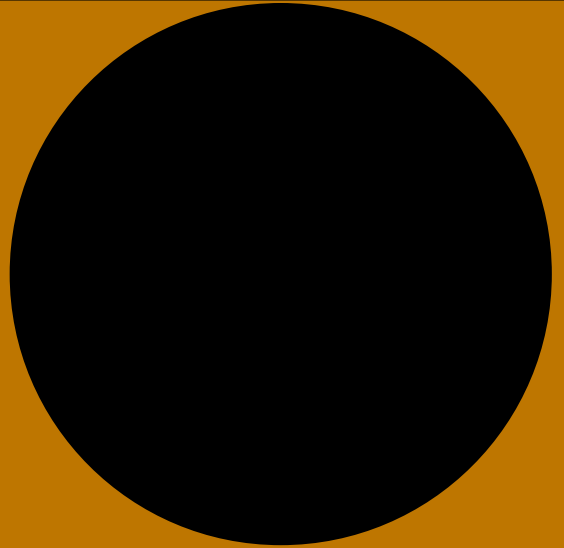
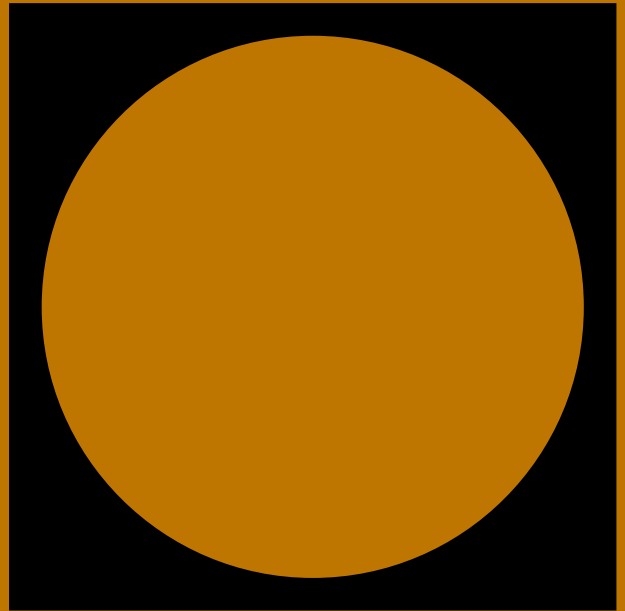


