*all-ukrainian harm reduction association*
*international centre for policy studies*

# Priorities in preventing HIV/AIDS– harm reduction strategy

*kyiv 2005*

This White Paper has been prepared under the "Policy Campaign for Harm Reduction" project. The project is the result of a joint initiative by the All-Ukrainian Harm Reduction Association (Kyiv) and the International Centre for Policy Studies (Kyiv), with financing from the International Renaissance Foundation (Kyiv) and the International Harm Reduction Development Program of the Open Society Institute (New York).

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We thank for preparing this policy paper to all project experts who provided comments and suggestions: Tetiana Afanasiadi, Natalia Baleha, Viktor Hrek, Yuriy Kalashnikov, Svitlana Khotina, Oleksandra Khudoba, Vadym Klorfain, Yuriy Lesiuk, Nadia Melnyk, Ivan Myroniuk, Mykola Ovcharenko, Serhiy Panasiuk, Svitlana Piven, Ghennadiy Razumov, Vladyslav Romanov, Mykhailo Rykhalskiy, Petro Vetrenko, Valentyna Yefimova, Natalia Yuzhna, and Olena Zahainova.

Special thanks to Serhiy Dvoriak, Director of the Ukrainian Institute of Public Health Policy; Alla Shcherbynska, Director of the Ukrainian Center for Preventing and Fighting AIDS; Pavlo Skala, advocacy specialist of the International HIV/AIDS Alliance; Tamara Tretska, consultant for the "Policy" project; and all other participants in the debates for their consultations and the materials they provided for the preparation of this paper and assistance in carrying out this project.

The project's partners were community organizations who are members of the All-Ukrainian Harm Reduction Association that carried out this project in their own regions:

- Virus Rehabilitation Center for Drug Addicts, a charity fund, **Dnipropetrovsk**
- Povernennia to Zhyttia [Return to Life], an oblast fund, **Znamianka, Kirovohrad oblast**
- Krok u Maibutnye [A Step to Future], an oblast fund, **Luhansk**
- Usi Razom [All Together] Center for Social and Psychological Information, a non-government charity fund, **L'viv**
- Vykhid [Way Out], a local charity fund, **Mykolayiv**
- Doroha Dodomu [Way Home], a local charity fund, **Odesa**
- Svit Nadiyi [The World of Hope], a charity association, **Poltava**
- Nadia i Spasinnia [Hope and Salvation], a charity fund, **Simferopol**
- Zakarpattia Proty SNIDu [Zakarpattia against AIDS], an oblast charity fund, **Uzhorod**
- Nova Simya [New Family], a charity fund, **Chernivtsi**
- Klub Enei [Aeneas Club], a community organization, **Kyiv**

We thank the representatives of these organizations for their professional preparation of local public hearings on government policy issues: Larysa Anokhina, Inna Banakh, Valeriya Brych, Maksym Demchenko, Oleh Dymaretskiy, Olena Horiacheva, Ihor Kaminnyk, Halyna Kaminska, Larysa Melanych, Iryna Oros, Oleksandr Ostapov, Stanislav Pokutniy, Alla Shkreta, Mykola Shuliko, Leonid Vlasenko, Oleksandra Yatsiuk, and Serhiy Zhuk.

The opinions presented in this publication do not necessarily coincide with the positions of the experts who provided comments and participated in the discussion of this paper.

# Contents

# List of abbreviations

AIDS – Acquired Immunodeficiency Syndrome
ARV – Antiretroviral, a type of drug to combat HIV/AIDS
AUHRA – All-Ukrainian Harm Reduction Association
DFIDC – Department for Combating Drug Trafficking, Ministry of Internal Affairs
DRT – drug replacement therapy
HAART – Highly Active Antiretroviral Therapy
HIV – Human Immunodeficiency Virus
HR – Harm Reduction
IDUs – injecting drug users
MOH – Ministry of Health
NEP – needle exchange points
NGO – non-government organization
PLHA – People living with HIV/AIDS
UNAIDS – the joint United Nations Program on HIV/AIDS
UNDP – United Nations Development Program
UNICEF – United Nations Children's Fund
WHO – World Health Organization
YSC – Youth Services Center

# Overview

Ukraine is the leader in Eastern Europe and one of the world leaders in terms of the spread rate of HIV. The numbers offer cold comfort: in 2004, Ukraine registered more than 12,000 new cases of HIV infection, a 270-fold increase of figures registered 10 years back. Today, official statistics talk about more than 75,000 registered HIV-positive Ukrainians, a 200-fold increase since 10 years ago. According to WHO estimates, however, the real situation is much worse: as many as 1.4% of adult Ukrainians or 360,000 individuals could be HIV-positive.

