Available online at www.sciencedirect.com
ScienceDirect
International Journal of Drug Policy 18 (2007) 129–135
THE INTERNATIONAL JOURNAL OF DRUG POLICY
www.elsevier.com/locate/drugpo

Research paper

Implementation of harm reduction in Central and Eastern Europe and Central Asia

Anya Sarang [a,b,*], Raminta Stuikyte [b], Roman Bykov [b]

[a] *Russian Harm Reduction Network, Ilimskaya St., 4-1-38, 127576 Moscow, Russia*
[b] *Central and Eastern European Harm Reduction Network, Vilnius, Lithuania*

Received 23 September 2006; received in revised form 12 November 2006; accepted 15 November 2006

Abstract

Harm reduction (HR) interventions began in Central-Eastern Europe and Central Asia in the mid-1980s with the establishment of substitution treatment (ST) in Yugoslavia. In the mid-1990s, the first needle and syringe programmes (NSPs) opened in selected countries following the outbreaks of HIV among injecting drug users (IDUs). The number of NSPs continues to increase via a combination of international and state funding with large expansions made possible via the Global Fund to Fight AIDS, Tuberculosis and Malaria. While ST is still unaccepted in several countries, others have made some progress which is especially visible in South Eastern and Central Europe and the Baltic States. Development of regional networking including Central and Eastern European HR Network and a number of national networks helped to coordinate joint advocacy effort and in some cases sustain HR services. Activism of drug users and people living with HIV (PLWH) increased in the region in the last several years and helped to better link HR with the affected communities. Still a number of challenges remain important for the movement today such as repressive drug policies; stigma and discrimination of IDUs, PLWH, sex workers and inmates, including poor access to prevention and treatment; lack of important components of HR work such as naloxone distribution and hepatitis B vaccination, prevention in prisons; issues of quality control; sustaining services after finishing of major international projects; reaching of adequate coverage and others.

Keywords: Harm reduction; Needle and syringe programmes; Substitution treatment; Community activism; Networking; Central and Eastern Europe; Central Asia; Russia; History

Introduction

The history of harm reduction (HR) in Central-Eastern Europe and Central Asia (CEE/CA) began at least 18 years ago when the first substitution treatment (ST) programmes were established in Yugoslavia in mid-1980s (Subata & Stuikyte, 2006) and the first needle and syringe programmes (NSPs) opened in Poland, Slovenia and the Czech Republic in late 1980s and early 1990s (EMCDDA, 2003). Back then almost no country in the region reported more then few human immunodeficiency virus (HIV) infections: in 1995 there were still less then 30,000 cases throughout CEE/CA (Grund, 2001) and almost no cases registered among injecting drug users (IDUs). In 1995–1996 the situation changed drastically: the region witnessed its first HIV outbreaks among IDUs in Odessa and Nikolaev (Ukraine), Svetlogorsk (Belarus), and Kaliningrad (Russian Federation (RF)) (Dehne, 1999; Grund, 2001). In the eastern part of the region the situation was getting worse rapidly and by 1998 the number of people living with HIV (PLWH) has increased more than eightfold (Dehne, Grund, Khodakevich, & Kobyshcha, 1999). It became clear that the regional explosive epidemic among IDUs (Rhodes et al., 2002) can skyrocket and that without targeted harm reduction activities it would be impossible to stop it.

Most countries in the region were not prepared to the outbreaks, as the public health infrastructures were poorly developed and weakened by the process of social–economic transition (Rhodes & Simic, 2005). AIDS centres were oriented towards soviet style epidemiology with its focus on mass screening and mandatory testing of 'risk groups' (Dehne et al., 1999; Grund, 2001), and drug treatment facili-

* Corresponding author. Tel.: +7 926 5004818.
E-mail address: anyasarang@mail.ru (A. Sarang).

0955-3959/$ – see front matter © 2006 Elsevier B.V. All rights reserved.
doi:10.1016/j.drugpo.2006.11.007

ties inherited repressive soviet narcology which was closely connected with police (Rhodes et al., 2006; Subata, 2001a). There were few non-governmental organisations (NGOs) that worked in the field and the legal and state support environment for these few was often not very enabling (Grund, 2001; Rhodes & Simic, 2005).