# REGIONAL OVERVIEW: EURASIA



**TABLE 4** EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EURASIA

| Country/territory      | People who inject drugs <sup>a</sup> | HIV prevalence among people who inject drugs (%) <sup>a</sup> | Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) <sup>a</sup> | Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) <sup>a</sup> | Harm reduction responses <sup>b</sup> |                  |  |                  |                                      |
|------------------------|--------------------------------------|---|--|--|---------------------------------------|------------------|--|------------------|--------------------------------------|
|                        |                                      |   |  |  | NSP <sup>c</sup>                      | OAT <sup>d</sup> | Peer distribution of naloxone <sup>e</sup> | DCR <sup>f</sup> | Safer smoking equipment <sup>g</sup> |
| Albania                | 7,000                                | 0.5   | 34   | 20.2   | ✓ 2                                   | ✓ M B            | ×  | ×                | ×                                    |
| Armenia                | 9,000                                | 1.1   | 49.2   | nd   | ✓ 12                                  | ✓ M              | ×  | ×                | ×                                    |
| Azerbaijan             | 60,300 <sup>22</sup>                 | 9.8   | 59.3   | 7.9  | ✓ 17                                  | ✓ M              | ×  | ×                | ×                                    |
| Belarus                | 79,500                               | 25.2  | 59   | 9.6  | ✓ 34                                  | ✓ M B            | ×  | ×                | ×                                    |
| Bosnia and Herzegovina | 10,500                               | 0.1   | 39.5   | 0.2  | ✓ 2                                   | ✓ M              | ×  | ×                | ×                                    |
| Bulgaria               | 17,000                               | 4.4   | 67.8   | 6  | ×                                     | ✓ M B O          | ×  | ×                | ×                                    |
| Croatia                | 6,000                                | 0.4   | 36.7   | 1  | ✓ 137                                 | ✓ M B O          | ×  | ×                | ×                                    |
| Czechia                | 40,500                               | 0.3   | 17.4   | 15.1   | ✓ 111                                 | ✓ M B            | ×  | ×                | ✓                                    |
| Estonia                | 7,000                                | 51.4  | 79.2   | 4.8  | ✓ 23                                  | ✓ B              | ×  | ×                | ✓                                    |
| Georgia                | 52,500                               | 1.6   | 62.4   | 7.2  | ✓ 14                                  | ✓ M B            | ✓  | ×                | ×                                    |
| Hungary                | 6,500                                | 0   | 35.9   | 1  | ✓ 31                                  | ✓ M B            | ×  | ×                | ×                                    |
| Kazakhstan             | 113,000                              | 9.2   | 58.8   | 7.9  | ✓ 125                                 | ✓ M              | ×  | ×                | ×                                    |
| Kosovo                 | 4,600 <sup>23</sup>                  | 0 <sup>23</sup>   | 23.8 <sup>23</sup>   | 0.1 <sup>23</sup>  | ✓                                     | ✓ M              | ×  | ×                | ×                                    |
| Kyrgyzstan             | 28,000                               | 12.4  | 43.9   | 11.3 <sup>22</sup>   | ✓ 40                                  | ✓ M              | ✓  | ×                | ×                                    |
| Latvia                 | 7,000                                | 16.2  | 69.2   | 2  | ✓ 20                                  | ✓ M              | ×  | ×                | ×                                    |
| Lithuania              | 8,000                                | 8.3   | 65.6   | 10.5   | ✓ 11                                  | ✓ M B            | ×  | ×                | ×                                    |
| Moldova                | 27,500 <sup>22</sup>                 | 28.3  | 50   | 4.8  | ✓ 28                                  | ✓ M B            | ×  | ×                | ✓                                    |
| Montenegro             | 2,300                                | 0.1   | 44.2   | 0  | ✓ 2                                   | ✓ M B            | ×  | ×                | ×                                    |
| North Macedonia        | 6,500                                | 0   | 65.4   | nd   | ✓ 16                                  | ✓ M B            | ×  | ×                | ×                                    |
| Poland                 | 14,664 <sup>24</sup>                 | 15.4  | 58.7   | 3.9  | ✓ 7                                   | ✓ M B            | ×  | ×                | ×                                    |
| Romania                | 17,024 <sup>25</sup>                 | 19.4 <sup>25</sup>  | 72.7 <sup>25</sup>   | 3.2 <sup>25</sup>  | ✓ 2                                   | ✓ M B            | ×  | ×                | ×                                    |
| Russia                 | 1,274,000                            | 49.8  | 72.5   | 9  | ✓                                     | ×                | ×  | ×                | ×                                    |
| Serbia                 | 28,500                               | 0   | 42.6   | 10.5   | ✓ 2                                   | ✓ M B            | ×  | ×                | ×                                    |
| Slovakia               | 18,000                               | 0   | 38.5   | 2.7  | ✓ 19                                  | ✓ M B            | ×  | ×                | ✓                                    |
| Slovenia               | 5,500                                | 0.3   | 28.6   | 3.4  | ✓ 139                                 | ✓ M B O          | ✓  | ×                | ✓                                    |
| Tajikistan             | 26,000                               | 18  | 61.3   | 2 <sup>26</sup>  | ✓ 48                                  | ✓ M              | ✓  | ×                | ×                                    |
| Turkmenistan           | nd                                   | nd  | nd   | nd   | ×                                     | ×                | ×  | ×                | ×                                    |
| Ukraine                | 296,000                              | 20.4  | 60.6   | 4.6  | ✓ 2,380                               | ✓ M B            | ×  | ×                | ×                                    |
| Uzbekistan             | 54,500                               | 7.3   | 51.7   | nd   | ✓ 230                                 | ×                | ×  | ×                | ×                                    |

a Unless otherwise stated, data is from Degenhardt et al (under review).<sup>1</sup>

b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.<sup>2-21</sup>

c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)

d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=metadone.

e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.

f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.

g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs

h Although one harm reduction facility in Ukraine permits drug use on site, it is not officially sanctioned by local or national government.