The main pathway to the spread of this infection is the injection of drugs. Unfortunately, traditional repressive soviet anti-drug policy, the lack of coordination of anti-drug and HIV preventive efforts, and the lack of political leadership in the country have conspired to make it impossible to provide an effective response to the HIV problem in Ukraine.

In other words, the spread of HIV has compounded the problem of illicit drug use in Ukraine because of the tendency of drug users to share needles. About 70% of HIV infection cases have been registered among injecting drug users (IDUs).

The problem of illicit drug use is also extremely urgent, especially when it goes in tandem with HIV infection. Each year, the Ministry of Internal Affairs registers about 20,000 new drug addicts. At the moment, its registry contains nearly 120,000 individuals. But the real number of drug users is much higher. According to some estimates, it could be as high as 500,000.

## Incompatible policies make it impossible to overcome the epidemic

Today, drug users are simultaneously the focus of anti-drug policy and HIV-prevention policy. But incompatible approaches to policy-making in these two areas are making it impossible to effectively implement measures to prevent HIV among IDUs.

The approach to fighting drugs in Ukraine is based on the old soviet paradigm. When it comes to drug addicts, this policy is limited to voluntary or compulsory treatment and criminal prosecution. The objective of such an approach is to totally eliminate drug abuse. It does not leave room for the legitimate existence of drug addicts in a society, which means that there is no room at all for harm reduction measures.

Meanwhile, the Government's declared approach to preventing HIV among IDUs is based on harm reduction principles,[1] which are based on a humane attitude to those suffering from drug addiction. This approach begins with a realistic evaluation of the spread of drug addiction in a society and, thanks to realistic measures, it makes it possible to lower the spread rate of infectious diseases among IDUs and to reduce the negative social impact of drug addiction. The main measures are needle exchanges, the resocialization of drug addicts, replacement therapy for those who cannot recover from opiate addiction, and public awareness campaigns.

[1] This was determined by the HIV/AIDS Prevention Program for 2001–2003 approved by the 11 July 2001 Cabinet Resolution, the National HIV Prevention Program for 2004–2008, as well as the 12 December 1991 Law "On preventing the Acquired Immunodeficiency Syndrome (AIDS)."

# Efforts need to be coordinated

The numerous sources of financing and variety of organizations implementing harm reduction programs need coordination at a high political level. Financing comes from State Budget funds and local budget funds and from international donors—a US $92mn grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria and a US $60mn loan from the World Bank. Harm reduction programs are being implemented by both NGOs and a network of Dovira [Trust] support centers under Ukraine's Ministry of Youth and Sports.

However, the Government is not effectively carrying out the functions of coordinating and overseeing the prevention of HIV, especially when it comes to harm reduction. No government agency has a full picture of ongoing programs in this area. As a result, these seemingly serious efforts have not made a real impact on the epidemic.

# Services for drug addicts need to be increased

Inaccessible and unaffordable drug addiction treatment, medical services and social assistance for addicts have a negative impact on the situation with illicit drug use and the related spread of HIV and other infections. Rehabilitation services for drug addicts are provided mainly by NGOs and they are either financially or geographically beyond the reach of the majority of those who need them. Meanwhile, replacement therapy programs for drug addicts who have been taking drugs for a long time and whom rehabilitation program did not help are currently available only as pilot projects.

The conflict between anti-drug and HIV prevention policies and insufficient funding make it impossible to expand programs that could really stem the epidemic. In short, the lack of a broad-based approach to drug addiction in government policy makes it hard to ensure even a minimal level of affordable and accessible treatment.

# Why is current policy so ineffective?

1. The Government's Harm Reduction Strategy is being implemented haphazardly, while medical and social services for drug addicts remain unaffordable. This makes it impossible to reduce negative impact of drug addiction, such as the spread of HIV.

2. The government has not made any effort to harmonize its anti-drug and HIV prevention policies. This specifically affects the effectiveness of HIV prevention work: fearing prosecution, IDUs do not participate in prevention programs.

3. The state is not coordinating or overseeing the implementation of HIV prevention policy, whether in terms of identifying priorities or in terms of implementing and monitoring programs.

# How can this be fixed?

1. **Information policy:** to increase the awareness among the general pubic and specialists alike of the modes of transmission of HIV and the ways to prevent it.

2. **Harm reduction programs:** to implement them full-force, covering at least 60% of the target group. This means providing:

a. sterile syringes and disinfectants to individuals who inject drugs;

b. drug replacement therapy to individuals who suffer from opiate addiction;

c. information and educating the entire population, as well as carrying out public awareness campaigns among drug users;

d. easy access to social and medical services.

3. **Social reintegration and rehabilitation of addicts:** to improve access to services.

