% ^[17]	2.2% ^[4]	✓43 ^[13]	✓15 ^{[2](M,BN)}	x	x
Kazakhstan	120,500 ^[18]	9.2% ^[4]	58.8% ^[4]	7.9% ^[4]	✓144 ^[19]	✓10 ^[19]	x	x
Kosovo	nk ^e	nk	26.6% ^[20]	4.1% ^[20]	✓2 ^[2]	✓3 ^[2]	x	x
Kyrgyzstan	28,500 ^[4]	12.4% ^[4]	43.9% ^[4]	nk	✓40 ^[21]	✓31 ^[22]	x	x
Latvia	12,537 ^[23]	6.5% ^[23]	52.5% ^[23]	3.8% ^[23]	✓25 ^[13]	✓10 ^{[2](M,B,BN)}	x	x
Lithuania	5,000 ^[4]	8% ^[4]	41% ^[4]	10.5% ^[4]	✓14 ^[13]	✓1 ^{[3](M,B,BN)}	x	x
Macedonia	nk	nk	64% ^[24]	nk	✓16 ^[24]	✓16 ^[24]	x	x
Moldova	12,000 ^[4]	nk	50.1% ^[4]	5.7% ^[4]	✓28 ^[25]	✓19 ^{[2]f}	x	x
Montenegro	nk	0.2% ^[4]	43.4% ^[4]	nk	✓13 ^[2]	✓5 ^[2]	x	x
Poland	14,670 ^[26]	3% ^[26]	58.7% ^[4]	4.9% ^[4]	✓36 ^[13]	✓ ^[26]	x	x
Romania	81,500 ^{[4]g}	20.5% ^[4]	83.8% ^[4]	5.2% ^[4]	✓2 ^{[27]h}	✓ ^[28]	x	x
Russia	1,881,000 ^[4]	30.4% ^[4]	68.7% ^[4]	9% ^[4]	✓20 ^[4]	x	x	x
Serbia	29,000 ^[4]	<1% ^[4]	25.9% ^[4]	3.6% ^[4]	✓2 ^[29]	✓23 ^[30]	x	x
Slovakia	20,000 ^[4]	0.1% ^[4]	56.1% ^[4]	1.7% ^[4]	✓13 ^[13]	✓1 ^{[3](M,B,BN)}	x	x
Slovenia	6,000 ^[4]	0.5% ^[4]	30.5% ^[4]	3.4% ^[4]	✓102 ^[13]	✓10 ^{[3](M,B,BN)}	x	x
Tajikistan	23,100 ^[31]	27% ^[4]	61.3% ^[4]	nk	✓51 ^[32]	✓12 ^{[32](M)}	x	x
Turkmenistan	nk	nk	nk	nk	x	x	x	x
Ukraine	319,500 ^[4]	19.1% ^[4]	53.9% ^[4]	5.6% ^[4]	✓1,667 ^[3]	✓174 ^{[33](M,B)}	✓ ^[34]	x
Uzbekistan	94,000 ^[4]	7.3% ^[4]	21.8% ^[35]	nk	✓230 ^[36]	x	x	x

nk – not known

a This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets.

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

c Naloxone can only be provided by medical personnel.

d Data from 2014; however, civil society report an increase in HIV diagnoses attributed to injecting drug use in 2018.

e Recent studies on drug use and the public health response have not been undertaken in Kosovo since 2008.

f Of these services, 13 are based in prisons.

g National estimates for the number of people who inject drugs in Romania vary widely among different international agencies. The figure cited represents the most recent from an independent study.

h An additional 9 NSPs operate in prisons in Romania. However, this service has never been utilised by people in prison. Please refer to prison section (p56).

Map 2.2.1: Availability of harm reduction services



Harm reduction in Eurasia

Overview

The region of Eurasia covers diverse countries, with varied levels and types of drug consumption. Every country in the region reports injecting drug use,^[4] but, as in all other regions of the world, cannabis remains the most commonly used drug.^[18,37] In Eurasia, there is a growing trend in the use of amphetamine-type stimulants (ATS) over the last decade.^[37] In particular, the Czech Republic (and more recently, neighbouring countries) have been associated with the production of much of Europe's methamphetamine market, with stimulants reported as the primary drug injected in the Czech Republic, Hungary and Latvia.^[38] Although injecting drugs as the primary route of administration has reduced *overall* in Eurasia over recent years, data also reveal a general upward trend in the use of ATS and new psychoactive substances (NPS) via other routes of administration (e.g. swallowing, snorting or smoking).^[18,37]

The state of harm reduction in Eurasia has remained largely stable since 2016, with the exception of certain countries, namely Bosnia and Herzegovina, Bulgaria, Hungary and Romania, which have seen the closure/scaling back of harm reduction services. Harm reduction is still mentioned in national government policies in 26 of the 29 countries in the region.¹ Needle and syringe programmes are available in 27 of the 29 countries in the region, the notable change being the closure of NSPs in Turkmenistan and Bulgaria since the *Global State of Harm Reduction* last reported.