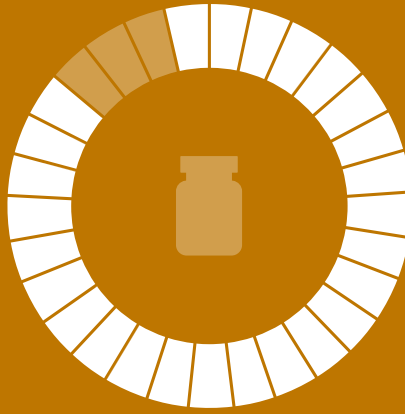
# G1. AVAILABILITY OF HARM REDUCTION SERVICES



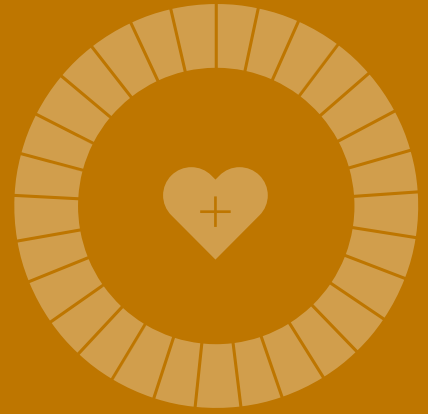
## NSPs, OAT AND DCRs SINCE 2020



**27 countries** (93%) in Eurasia provide **needle and syringe programmes** (no change from 2020)

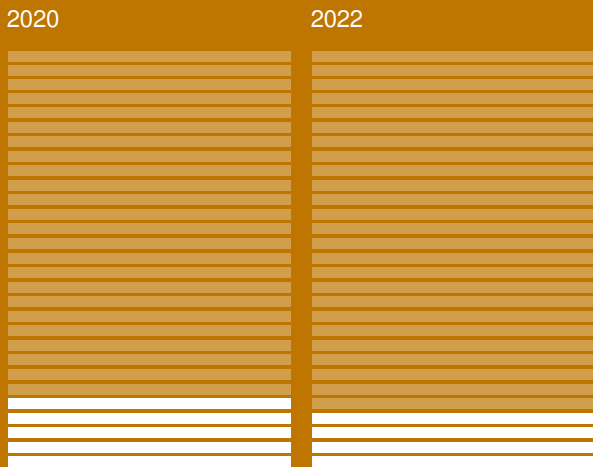


**26 countries** (90%) in Eurasia provide **opioid agonist therapy** (no change from 2020)

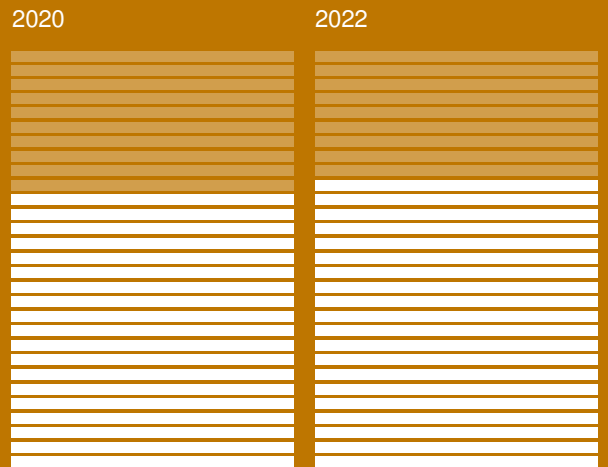


**No country** in Eurasia provides **officially sanctioned drug consumption rooms** (no change from 2020)

## HARM REDUCTION IN PRISONS



**4 countries** in Eurasia provide **needle and syringe programmes** in prisons.<sup>a</sup>



**20 countries** in Eurasia provide **opioid agonist therapy** in prisons (+1 since 2020: Kosovo introduced prison OAT, while reports suggest it is no longer available in Georgia and Hungary)

## SAFER SMOKING KITS ARE NOW AVAILABLE IN CZECHIA, ESTONIA, SLOVAKIA AND SLOVENIA

<sup>a</sup> In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP has never been meaningfully implemented in the country.