4. **HIV prevention and anti-drug policies:** to make them more compatible by removing obstacles to harm reduction measures. This includes:

   a. amending Art. 309 of the Criminal Code, replacing imprisonment as the main punishment for the possession of narcotic substances without the intention of selling them with a simple fine;

   b. amending the table that determines what minimum amount of a given narcotic substance leads to criminal liability before the law;

   c. removing the number of cases opened on the basis of possessing narcotic substances without the intention of selling them from the list of police performance indicators in the drug war;

   d. revising the way the police work with drug addicts to include cooperation with harm reduction programs.

5. **Eliminating the stigmatization of drug addicts and PLHAs:** to develop a more compassionate attitude in the society.

6. **Political leadership:** to ensure the implementation of HIV prevention and anti-drug policies and organize national and regional coordination of HIV prevention efforts; to institute mechanisms for involving stakeholders in the formulation of state policy; establish workable mechanisms for reporting on and allowing public oversight of the implementation of policies once they are approved.

# Why talk about harm reduction?

## What is "harm reduction"?

Public health professionals use the term "harm reduction" to describe a concept of reducing or preventing the negative consequences to health associated with specific behavior. According to WHO, harm reduction (HR) in the context of drug addiction means preventing the transmission of HIV that occurs when users share needles and syringes and other negative consequences of drug abuse to the individual and the society.

In public health, the harm reduction approach appeared as an alternative to the earlier approach of complete abstinence from drug use. This new approach is aimed at those drug addicts who cannot be expected to quickly give up drugs, although it does not deny the importance of giving up drugs as the ultimate goal. So, the definition of a harm reduction policy is: a policy or program aimed at reducing the negative health, social and economic impact of drug abuse without requiring the immediate giving up of drugs.

Although many drug addicts need a lot of time to give up their addiction, harm reduction measures need to work immediately to prevent the spread of the HIV epidemic. The set of harm reduction measures is based on three principles:

- **Pragmatism**: Some part of the population will always use drugs, so state policy should be focused not only on fighting drug abuse but also on reducing daily harm from drug abuse;

- **Humanism**: People cannot be condemned for using drug because everyone has a right to choose in a democratic society. Condemnation, prosecution and stigmatization make it impossible to carry out effective prevention work with drug addicts.

- **Economy**: HIV prevention is cheaper than HIV treatment.

Experience in implementing HR programs in Ukraine has shown that the cost of preventing a new case of HIV is about US $194,[2] whereas the annual cost of treating and caring for a single HIV patient is nearly US $1,300.[3]

In European practice, harm reduction is an element of both anti-HIV/AIDS[4] and anti-drug policy.[5] In particular, harm reduction is part of anti-drug measures to lower demand for illegal drugs, including primary prevention, early detection, treatment, harm reduction, rehabilitation, and resocialization. As part of anti-HIV/AIDS policy, HR measures go hand-in-hand with measures to prevent HIV transmission by other means: sexual transmission and vertical transmission (Mother To Child Transmission—MTCT), and so on.

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[2] Ukrainian Center for Preventing and Fighting AIDS. Results of an analysis of the HIV/AIDS prevention program among IDUs in Odesa.

[3] In 2004, the average annual cost of treating one adult through a Global Fund grant was US $1,369; through Budget funds it was US $6,322, according to the Ukrainian Center for Preventing and Fighting AIDS.

[4] Coordinated and Integrated Approach to Combat HIV/AIDS within the European Union and in Its Neighborhood. European Commission. Brussels. 08 September 2004 C (2004) 3414.

[5] EU Drug Strategy (2005–2012), Council of the European Union, 22 November 2004.

# Previous efforts

This White Paper is the outcome of government policy research on stemming the spread of HIV/AIDS among IDUs. The research was carried out by experts from the All-Ukrainian Harm Reduction Association (AUHRA) and the International Centre for Policy Studies (ICPS). Work on the White Paper was accompanied by consultations with experts in HIV prevention and anti-drug measures and a series of public debates involving a broad base of stakeholders.

The research, consultations and debates were organized in two stages. During the first stage, a Green Paper identified the problem, outlined its scale and proposed different strategies for its solution. More than 20 experts—specialists in law enforcement, social and healthcare areas representing 11 regions and various kinds of organizations with a variety of aims—provided comments and suggestions for the Green Paper.

The Green Paper was presented at public hearings that took place in 11 cities during January–February 2005. Each of the debates involved a broad base of stakeholders representing government bodies, community organizations, healthcare, social and law enforcement agencies, people living with HIV, and former drug users and their relatives. Participants in 10 regions were presented with three policy options regarding IDUs:

- maintaining status quo, which means implementing a few components of harm reduction policy;
- strengthening the prosecution of IDUs;
- introducing a full-strength harm reduction policy.