Opioid substitution therapy (OST) remains available in 26 of the 29 countries in the region. In Russia, which retains considerable influence in parts of the region, the government's punitive policies and practices towards drug use continues, with a national ban on OST and extremely limited NSP site provision, despite increasing rates of HIV^[38] and hepatitis C in the country among people who inject drugs.^[38] Ideology surrounding drug use in Russia, often entrenched in unscientific drug prevention and treatment measures which deny people access to essential medicines and services, has led to gross violations of a number of human rights, including exploitation by law enforcement officials, pain and suffering associated with withdrawal, and coerced confessions regarding drug use.^[39,40] OST is also unavailable in Turkmenistan and Uzbekistan. Civil society in Russia and neighbouring countries continues to advocate for the implementation of the nine core harm reduction interventions recommended by the World Health Organization (WHO).^[2]

Across the region, HIV transmission attributed to injecting drug use has seen a decline in some countries (detailed below). In contrast, Russia and Hungary have seen an increase in HIV prevalence,^[38] and according to a 2018 report from UNAIDS, people who inject drugs account for 39% all of new HIV infections in the region.^[41] In 2016, people accessing harm reduction services in Hungary reached their lowest level in seven years.^[17] Ukraine bears the second largest HIV epidemic in the region, concentrated among key populations.^[42] In many countries there also remains a distinct lack of integration of HIV testing and treatment services within harm reduction programmes.^[2]

The funding crisis for harm reduction is having a negative impact on a number of countries in Eurasia.^[43] Austerity, international donor retreat and poor political support for harm reduction are the primary factors underpinning this.^[43] In some countries in Eurasia, the withdrawal of the Global Fund has left gaps in service provision that government support is yet to fill.^[43] Civil society in the region reports the closure of community organisations and the closure of services. In some cases, the transition to government support impacts upon quality of services, such as poor-quality needles being supplied.^[2,44] Often where harm reduction services do exist, they are not inclusive; for example, women experience greater difficulty in accessing services and very few, if any, adapted models of harm reduction service provision for women are in operation.^[45] The role of NGOs and community-led service providers in harm reduction is still not supported by the majority of governments in the region of Eurasia.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

The number of countries in Eurasia in which NSPs operate has reduced by one since the *Global State of Harm Reduction 2016*, with services currently available in 27 of the 29 countries. Notwithstanding this, restrictive opening hours, poor-quality equipment and stigma remain barriers to NSPs in many countries in the region.^[2] In 2016, it was reported that Turkmenistan had two NSPs, but these services no longer exist. In 2017, due to the withdrawal of donor funding and the lack of government support, all NSPs in Bulgaria have closed down or ceased providing needles and syringes.^[10] In 2016, the WHO adjusted

i Azerbaijan, Russia and Turkmenistan do not have harm reduction within any national policies.

its targets for high coverage syringe programmes, from its 2009 target of 200 syringes per person who injects drugs per year to a target of 300 syringes per person who injects drugs per year by 2030.^[46] Increases and decreases in accessibility, availability and coverage of NSPs have been observed in Eurasia. When looking specifically at the number of sites providing NSPs, this increased in eight countries since the *Global State of Harm Reduction* reported in 2016 (Croatia, the Czech Republic, Estonia, Georgia, Latvia, Poland, Slovakia and Slovenia). In the Czech Republic, just short of 6.5 million syringes have been dispensed since 2007 and the number of people who use drugs accessing NSP services increased, with over 8,000 new clients in 2016 alone.^[47] With injecting more frequently associated with methamphetamines rather than opioids in the Czech Republic (estimates suggest around 75% of needles procured are for methamphetamine use), a greater number of syringes are required due to the fact people who inject stimulants often inject more frequently. Syringes are accessible via vending machines in the Czech Republic^[47] and Hungary.^[13]

A number of countries in the region also have mobile NSPs or outreach programmes which deliver needles and syringes alongside other injecting equipment and, in many cases, healthcare services or referrals. In Estonia, two mobile NSP units began operating in 2018 via van, and combine HIV/hepatitis C/ tuberculosis and STI testing and treatment, although treatment for hepatitis C is not available.^[48] In 2016, 2.1 million syringes were distributed via NSPs (at both mobile and fixed sites) in Estonia, and although regional coverage could be improved, overall satisfaction has been reported by people using the services.^[48] In Slovakia between 2015 and 2016, an increase in the number of syringes distributed was reported which, similarly to the Czech Republic, is due to an increase in stimulant injecting.^[49] Latvia and Hungary also report stimulants as the primary drug injected.^[37] However, in Latvia NSP site provision has increased since 2016, whereas in Hungary, two key needle and syringe sites have been closed down.^[17,50] The number of syringes distributed per person who inject drugs per year was already only 10% (n=30) of the recommended WHO standard of 300^[46] prior to the closure of these services and concerns have been raised over the gradual increase in HIV among people who use drugs.^[17,52] With the closure of all NSP services in Bulgaria there are similar fears.^[10]

Decreases in NSP site provision have been also been observed in Serbia and Uzbekistan since the *Global State of Harm Reduction* last reported in 2016. In 15 countries (Albania, Armenia, Azerbaijan,

Belarus, Bosnia and Herzegovina, Kazakhstan, Kosovo, Kyrgyzstan, Lithuania, Macedonia, Moldova, Montenegro, Tajikistan, Russia and Ukraine) provision of NSP has remained stable. In Russia, there are reported to be 100,000 new HIV diagnoses each year, with a high proportion believed to be attributed to unsafe injecting drug use and a lack of harm reduction provision and funding.^[38] Civil society in Kazakhstan reports poor-quality syringes distributed by government-funded programmes, leading to the potential for increased unsafe injecting.^[2,44] In Romania, two NGOs provide NSPs; however, geographical coverage remains poor and services are only available in Bucharest and Ilfovy County.^[28] In Ukraine, women experience a high level of stigma, discrimination and violence, making them harder to reach with NSP services.^[45] Adapted services are therefore needed and are being advocated for by the Women's Harm Reduction International Network (WHRIN).^[45]