# REGIONAL OVERVIEW

AUTHOR:  
MARIA PLOTKO



## INTRODUCTION

Harm reduction is included in national government policies in 25 of the 29 countries in Eurasia. Despite this, in the majority of countries in the region, the policy environment is dominated by punitive approaches focused on supply reduction and criminalisation. People who use drugs are vulnerable to stigma, discrimination, arbitrary arrest, and ill-treatment by police, health professionals, social services and society at large.<sup>27,28,29</sup> According to HIV Justice Worldwide, Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure, non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws.<sup>30</sup>

Approximately 2.2 million people inject drugs in Eurasia (see Table 4, page 72). However, there is no data from Turkmenistan, and many countries in Eurasia do not collect regular data on the number of people who use drugs. When they do collect data, it frequently lacks even basic disaggregation by gender. This negatively impacts advocacy and the expansion and introduction of new harm reduction services.

According to national experts, injecting drug use has reduced over recent years, but it is still common, particularly in Belarus, Estonia, Georgia, Russia and Ukraine.<sup>2–21,26</sup> Cannabis remains the most commonly used drug, followed by opioids (illicit methadone, fentanyl and heroin) in the eastern part of the region, and stimulants (primarily methamphetamine and cocaine) in the western part, in countries such as in Czechia and Hungary.<sup>31</sup> Amphetamine-type stimulants are reported to be the most popular injected substances in Czechia, Slovakia and Hungary.<sup>32,33,34</sup>

New psychoactive substances (NPS) are becoming increasingly popular in the post-Soviet part of the region due to their low price and high availability.<sup>35</sup> A recent study in Moldova provided evidence of a significant increase in the use of synthetic cathinones and synthetic cannabinoids.<sup>36</sup> The use of NPS is associated with increased risk of HIV due to multiple injections and an increased number of sexual contacts.<sup>37,38</sup> There are also reports of an association between the use of NPS and mental health issues.<sup>38</sup>

**“Eastern Europe and Central Asia has the second highest number of laws criminalising HIV exposure non-disclosure and transmission, with Belarus, Russia and Uzbekistan having particularly high numbers of criminal cases related to these laws”**

## HIV AND TUBERCULOSIS



According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), Eastern Europe and Central Asia has the fastest growing HIV epidemic in the world with 43% of new cases attributed to injecting drug use.<sup>22</sup> For example, HIV self-testing is approved in national policy in Albania, Armenia, Belarus, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Latvia, Republic of Moldova, Poland, Romania, Russia, Tajikistan, Ukraine, Uzbekistan and is available at harm reduction sites in Ukraine, Estonia, Lithuania, Latvia, Moldova, Poland and Russia. In Poland, Projekt Test runs an HIV helpline that assists with home self-testing.<sup>39</sup>

A high prevalence of HIV and criminalisation make people who use drugs vulnerable to tuberculosis.<sup>40</sup> People in prison are more likely to acquire tuberculosis, and tuberculosis services both in prisons and in the community are rarely tailored to the needs of people who use drugs.<sup>41</sup> As a result, interruptions to tuberculosis treatment are common, resulting in high prevalence of multi-drug resistant tuberculosis.<sup>42</sup> Low access to testing and treatment services often means that people who use drugs come in contact with the health system at late stages of the disease.<sup>42</sup>

## NEEDLE AND SYRINGE PROGRAMMES (NSPs)

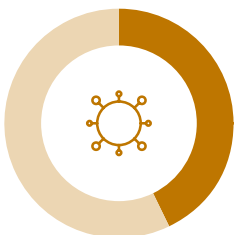


As of 2022, NSPs were available in 27 out of 29 countries in Eurasia. The two exceptions are Turkmenistan, where there have never been NSPs, and Bulgaria where services closed in 2020 following the withdrawal of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). NSP facilities are mainly located in big cities. In Uzbekistan, NSPs are only available through general primary healthcare facilities, making them less acceptable to clients due to the stigma, discrimination and criminalisation they experience. Syringes are accessible via vending machines in Czechia, Hungary, and Georgia, and there are plans to introduce them in Moldova in late 2022.<sup>5,16,17,20,43</sup>

However, in most countries in the region, NSPs are operated by community organisations, which integrate services with HIV and hepatitis C testing, mental health consultations, legal assistance, support from social workers and referrals to other health and social services.<sup>2-21</sup> Across the region during the COVID-19 pandemic, the social component of NSPs (personal interaction between clients, peers and service providers) went online, expanding the pool of clients and making services more accessible.<sup>44</sup>