However, the region was not the first in the world to witness massive and rapid outbreaks of HIV among IDUs—countries of South East Asia (Crofts, Reid, & Deany, 1998), Europe (EuroHIV, 2004) and the North America (Des Jarlais et al., 1994) already had a similar experience. A recipe for successful prevention existed—a combination of needle and syringe provision, substitution treatment, outreach work and community empowerment (Ball, 1998), but all these were quite alien approaches to the post-soviet mentality. To avert the HIV crisis it was necessary to challenge this mentality and boost the energy of a few enthusiasts willing to develop HR in the region.

The turning point in the history of resistance to the epidemic was establishment in 1995 of International Harm Reduction Development Program (IHRD) of the Open Society Institute (OSI) which aimed to assist in development of HR initiatives in the region. In 1996 IHRD supported 12 pilot projects in Bulgaria, the Czech Republic, Hungary, Latvia, Lithuania, Macedonia, Poland, the Slovak Republic, and the Russian Federation (Coffin, 2002). Several projects were supported by other international organisations, such as a NSP bus in Saint Petersburg, RF (Medecins Du Monde) and a peer outreach group in Moscow, RF (Medecins Sans Frontieres, Netherlands) (Rhodes, Sarang, Bobrik, Bobkov, & Platt, 2004) and others. Still, altogether the number of projects was very small and their coverage inadequate.

Needle and syringe programmes

On August 27, 2003 the electronic news digest of Central and Eastern European Harm Reduction Network (CEEHRN) posted information about starting of a NSP in Armenia. This was great news for CEEHRN, as now there was virtually no country in the region without at least one NSP (CEEHRN, 2003).

The number of NSPs gradually expanded, starting from a few programmes in early 1990s to 219 syringe exchange identified in CEEHRN review in 2004 (Bykov, Sarang, Stuikyte, & Subata, 2004). This may not be an overwhelmingly impressive figure given how large the region is, but one should consider that for most countries establishing NSPs was not an easy political decision. Introduction of a NSP by a country was often taken as a signifier of a country having mobilised towards more advanced policies to combat HIV among IDUs. This symbolic meaning of needle exchange was sometimes even more important than its practical effect. It was clear from the very beginning that the small pilot projects would not be able to curb the epidemic. The main expectation was that countries would appreciate the results of the pilot programmes and eventually sustain and expand them out of their own budgets. Therefore, the coverage of NSPs remained very low in most countries while differing significantly across the region: for example, according to CEEHRN estimates in 2001–2002, 13 syringe exchange programmes in the Czech Republic served about 82% of the IDU population at least once per year. At the same time, in Russia, 52 NSPs were reaching only about 4.4% of the country IDU population annually (Bykov et al., 2004).

Even when the idea of NSPs was accepted politically it was difficult for countries surviving the period of economic transition to provide any financial support to the programmes. For example, in Kazakhstan and Belarus establishment of NSPs was included in the national AIDS programmes and was supposed to operate throughout each country (Belarus, 2000; Government of the Republic of Kazakhstan, 2000) in reality it received no real funding or technical expertise.

The situation changed when the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was established in 2001–2002. While in 2004, 8 out of 27 countries in the region joined the European Union (EU) thus opening opportunities for albeit limited EU structural funds for public health and social cohesion, others received an opportunity to apply for funding to the GFATM. It is worth noting that GFATM not only provided financial support to the countries but also mobilized them politically, pushing for establishing of Country Coordinating Mechanisms—a step which arguably improved a coordinated response to the epidemic in many countries. By the end of its fifth round of funding, GFATM approved 23 HIV programmes from 20 countries of the region with total funding of almost US$ 418 million (GFATM, 2006).

Substitution treatment

While in the EU alone there was more than 450,000 people receiving ST (EMCDDA, 2005), in CEE/CA countries its use still remains extremely limited (Subata & Stuikyte, 2006) (Table 1).

The first ST programmes in the region were established in Yugoslavia (1984–1989), Slovenia (1990), the Czech Republic (1992) and Poland (1993) (EMCDDA, 2003; Subata & Stuikyte, 2006). During the next decade, ST in these countries expanded to become national programmes. For example, 4 years after introduction of pilot programmes in Poland, ST was approved by the national legislation. The adoption of the official ST guidelines in the same year (1997) was followed by establishment of more than 10 new programmes in the period of 1998–2001 with all expenses covered by the state (Kastelic, Zabranski, & Subata, 2003). This progress though was not growing during the last 3 years and number of people on ST decreased (Subata & Stuikyte, 2006). Similarly Hungary and the Czech Republic witnessed growth of the government funded methadone programmes. Montenegro and Albania are the countries where ST was introduced the most recently, starting with 2005. Of the former Soviet