Opioid substitution therapy (OST)

As reported in 2016, 26 countries in the region have some form of OST provision available for people who inject/use opioids. OST is prohibited in Russia, Turkmenistan and Uzbekistan, despite the WHO's recommendation that where injecting drug use occurs, the country must *prioritise* implementation of both OST and NSP as a public health concern.^[51] Table 2.2.1 shows high rates of HIV and hepatitis C are reported for the 1.8 million people who inject drugs in Russia. To put the figures in perspective, between 2011 and 2016 the annual increase of HIV prevalence globally was 10% (including sub-Saharan Africa with the highest burden of disease). In Russia during the same period, HIV prevalence increased 75%.^[52] Harm Reduction International's research found that while Russia accounts for 20% of all people who injects drugs in low- and middle-income countries (LMICs), investment in harm reduction is so low that it is equivalent to only 1% of all identified harm reduction funding in LMICs.^[53]

Across the 26 countries in the region that offer OST, provision has been largely stable over the last two years; however, coverage varies considerably and is extremely low in some states.^[2] Heroin assisted therapy (HAT) as a form of OST remains unavailable in Eurasia. In Romania, civil society reports a reduction of OST provision.^[27] In Kosovo, less than 0.3% of the estimated number of people who inject drugs receive OST.^[20] In Lithuania, OST can be prescribed via specialist centres and psychiatrists only, and the person must have health

j Vending machines do not supply needles and syringes free of charge.

insurance.^[30,54] Methadone remains the most widely used form of OST in the region; however, the lack of take-home dosing in many countries due to rigid regulatory frameworks, the position of law enforcement officials and a lack of trust between service providers and attendees serve to exacerbate issues of access for people who inject drugs.^[2]

Unlike NSP services, many governments fully fund OST provision in the region, including Azerbaijan, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Serbia, Slovakia, and Slovenia.^[2] In Belarus and Georgia, government funding for OST has recently increased.^[2] In Belarus, the state now funds OST provision, with the exception of the medication costs (funded through the Global Fund).^[2] In 2017, Georgia began to fully fund all methadone programmes, covering approximately 6,000 people. An additional 1,200 people receive buprenorphine through the private system.^[2,55] In Estonia, coverage of OST is considered stable and state funding for harm reduction services has been increasing; however, there are waiting lists for those initiating treatment.^[48] In 2018, the government of Ukraine committed to fund and expand access of OST to over 10,000 people at 178 health-care facilities.^[56]

In Kazakhstan, reduced Global Fund funding and limited political support has seen OST restricted to pilot programmes at 10 sites across three cities, with less than 1% of people who use drugs accessing the programme.^[53] A repressive policy and legal environment, unequal coverage between rural and urban settings, stigma, and the requirement to abstain from illegal drugs all form barriers to access and adherence to OST. Earlier in 2018, the government of Kazakhstan threatened to close the country's OST programmes, highlighting the political vulnerability of the service. The prompt civil society advocacy response appears to have paused this decision.^[57]

Amphetamine-type stimulants (ATS), cocaine and its derivatives, and new psychoactive substances (NPS)

Cannabis is the most commonly used drug in nearly every county in the region, but a growing trend in the use of amphetamine-type stimulants has emerged in Eurasia over the past decade.^[37] In particular, the Czech Republic (and more recently, neighbouring countries) have been associated with much of Europe's methamphetamine market, with stimulants reported as the primary drug injected in the Czech Republic, Hungary and Latvia.^[37] Although injecting drugs as the primary route of administration has

declined in general over the last decade,^[37] data in many countries reveal a general upward trend of ATS use via swallowing, snorting or smoking; for example, in Poland,^[26] Estonia^[14] (where amphetamines are the most commonly used stimulant), Lithuania^[54] (with the city of Vilnius having the highest levels of methamphetamine residue detected in wastewater in the whole of the European Union) and Slovakia.^[49]

A recent report by Mainline, a Netherlands-based harm reduction organisation, provides the most comprehensive review of stimulant harm reduction programmes and practices to date.^[58] The report provides a literature review on various types of stimulants, routes of administration and harm reduction strategies, case studies from across the globe and reviews interventions specific to people who use stimulants. The potential health-related harms of stimulant use are different to those experienced by people who use opioids. People who use stimulants report feeling that they belong to different (social) networks of people who use drugs, meaning they may feel opioid-focused harm reduction services are irrelevant or inaccessible to them.^[58] However, similarly to people who use opioids/inject drugs, there is no single intervention which is recommended, but a comprehensive body of interventions.^[58] These include: safer smoking kits for people who smoke (crack cocaine and methamphetamines); prevention of sexual risk; female-focused interventions; drug consumption rooms; self-regulation strategies; substitution; outreach and peer-based interventions; drop-in centres; housing first; therapeutic interventions; and drug-checking services.^[58]