**Injecting drug use is the leading cause of new HIV infections in Eastern Europe and Central Asia**

**Syringe dispensing machines are available in at least three countries**



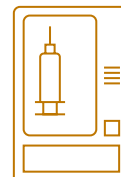
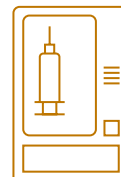
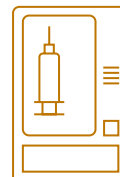
**43%**

43% of new HIV cases in Eurasia are attributed to injecting drug use

Czechia

Hungary

Georgia



**“In most countries in the region, NSPs are operated by community organisations, which integrate services with HIV and hepatitis C testing, mental health consultations, legal assistance, support from social workers and referrals to other health and social services.”**

## OPIOID AGONIST THERAPY (OAT)



As of 2020, OAT was available in 26 countries, but remains prohibited in Russia, Turkmenistan, and Uzbekistan. Coverage varies considerably and is extremely low in some states. There are only six countries in which more than 20% of people who primarily inject opioids receive OAT (Croatia, Estonia, Hungary, Montenegro, North Macedonia and Slovenia).<sup>45</sup> The Eurasian Harm Reduction Association reports that services are of poor quality, as most OAT services do not operate according to person-centred and gender-sensitive principles.<sup>46</sup> Additional services provided by OAT programmes, such as psychosocial support and training for health workers, are the two areas that have suffered the most during the transition to national funding after the withdrawal of the Global Fund, including in Belarus and Moldova.<sup>47</sup> Some countries have private OAT sites, for example, Ukraine and Romania.<sup>3,7,15</sup>

Heroin-assisted therapy (HAT) as a form of OAT remains unavailable throughout the region.

Significant barriers to OAT remain. These include a repressive policy and legal environment, unequal coverage between rural and urban areas, stigma, a lack of take-home dosing (notably in Azerbaijan, Belarus and Kazakhstan), opposition by law enforcement officials, a lack of trust between service providers and clients, and abstinence-based approaches.<sup>2–21</sup> Using opioids with other drugs can lead to people being excluded from OAT programmes in Azerbaijan, Belarus, Kazakhstan, Montenegro, Poland and Ukraine.<sup>14,15,21,24</sup>

During the COVID-19 pandemic, all countries with OAT programmes introduced take-home dosing for all clients. Unfortunately, some (for example Azerbaijan and Georgia) stopped this practice as soon as COVID-19 infection levels decreased.<sup>17,44</sup> Civil society efforts have helped to reinstate, and will work to maintain, take-home dosing in Georgia to ensure higher levels of accessibility.<sup>44</sup>

## SAFER SMOKING KITS, STIMULANT PRESCRIBING AND DRUG CHECKING



Safer smoking kits are now available in Czechia, Estonia, Slovakia and Slovenia.<sup>4,9,11,18–20</sup> In Moldova, thanks to civil society’s efforts, a new package containing pipes, saline solution, calcium, lip balm, and over-the-counter medications for heart

### Drug checking is available in at least seven countries



Czechia



Estonia



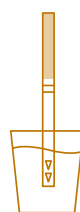
Georgia



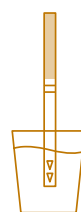
Lithuania



Poland



Slovenia



Ukraine

palpitations, pain and anxiety has been introduced for people who use NSPs.<sup>5,6,16</sup>

In 2020, Czechia introduced a stimulant prescription programme for people who use stimulants, following similar principles to OAT.<sup>20,48</sup> Psychiatrists are now able to prescribe methylphenidate (also known as Ritalin) to people who use methamphetamines, whereas previously methylphenidate could only be formally prescribed for hyperactivity and sleep disorders.<sup>48,49</sup>

Drug checking is mostly provided through the distribution of reagent test kits at festivals and in nightlife settings in Czechia, Estonia, Georgia, Lithuania, Poland, Slovenia and Ukraine.<sup>49,50,51,52</sup> In Slovenia, a civil society organisation called DrogArt accepts samples of substances on a regular basis and provides data to the national early warning system, making it possible to issue alerts about potentially dangerous batches of drugs.<sup>50,53</sup> There are still no licensed drug consumption rooms (DCRs) in the region, although the first harm reduction site that allows drug use on its premises was opened in Sumy, Ukraine in 2019 and continues to be operational as of September 2022.<sup>a</sup> DCRs continue to be on the advocacy agenda for civil society organisations in Czechia, Estonia, Moldova, Montenegro, Poland and Slovenia.<sup>2,9,11,18–20</sup>