Harm reduction responses for people who use stimulants, including cocaine and its derivatives, MDMA and psychedelics such as LSD (commonly referred to as "party drugs") are relatively limited in Eurasia. The response to ATS use in all countries in Eurasia is almost exclusively abstinence-based, the exceptions being harm reduction approaches in the Czech Republic and Poland.^[2] In the Czech Republic, given the high proportion of people who inject methamphetamines, together with data that suggests more than half of people surveyed had ever shared their injecting equipment with peers,^[47] many harm reduction programmes (including NSPs) distribute gelatine capsules as an oral alternative to injecting.^[47] This simple and low cost approach can contribute to the reduction in risk of blood-borne viruses and of smoking with toxic materials.^[59] The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports that there has been a steady increase in the number of people coming into contact with harm reduction services in the Czech Republic.^[47] In Poland, a pilot project operating in

Warsaw offers drug-checking via pre-distribution of testing strips at clubs, festivals and events.^[60] The project also procures samples from online shops, tests and evaluates the substance and shares information with people who use drugs.^[60] In many cases, NPS are advertised as synthetic cannabinoids but contain synthetic opioids.^[60] In a number of countries, a barrier to drug-checking services is the requirement that service providers obtain licences to possess and work with scheduled substances; many countries do not accept drug-checking as a valid reason to issue such licences.^[61]

New psychoactive substances contribute to the growth in ATS use in Eurasia. In 2018, the United Nations Office on Drugs and Crime (UNODC) *World Drug Report* noted that 36% of all NPS on the global market were stimulants.^[18] Since the *Global State of Harm Reduction* last reported in 2016, many countries in Eurasia report an increase in NPS use.^[2] NPS can be swallowed, snorted, smoked or injected; but in most cases, injecting is associated with either synthetic stimulants or opioids.^[2] In a number of cases, people using heroin or methamphetamine, specifically where these substances may be temporarily unavailable, will switch to a NPS.^[2] Reasons for switching to NPS rather than traditional substances are often based on price, availability and less fear of detection of the substance by police and law enforcement officials.^[2] NPS have been associated with younger people, representing a challenge to harm reduction programmes in terms of reach, particularly if young people are injecting and unaware of potential harms.^[2,37]

In Hungary, a shift from injecting established drugs (such as heroin or amphetamines) to injecting NPS (namely synthetic cathinones similar to amphetamines and MDMA) has been observed in recent years.^[17] Other NPS, consumed via different routes of administration (e.g. swallowing, snorting or smoking) have become popular among younger people and are increasing in use.^[17] In 2018, the EMCDDA reported that, although the number of new psychoactive substances was down from the peak reached in 2015, around 400 new substances are reported each year.^[37] NPS, mostly synthetic cannabinoids and cathinones, are mainly imported from the Czech Republic, Poland and Hungary, or arrive directly from countries in East Asia (mainly China).^[49]

NPS present an evolving challenge to harm reduction practices and the harm reduction response fails to meet need in the region. Even in countries where there is political will for greater syringe distribution

for people who inject stimulants/NPS, services are often unable to provide a sufficient number of syringes or syringes of good quality.^[44]

Overdose, overdose response and drug consumption rooms (DCRs)

Overdose continues to account for the majority of morbidity and mortality associated with opioid drug use in Eurasia.^[37] From estimates of drug use in the European Union (of which some countries in the Eurasia region of this report overlap), opioids were found in 84% of fatal overdoses.^[37] In 2018, Estonia had the highest rate of fatal overdose of all the European Union countries, with fentanyl^k found in the majority of these cases.^[37] It is difficult to assess the true scale of overdose and morbidity and mortality, due to inconsistent reporting and differences in surveillance systems, which have led to systematic under-reporting of overdose-related death. In Lithuania, for example, the drug-induced mortality rate among adults between the ages of 15-64 was more than double the European average.^[54] In Hungary, approximately one quarter of all drug-related deaths involved opioids, always found in combination with other substances.^[17] Although in the Czech Republic a lower proportion of drug-induced deaths were recorded with opioids as the principal drug involved in 2015, the proportion of *prescribed* opioid-related death increased in 2016.^[47] In Slovakia, similarly to many other countries in the region, although the number of drug-induced deaths is relatively small, approximately nine out of 10 were linked to opioids.^[49]

Naloxone is a highly effective opioid antagonist used to reverse the effects of opioid overdose in minutes. The medicine, which can be delivered in various ways (intra-nasal, sublingual and buccal) can, however, only be effective if accessible.^[62-65] In Estonia, a total of five service providers (in Harju County and Ida-Viru County) provide naloxone, but kits must be provided via medical personnel. People who use opioids and their relatives are trained in how to recognise an overdose, administer naloxone and provide first aid until the emergency services have arrived.^[14] Between 2013 and 2016, 1,770 people had undergone naloxone training and 1,764 pre-filled syringe kits had been distributed.^[48] Four hundred and sixty-six kits were issued to repeat clients, with 95% of the reason for requesting a repeat because the pre-filled syringe had been used to save someone's life.^[48]

In Lithuania, a small-scale pilot naloxone initiative began in late 2016, but naloxone is given to

k Fentanyl and its analogues are synthetic opioids which can be 50 times more potent than heroin and 100 times more potent than morphine.

people only upon completion of a detoxification programme.^[54] In 2013, two pilot naloxone programmes were launched in Kyrgyzstan and Tajikistan, where people who inject drugs were trained in overdose prevention and naloxone use.^[66] Over the course of the pilot, 81.5% of participants in Kyrgyzstan and 59.3% of participants in Tajikistan reported receiving naloxone to reverse an overdose.^[66] In Tajikistan, naloxone programmes remain operational, with people able to access the medication through harm reduction programmes.^[2] In Ukraine, with funding from the Global Fund, naloxone is available through healthcare and social workers trained in overdose prevention and distributed via harm reduction programmes and outreach.^[34] In Russia, organisations like the Andrey Rylkov Foundation provide naloxone to people who use drugs via outreach harm reduction programmes. In 2018, production of naloxone stopped in Russia and civil society reports they now face challenges in accessing the medicine.^[67]

In many other countries in the region, naloxone is only available via a prescription.^[2] Although emergency medical staff have access to the medication in all countries, for those most likely to witness an overdose, access is extremely limited.^[2] Harm reduction programmes distribute naloxone in Belarus, Georgia, Estonia, Lithuania (to some degree), Kazakhstan and Kyrgyzstan.^[2] However, overdose prevention (if undertaken in countries) is often fragmented due to a lack of funding, a lack of resources and a lack of awareness by states regarding the effectiveness of a life-saving medication.^[2]

In 2018, there remain no drug consumption rooms (also known as overdose prevention sites) or safe injecting facilities in Eurasia.

Viral hepatitis

In 2016, the *Global State of Harm Reduction* reported that hepatitis C prevalence among people who inject drugs was over 50% in 16 countries in Eurasia (see Table 2.2.1) and the same is true in 2018. Since 2011, for example, the rate of hepatitis C infection among people who inject drugs in Hungary has doubled^[17] and in 2014, a study in Latvia reported prevalence rates of 85.4% among people who inject drugs.^[23] Few countries in the region have national hepatitis C treatment programmes, irrespective of action plans or policy statements.^[2] Treatment for hepatitis C is often at a high financial cost to the person and not free at the point of access.^[2] Where treatment is available, there are often restrictive criteria; for example, in Belarus and Kazakhstan, the state will

only cover the cost of treatment if the person is co-infected with HIV.^[2] In Hungary, while treatment is available and cost-neutral, long waiting lists restrict access.^[2] In Estonia and Lithuania, treatment is only available at no cost to the person during the late stages of fibrosis.^[2] In Estonia, hepatitis C treatment is provided primarily through health insurance; this represents a barrier for many people who use drugs who do not have private health insurance.^[48]

In the Czech Republic and Slovenia, treatment for the hepatitis C virus is available to all people who inject drugs via public health facilities, but access remains limited.^[47,49] Access to hepatitis C testing and treatment in Lithuania, Moldova, and Romania is specifically limited to those who have state health insurance or are willing to cover the cost of testing and treatment themselves, and in Lithuania only four units in the whole country provide viral hepatitis testing.^[54] In Ukraine, through funding provided by the Global Fund, hepatitis C treatment is available free of charge to key populations, including people who use drugs (the government funds treatment for the general population).^[68,69] In Armenia, Russia and Tajikistan, hepatitis C treatment is only available to those who can cover the cost in full themselves.^[2] In Latvia, Montenegro, Serbia and Albania, people who inject drugs are required to stop using drugs prior to receiving treatment for hepatitis C.^[2]

Hepatitis C testing and treatment: the integrated care approach in Georgia

Georgia is the first country in the region to launch a nationwide hepatitis C elimination programme for people who inject drugs. The programme launched in April 2015, with partnership and technical assistance provided by the United States Centres for Disease Control and Prevention, and commitment from Gilead Sciences to donate direct-acting antivirals (DAAs).^[70] As of March 2018, 31 sites for hepatitis C treatment were in operation throughout the country, being integrated into OST services in 2017, and NSPs in 2018.^[2,55] To date, 500,000 people have been screened and just over 40,000 people enrolled in treatment.^[55]

Civil society, researchers and public health advocates believe that Georgia's hepatitis C elimination programme will provide lessons for future hepatitis treatment programmes, particularly as treatment becomes more affordable and more countries seek to provide care and treatment services.^[71]

Tuberculosis (TB)

Data on TB prevalence among people who inject/use drugs are often sparse, and without these it is difficult to assess the true prevalence of TB among this population in the region. Overall incidence of TB in countries within the European Union (Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia) is low.^[72] However, new cases of multi-drug resistant TB rates remain at the highest in Eurasia,^[72] with Belarus, Moldova and Uzbekistan accounting for 35.8%, 31.1% and 44.6% of all cases of multi-drug resistant TB respectively.^[72] Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine all had prevalence between 20-29%, whilst Armenia, Azerbaijan, Estonia and Latvia all had a prevalence rate of between 10-19% of multi-drug resistant TB.^[72] The Russian Federation is a high-burden country that has seen rates of TB in decline, dropping 13% between 2013-2017.^[73] However, Russia remains one of the three countries that account for almost half of the world's cases of multi-drug resistant TB.^[73] Tuberculosis also remains the main AIDS-related cause of death among people living with HIV in Ukraine.^[42]

The level of integration of TB into harm reduction programmes varies across the region, and theoretically TB screening and treatment is available across Eurasia. In Estonia, taking into account that tuberculosis remains a significant health challenge among people who live with HIV, free tuberculosis screening is provided on a regular basis for high-risk groups not covered by health insurance, including people who inject drugs.^[14] In Romania, the treatment of TB and HIV infection is universally provided for anyone infected, but levels of access to treatment for chronic HCV infection remain low.^[28]