## HARM REDUCTION IN PRISONS



Twenty-one countries in Eurasia provide OAT for maintenance in prisons. There are reports that Kosovo now implements OAT in prisons, but in Georgia OAT is only available for short detoxification rather than long-term maintenance treatment, and in Hungary prison OAT is virtually inaccessible in practice.<sup>54</sup> Even where it is implemented, OAT in prisons is not widely accessible. In Albania, Latvia, Montenegro and Serbia, people cannot start OAT while in prison, but it is available if people were on OAT before being incarcerated.

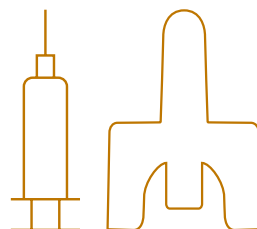
As of 2022, only four countries had NSPs in prisons (Armenia, Kyrgyzstan, Moldova, and Tajikistan). Research in Moldova in 2021 found some concerns around the accessibility of NSPs in the country's prisons, including issues related to confidentiality and discrimination when accessing other health services.<sup>55</sup> No programmes providing naloxone on release from prison were reported in the region.<sup>56</sup>

### Naloxone availability in Eurasia



#### Take-home naloxone programmes:

Albania, Czechia, Estonia, Georgia, Kyrgyzstan, Lithuania, Moldova, Slovenia, Tajikistan and Ukraine



#### Naloxone peer-distribution programmes:

Georgia, Kyrgyzstan, Slovenia and Tajikistan.

<sup>a</sup> While this service has some support from a government narcological clinic, it does not have the formal endorsement of local government. For this reason, it is not included in the *Global State of Harm Reduction* global figures on DCRs. In 2018 and 2020, the *Global State of Harm Reduction* reported the existence of prison NSP in North Macedonia. However, new reports from national civil society organisations show that prison NSP has never been meaningfully implemented in the country.



## OVERDOSE AND NALOXONE PROGRAMMES



The proportion of deaths due to overdose in Eurasia is likely to be underestimated, in part due to the stigma related to drug use. In many cases, overdose goes unreported on death certificates; anecdotal evidence suggests families often request that the cause of death be recorded as a heart-related condition.<sup>2–21</sup>

Although emergency medical staff have access to naloxone in all countries, for those most likely to witness an overdose (such as people who use drugs and their friends and family), access is extremely limited. In many countries in the region, naloxone is only available via prescription. Nevertheless, naloxone and overdose prevention education is explicitly stated as part of the harm reduction programmes for people who use drugs in Georgia, Kyrgyzstan, Moldova, Tajikistan and Uzbekistan.<sup>56</sup>

Naloxone peer-distribution programmes exist in four countries in the region (Georgia, Kyrgyzstan, Slovenia and Tajikistan), while other forms of take-home naloxone programmes operate in a further six countries (Albania, Czechia, Estonia, Lithuania, Moldova and Ukraine).<sup>6,7,9,11,12,15–20,36</sup>

## WOMEN WHO USE DRUGS AND PARENTAL RIGHTS

There are insufficient services tailored to the needs of specific populations in Eurasia, notably sex workers, gay men and other men who have sex with men, LGBTQI+ people, and young people who use drugs. In particular, there is a lack of gender-sensitive services for women who use drugs.<sup>2–21</sup>

There is little data on the number of women who use drugs in the region, and OAT is frequently inaccessible to pregnant and parenting people who use drugs.

A particular issue in the region is the deprivation of parental rights based solely on drug use. One of the most extreme situations is in Belarus, where children are deemed to be in a ‘socially dangerous situation’ if they are parented by a woman who either uses drugs or is on OAT.<sup>21</sup> If the state recognises a child as being in a socially dangerous situation, a mark is put in the parent’s passport and medical record, increasing stigma and discrimination. In addition, social services can take the child away from the family. In such cases, parents must pay monthly fees to the state. Conditions for returning a child to the mother often include providing what the state deems to be adequate housing and a sufficient income. Civil society organisations report that many people have difficulties complying with these conditions while paying the monthly fees to the state.<sup>21</sup>

In November 2021, the United Nations Committee on the Elimination of Discrimination Against Women urged Kyrgyzstan to amend a law which provides for the deprivation of parental rights based on parental drug dependence, and to improve access for women who use drugs to harm reduction services.<sup>57</sup>

## FUNDING FOR HARM REDUCTION

In almost all the region’s countries, due to criminalisation (de facto and de jure), harm reduction and other health services are severely underfunded and depend on international donors. Withdrawal of international funding from the region has left gaps in service provision which governments are reluctant to fill.