The DETECT-TB (Early Detection and Integrated Management of Tuberculosis in Europe) project launched in 2016 aims to contribute to the decline and eventual elimination of TB in the European Union. The project emphasises the importance of the early diagnosis of vulnerable populations, including people who inject drugs and prisoners, and the sharing of best practices between programme countries. The project works through a network of partners in six states, two of which are in Eurasia (Bulgaria and Romania) using a mobile van.^[74,75] Good practice notes that outreach to marginalised populations may help to mediate between these groups and formal health services.^[76] Similar to other infectious diseases associated with injecting drug use, stigma and a lack of awareness also play a significant role in compounding the TB epidemic among people who inject drugs.^[76-78]

HIV and antiretroviral therapy (ART)

In a 2018 UNAIDS report, 39% of all new HIV infections in Eurasia were due to injecting drug use.^[41] However, transmission patterns vary from country to country. Notably, HIV attributed to injecting drug use has seen a decline in Poland and Latvia,^[23] and in Estonia it is estimated that only 30 new HIV infections were associated with injecting drug use in 2016, lower than in previous years.^[14] In Slovakia, only one case of HIV was linked to injecting drug use in 2016.^[49] Overall, the proportion of new HIV infections linked to injecting drug use in Lithuania declined from more than 60% in 2010 to less than 30% in 2015, but increased to around 40% in 2016.^[54] In Latvia, the number of new HIV infections over the last decade has remained stable among people who inject drugs; however, findings from a study among people who inject drugs in Riga (the country's capital) indicated that around a quarter tested positive for HIV.^[23] This example illustrates the difficulty in assessing true rates of HIV among a heavily criminalised and stigmatised population. In Russia there has been a 75% increase in new HIV infections between 2011 and 2016.^[38]

In many countries in the region, there also remains a distinct lack of integration of HIV testing and treatment services within harm reduction programmes.^[2] Where integration of these services does exist, it often depends on ad-hoc collaboration between harm reduction services and specialised medical facilities.^[2] In Lithuania, rapid HIV testing for people who use drugs now occurs in medical centres, whereas previously NGOs employed an outreach nurse to carry out testing.^[2] Civil society organisations are concerned that this change may lead to reduced uptake amongst an already stigmatised and hard-to-reach population.^[2] In 2016, a study in Kazakhstan and Kyrgyzstan found that a fear of being registered with the Narcological Register prevented people who use drugs from accessing healthcare services.^[79] Further regulatory barriers to uptake of HIV testing and treatment have been noted in Armenia and Tajikistan, where NGOs are prohibited from performing rapid testing and treatment unless they hold a special medical licence. To bypass this, some NGOs collaborate with medical institutions to provide testing.^[2]

To achieve the 90-90-90 target set by UNAIDS,^[52] urgent scaling up of the nine core harm reduction interventions as recommended by the WHO is needed in the region,^[51] particularly given rising rates of HIV attributed to unsafe injecting in countries like Russia, Turkmenistan and Uzbekistan.

¹ It is believed the transmission route remains unreported in a large proportion of new infections in Poland, meaning the data may not be representative.

Harm reduction in prisons

UNAIDS have estimated that 56-90% of people who inject drugs will be incarcerated at some stage in their lives.^[80] In Eurasia, drug offences are a major contributor to high incarceration levels,^[81] though the proportion of prisoners incarcerated for drug-related offences in the region varies. In a 2015 survey, more than one-third of prisoners in Slovenia reported ever having used a drug in their lifetime, with one in four stating they had used drugs in prison.^[49] In Latvia, approximately 69% of prisoners had used drugs at some point in their life, with 40% having done so in the last month.^[23] Drug use was also found to be more common among female rather than male prisoners.^[23] In 2016, a survey conducted in Czech prisons found that more than half of those imprisoned had used an illicit drug prior to imprisonment, 41% of whom had used methamphetamine.^[47] Injecting drug use also occurs within the prison setting, with around 7% of people injecting in prisons and 6% reporting sharing injecting equipment inside prisons in the Czech Republic.^[47] At the time of publication, NSPs did not operate in prisons in the Czech Republic. In Russia, around 23% of people in prison have been convicted of drug-related offences.^[82]

Needle and syringe programmes only operate in prisons in five of the 29 countries in the Eurasia region: Armenia (all prisons),^[83] Kyrgyzstan (7 prisons),^{[21]m} Macedonia (no details available),^[84] Moldova (18 prisons),^[85] Tajikistan (1 prison).^{[86]n} Romania also operates NSPs in nine of its 45 prisons;^[13] however, reports suggest the service has never been utilised^[28] as prisoners must register formally for the programme.^[84,87] Moldova is one of the only countries in the region that has scaled up its NSP provision since the *Global State of Harm Reduction* last reported in 2016, going from 13 prisons in 2016 to 18 in 2018.

Access to OST in prisons is stronger than access to needles and syringes, and is currently available in 18 countries: Albania,^[88] Armenia,^[83] Bosnia and Herzegovina,^[89] Bulgaria,^[9] Croatia,^[12] the Czech Republic,^[47] Estonia,^[14,48] Georgia,^[90] Kyrgyzstan,^[21] Latvia,^[23] Macedonia,^[84] Moldova,^[85] Montenegro,^[2] Poland,^{[84]o} Romania,^[84] Serbia,^{[84]p} Slovenia^[91] and Ukraine. In 2016, the *Global State of Harm Reduction* reported that OST was available in Lithuania;^[54] however, research in 2018 indicates that OST is only available when a person is in police custody and already enrolled in an OST programme. OST is discontinued when the person is transferred to prison.^[54]

Although OST is provided in 18 countries, quality and accessibility vary considerably within and between countries. Estonia has OST available in all prisons.^[48] Moldova's OST scale-up in prisons positions it as a regional leader; services are implemented via 10 non-governmental organisations and the Department of Penitentiary Institutions.^[85] In Slovenia, the most recent data from 2016 indicates that around two-thirds of prisoners who were using opioids accessed OST.^[92] In Georgia, OST is only available in three out of the country's 15 prisons, and is provided for detoxification purposes only, for a maximum of three months.^[2] This approach is the same in Poland and is entwined within an abstinence-based framework.^[84] Both models are insufficient to be deemed harm reduction; however, the existence and provision of the service must be noted. In Hungary, OST is reportedly available, but is primarily provided as a form of detoxification treatment.^[17] In the Czech Republic, the *initiation* of OST only occurs on an exceptional basis, but is provided to people who accessed it prior to imprisonment and is available at six prisons in the country. At the time of writing, only 63 people were receiving OST in the Czech Republic.^[47,92] In Montenegro, Serbia, Albania and Latvia, OST cannot be initiated within the prison, but is available as a continuation of medication.^[2]

As reported in 2016, a blanket prohibition remains on OST in Russia, Turkmenistan and Uzbekistan, both in prisons and in the broader community. OST also remains unavailable in prisons in Azerbaijan,

Belarus, Hungary, Kazakhstan, Kosovo, Lithuania, Slovakia and Tajikistan. Research has indicated that prisoners are more likely to be exposed to blood-borne viruses in the prison setting,^[93,94] and reports of injecting drug use in prisons are found worldwide.^[95] A recent systematic review looking at the risk of HIV acquisition among people with a history of incarceration found that being incarcerated for drug offences as an injecting drug user was associated with an 81% increase in HIV acquisition risk.^[96]

The continuity of access to needle and syringe programmes and OST between the broader community and prisons is important in preventing transmission of blood-borne viruses and avoidable deaths in people who inject drugs and those who use opioids.^[97] A 2016 ruling by the European Court of Human Rights determined that denying OST treatment to a prisoner while in detention violates Article 3 of the European Convention on Human Rights, which prohibits inhuman or degrading treatment.^[98]

m Figure from 2014.

n Figure from 2014.

o However, this is only available for detoxification.

p OST cannot be initiated in prison, only delivered as a continuation of treatment.

People who inject drugs are also most vulnerable to overdose on release from prison,^[100-103] yet naloxone is reportedly unavailable to prisoners post-release in every country in the region, bar Estonia. Since September 2013, a take-home naloxone programme has been available in the two most affected counties of Estonia and in 2015 the programme was extended to prisoners before release.^[14,48]

HIV testing and treatment is available in prisons in all countries in Eurasia, although the regulation, quality and coverage of these services vary considerably.^[2] Hepatitis C testing, treatment and care in the region's prisons is scarce, which typically reflects the situation outside prisons.^[2] Only a few countries offer hepatitis C treatment in all prisons: Slovakia,^[84] Slovenia^[84] and Estonia.^[48] In Hungary and Ukraine, hepatitis C treatment is available in less than half of prisons.^[84] In Georgia, prisoners have had access to DAAs since the launch of the 2015 elimination strategy, with 2,753 people accessing treatment.^[103] Hepatitis C treatment is reportedly unavailable for people in prisons in Bosnia and Herzegovina, Croatia, Macedonia and Poland.^[84]

Civil society reports that in most countries, condoms are not available or available to only a limited extent in prisons.^[2] Although Estonia offers OST and naloxone, condoms for people in prison remain inaccessible.^[48] Since August 2017, a pilot condom distribution programme has been operating in one prison in the Czech Republic (prior to which condoms were only available in canteens in prisons and in some private visiting rooms).^[92] Under the pilot programme, four condom vending machines were installed in bathrooms/toilets, together with adjusted disposal bins for dangerous and infected waste. Four-thousand condoms were distributed in the first 12 months, resulting in the extension of the pilot programme and with a proposal for implementation of similar pilots in other prisons in the country in 2018/2019.^[92]

Policy developments for harm reduction

Twenty-six of 29 countries in Eurasia have national HIV or drug policies that include explicit references to harm reduction. The three countries which do not include harm reduction in national policy remain the same as reported in 2016: Azerbaijan, Russia and Turkmenistan. At least three countries (Albania, the Czech Republic and Estonia) have harm reduction as one of the four main pillars of their national Drugs Strategy.^[1,47] Despite the implementation of harm reduction services in many countries in the

region, for the vast majority of countries, the policy environment is dominated by punitive drug policies focused on supply reduction and criminalisation. Within this policy environment, hostility towards harm reduction is common. National legislation on drugs in the former Soviet states set low thresholds for possession offences, leading to prison sentences that are disproportionate in length to the associated drug arrest.^[2]