## SPOTLIGHT

# UKRAINE

**Since 24 February 2022, the Russian invasion of Ukraine has destroyed lives, cities and essential supply chains. Millions of Ukrainians have been forced to leave their homes. As of September 2022, more than 14 million Ukrainians had been displaced, either within Ukraine or to other European countries.**

## Inside Ukraine

Civil society has led the response to the humanitarian crisis. In the first few weeks of the war, regional and national organisations launched weekly coordination calls, which also included the Center for Public Health at the Ministry of Health in Ukraine and international donors.

Community-led and civil society organisations in Ukraine, such as the All-Ukrainian Association of People who Use Drugs (VOLNA), Light of Hope and Convictus, have provided shelter and delivered food, medication and harm reduction supplies to the Ukrainian regions that were cut off from supply chains or where people could not leave their homes. The Eurasian Harm Reduction Network (EHRA) provided

funds for VOLNA to evacuate people who use drugs from Donetsk and Luhansk; areas at the centre of the conflict. Support from Médecins du Monde ensured that civil society organisation Club Svitanok could continue providing harm reduction services in Donetsk, while MADRE funded the evacuation of some of Club Svitanok's staff from the region.

Early in the war, VOLNA and the Ukrainian Network of Women who Use Drugs (VONA) successfully advocated for changing national OAT protocols, allowing people to receive take-home doses. Initially, 15-day take-home doses were provided; later this was extended to 30 days. VOLNA and VONA also pushed to secure an uninterrupted supply of OAT across the Ukrainian regions most affected by war and violence. In the Donetsk region, as of September 2022, only the OAT site in Bakhmut has closed, while sites in Kramatorsk, Slavyansk, Pokrovsk and Druzhkovka continue to operate. In addition, policy changes now mean that people are no longer required to be registered in a city to receive OAT.

Service delivery is impeded by the fact that harm reduction organisations have not received funding from the Ministry of Health since March 2022. It is not known when committed funds will reach these organisations.

## Experiences in neighbouring countries

Due to stigma around drug use and HIV, upon arrival in new countries people tried to hide their status, avoid the public health system, and buy drugs through illicit channels rather than acquiring them through OAT programmes. Nevertheless, the governments of Hungary, Moldova, Poland, Romania, and Slovakia (all five border countries) issued special decrees ensuring continuation of treatment and access to medicines for refugees from Ukraine. For example, after 24 February 2022, everyone who arrived in Poland with a Ukrainian passport and PESEL identification number<sup>a</sup> could receive OAT and antiretroviral therapy (ART) free of



Photos from Ukrainian organisation Light of Hope (LoH).

charge. Most people with this documentation promptly received take-home OAT, either for a week or two weeks. In Slovakia, Ukrainian refugees do not need to have mandatory health insurance to receive OAT free of charge. This includes buprenorphine, a medicine which is limited in stock and not usually covered under the state's insurance programme.

Local civil society organisations helped newly arrived clients navigate the system and get medication faster. They also assisted with translation, which is one of the main barriers for accessing services. These activities are mostly supported by international donors or operate without any funding at all, making sustainability a significant challenge.

The sudden influx of new clients has highlighted deficiencies in existing HIV and harm reduction services. In Slovakia, for example, people needed additional approval from the Ministry of Health to start ART. In Romania, the additional clients exposed the precariously low funding for OAT programmes. More generally, the refugee crisis highlighted the absence or limited availability of social and psychological support services and shelters open to people who use drugs across the region. The fact that clients of private OAT clinics are not registered in the Ukrainian OAT database also complicated the process of getting the medication to all who needed it.