In 2016, the *Global State of Harm Reduction* reported that Armenia and the Czech Republic had decriminalised the possession of small quantities of drugs.^[104] Although the use and possession of a small amount of drugs in Armenia is not a criminal offence, the administrative fine for possession remains so high that many cannot afford to pay and instead are arrested for non-payment.^[2] In the Czech Republic, the low prevalence of both HIV and hepatitis C (the latter in relation to the region) among people who inject drugs has been attributed to sustained and scaled up provision of harm reduction services in combination with decriminalisation.^[105] In January 2017, Lithuania criminalised possession of small quantities of illicit drugs. Prior to this date, possession of small quantities had been an administrative offence, rather than a criminal sanction. This caused hundreds of people to be imprisoned.^[106] The Eurasian Harm Reduction Association (EHRA) conducted an assessment in Lithuania, finding that over €25 million was spent by the state on imprisoning people for drug possession.^[107] In 2018, Kyrgyzstan stated drug use would be decriminalised under the new Criminal Code; however, the implementation and impact of reforms need to be further assessed as at present the minimal fine for drug possession is the equivalent to 18 months' salary.^[108]

In 2017, a report was submitted to the UN Committee on Economic, Social and Cultural Rights (CESCR) which addressed a number of human rights violations in Estonia regarding the enjoyment of social rights among women who use drugs and/or living with HIV in Estonia.^[109]

Civil society and advocacy developments for harm reduction

Civil society organisations continue to form an important part of the harm reduction movement in Eurasia, as service providers, campaigning groups and advisory bodies to governmental agencies. In many countries, NGOs deliver harm reduction

services and either make referrals to healthcare services or provide testing and treatment for a number of communicable infections.^[2] A regional network, the Eurasian Harm Reduction Association (EHRA), forms the hub of 250 harm reduction organisations and activists from 29 countries in Eurasia, and works to create a favourable environment for sustainable harm reduction programmes, non-repressive drug policies and a good standard of living for people who use drugs.^[111] Country-based drug user networks also exist in Estonia, Macedonia, Georgia, Azerbaijan, Kyrgyzstan and Montenegro.^[2,48] The Belarusian national OST organisation Your Chance,^[108] the Lithuanian drug users' organisation Yang Wave^[108,111] and the Ukrainian Network of Women who Use Drugs have also recently been established.^[45] In Kazakhstan, a collective of people who use drugs has been formed, with representatives active in national harm reduction and healthcare advocacy.^[108]

Drug policy reform has become an important issue in Georgia, and has been a prominent theme in political debate for the last two years.^[2] Drug policy in Georgia is among the harshest in the region, with possession of any amount (for any purpose) a punishable offence attracting long prison sentences.^[2] In addition, mandatory drug testing on the street has become a flagship intervention for law enforcement in the country.^[2] The Georgian National Drug Policy Platform (a coalition of 41 NGOs) developed a series of legislative amendments aimed at changing the current drug-related legislation, and decriminalising drug use and possession of small amounts for personal use.^[55] In June 2017, a group of MPs from the parliamentary majority submitted the amended bill to parliament. Hearings of the proposed legislative amendments revealed a polarising attitude, both among decision makers and the general public, with the amendments still under review at the time of publication.^[2] The Georgian National Drug Policy Platform is an example of the coordinated and consolidated work of civil society, drug user activists, drug-related service provider organisations, human rights groups, clinicians, researchers, politicians and other interested groups.^[2]

Funding developments for harm reduction

A 2017 report by Harm Reduction International found that a number of countries in Eurasia are experiencing a funding crisis for harm reduction, with particularly grave situations in Bulgaria, Romania, Poland and Hungary.^[43] Austerity, international donor

retreat and poor political support for harm reduction are the primary factors underpinning the continued funding crisis.^[43] In 2016, a study on the allocated funding of HIV prevention and treatment for people who inject drugs in eight countries in the region (Armenia, Belarus, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Moldova and Ukraine) found that across Eurasia there was diversity in domestic and donor resourcing for services.^[112] Bulgaria, for example, allocated just 4% of its budget to HIV services for people who inject drugs, whereas Georgia allocated 40%.^[112]

A 2018 report by Harm Reduction International also highlights the impact of Global Fund retreat on harm reduction funding and service provision.^[53] Several countries that have been heavily reliant on the Global Fund for their harm reduction responses have seen dramatic reductions in their allocations for the period 2017-2019.^[53] For example, on a per-year basis, Moldova's 2017-2019 allocation represented a 43% drop from 2014-2016.^[113] Kazakhstan had relied on the Global Fund for a large proportion of its harm reduction funding, with much of this paying for needle, syringe and condom provision.^[53] When Kazakhstan gained upper middle-income status, this (combined with its low overall HIV prevalence) led to the country's ineligibility for Global Fund grants in the 2014-2016 allocation period. Although the national government also provided support to NSP sites, only 4.7% of the country's total HIV budget went towards prevention activities, and only 2.7% targeting people who inject drugs.^[53] In 2018, threats to OST services have escalated in Kazakhstan, with the government considering ceasing their operation.^[53,114] There are also reports from civil society of poor-quality syringes being distributed by the government, leading to the potential for unsafe and risky injecting behaviours.^[2,44] The example of Kazakhstan illustrates the political vulnerability of harm reduction programmes, and has prompted civil society action to hold the government to account.^[53]

In Poland, Georgia, Belarus and Estonia, state allocations for HIV programmes, including harm reduction, have been increasing since the *Global State of Harm Reduction* last reported.^[2,48] In Poland, a government decision to allocate funding to harm reduction from monies accumulated from gambling taxation has reportedly led to an increase for both harm reduction and drug treatment in the country.^[2] Here, harm reduction programmes are co-financed by local governments and the National Bureau for Drug prevention.^[26]

Central to the challenge of ensuring the sustainability and quality of harm reduction in the region is the lack of political acceptance for harm reduction.

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