In Romania, due to insufficient funding, the state OAT programme was unable to procure more medication, and instead referred new clients to the civil society organisation ARAS.<sup>3</sup> In Moldova, when people did not have their prescription with them, local community organisation Community Centre of Psychological Support for Drug Users (PULS) contacted staff at OAT centres in Ukraine to ensure continuity.<sup>6</sup>

The war intensified needs for psychological support, shelters and food packages. With the help of international donors (such as the Global Fund, which launched emergency grant programmes), these services were established then expanded upon by civil society organisations.

On a positive note, the dire situation has shown that the region's harm reduction systems can work in ways that are more responsive and people-centred. For example, both in Ukraine and neighbouring countries, clients were required to complete fewer documents to enrol in drug treatment and receive take-home OAT. But civil society representatives are not optimistic that these more flexible, person-centred services will continue, not only for people who are refugees but also for the national clients, because funding is linked to the refugee crisis and only applies to those who came from Ukraine after 24 February 2022.<sup>2,3,5,6</sup>

<sup>a</sup> Powszechny Elektroniczny System Ewidencji Ludności (PESEL), the Universal Electronic Population Registration System, is an 11-digit digital symbol that identifies an individual.'

## SPOTLIGHT

# WHEN AVAILABILITY DOES NOT MEAN ACCESSIBILITY

Harm reduction programmes in Eurasia first developed as HIV prevention interventions among people who inject drugs. Historically, these programmes have served as links to care for the most vulnerable people who use drugs. However, across the region there are barriers to HIV and harm reduction services which, in practice, makes them inaccessible to people who use drugs. Among these are requirements for registration and formal identification and geographic barriers.

## The need for ID

OAT programmes in Eurasia are often highly medicalised, high threshold and have strict rules. For example, programmes may require people to have government-issued identity documents (ID), referral from a psychiatrist or other supporting documentation to enrol.<sup>60</sup>

One of the most vivid examples of this is North Macedonia. Here, in order to access any state

supported services (except in prison, where people are identified by fingerprints), individuals need to have an ID.<sup>61</sup> But to get an ID, they need to have a residential address. This creates obstacles for certain populations; for example, many houses built and occupied by Roma people are built illegally and therefore cannot be used to register an ID. In addition, landlords are often unwilling to register people in their apartments, especially people who use drugs. People experiencing homelessness do not have an address to register. Even if a person manages to get an ID, they need to find a family doctor, who in turn will be willing to make a referral to a psychiatrist, who can then make a diagnosis and prescribe OAT. But family doctors are often unwilling to take on people who use drugs or Roma people. People who do manage to get a prescription must be able to travel to one of only two OAT centres, both of which are in Skopje, North Macedonia's capital city.<sup>65</sup>

Harm reduction organisations in Eurasia often assist with lost or expired IDs, or when people simply do not have one. In Romania, people without a permanent



**“In Poland, civil society organisations report that people have to travel up to 100km to receive OAT”**

address can get a temporary ID which can be renewed every two years.<sup>3</sup> In Slovakia, police can issue a temporary ID, and in Moldova, police can provide a certificate that can temporarily be used instead of an ID.<sup>4,6,16,36</sup>

## Geographic barriers

Across the region, both NSP and OAT programmes have limited geographical spread and usually operate only in big cities. In Poland, civil society organisations report that people have to travel up to 100km to receive OAT. This journey must be taken daily, until clients meet requirements for take-home doses (these requirements include abstaining from using illicit drugs and attending therapy sessions).<sup>2</sup> This issue is replicated across the region. In Belarus, Kazakhstan and Ukraine, even moving between cities is problematic, as you can receive OAT only where you are registered.<sup>7,14,15,21</sup> Furthermore, within a city there is usually only one OAT service, meaning people

may need to travel significant distances. The need to register to access take-home medication exacerbates the problem.<sup>7,14,15,21</sup>

Other issues include opening hours and the physical accessibility of sites. A lot of OAT sites open during work hours, making it difficult for clients who are employed to attend. People living with a disability may also have difficulties accessing OAT sites. For example, in Kazakhstan civil society organisations report that some OAT sites have stairs.<sup>14</sup>

In Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine, in order to enrol on OAT or other drug dependence treatment, people are required to register in a ‘drug user registry’, but registering can limit people’s ability to find a job, study and raise children.<sup>14–16,21</sup> This is also the case for people accessing drug treatment in Russia and Uzbekistan. Criminalisation, discrimination and stigma mean that many people who use drugs are not inclined to access such services.

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