The proposed options were considered from a number of positions:

- How effective will this be to fight the spread of HIV?
- What will society lose if these steps are implemented?
- How will society benefit if these steps are implemented?

The overwhelming majority of participants rejected the first two options: maintaining status quo and strengthening prosecution. According to stakeholders, neither will help stop the HIV/AIDS epidemic.

According to participants, maintaining status quo towards IDUs is likely to accelerate the spread of the epidemic, primarily among and through IDUs. Although the implementation of some harm reduction policy elements might help reduce negative social consequences of drug addiction, it cannot affect the situation as a whole.

The most powerful argument against strengthening prosecution for drug abuse was the firm conviction among participants that this approach will only drive the problem into the shadows. Addicts will avoid any contacts with government agencies and will find themselves effectively isolated from HIV/AIDS prevention and treatment programs. The negative consequences for Ukrainian society will only grow worse as a result.

**Given that most interest groups that participated in the debate support a harm reduction strategy, this White Paper was developed during the second phase, offering a full-range plan of action to institute such a this in Ukraine.**

The White Paper outlines the problem, its roots and recommendations for overcoming the causes following the chosen strategy. Experts also provided feedback on the

White Paper and it was then presented for public debates that took place in 11 cities in April 2005.

The results of the series of debates are summarized in **Appendix I**. The text of the Green Paper and a full report on the results of these debates can be found on the ICPS website at *http://www.icps.kiev.ua/eng/project.html?pid=18*.

# Why harm reduction a priority?

Today, the spread of HIV/AIDS in Ukraine is among the fastest in Eastern Europe. Despite the efforts of NGOs, community organizations and international donors to actively deal with this problem for a number of years, the trends are getting worse. Still, Ukraine can take control of the situation and reduce the spread of the epidemic. If more time is wasted, however, this window of opportunity will soon close.

For more than 10 years, the expansion of the HIV epidemic in Ukraine was closely connected to users of injecting drug (IDUs). Most specialists connected in one way or another to this problem recognize the need to immediately reconsider the current approaches towards IDUs and, of course, anti-drug and anti-HIV policies. Primary preventive measures alone can never be a full-fledged response to the situation today. The majority of experts agree that current trends in the spread of HIV/AIDS make it clear that harm reduction must become a priority. Harm reduction measures need to go hand-in-hand with the prevention of HIV transmission by other means, such as sexual transmission and vertical transmission (mother-to-child-transmission or MTCT).

**Harm reduction needs to become the foundation for a policy towards IDUs, both in the combat against drug trafficking and in the prevention of HIV/AIDS in Ukraine.** If Ukraine does not make this choice soon, the projections of government policy will be disastrous for the nation's health.

Experts believe that the Ukrainian government should take the lead in this area. And this means there has to be high-quality public policy that: (1) clearly identifies goals and priorities; (2) responds, in terms of its content, to the current situation and development forecasts; and (3) matches the conditions for implementation, which in turn include rules and regulations (legislation), institutions (agencies, organizations), financing, those responsible for implementation, and coordination.

## HIV and injecting drug users

The spread of HIV/AIDS and related diseases poses a threat to specific individuals, to the domestic economy, to the labor force, to the healthcare system, to the social infrastructure, and to the social security system. The vast majority of the HIV-positive in Ukraine are young people aged 20–39, that is, people in the prime of their lives in terms of physical, creative and intellectual capacities.

According to official data, the total number of HIV-positive individuals registered since 1987 was 75,796 as of 1 January 2005—almost 200 times more than 10 years ago. More than 5,500 Ukrainians have already died from AIDS.

However, the official statistics reflect only the tip of the iceberg. According to estimates by the joint United Nations Program on HIV/AIDS (UNAIDS), the number of HIV-positive individuals in Ukraine in 2003 was estimated at about 360,000 people aged 15–49—at least 1.4 % of the adult population—while the number who have died from AIDS was projected at 20,000.[6]

[6] Evaluation of the possibility of developing programs to prevent HIV among IDUs. The UNICEF office in Ukraine and the Social Monitoring Center, with the support of UNAIDS in Ukraine and the International Renaissance Foundation. Research Manager O. Balakiryeva. Kyiv. 2003. p. 5.

A comparison with Eastern European countries and neighboring Russia (see **Table 1**) confirms the hypothesis that Ukraine is facing a critical situation with the spread of HIV/AIDS.

*Table 1. Adults living with HIV in selected Eastern European and Asian countries*[7]

| Country | Estimated # of adultsliving with HIV | Estimated # of adultsliving with HIV, per 100,000 |
|---|---|---|
| Ukraine | 360,000 | 748 |
| Russia | 860,000 | 604 |
| Estonia | 7,700 | 589 |
| Kazakhstan | 16,400 | 106 |
| Hungary | 2,800 | 28 |
| Slovenia | 500 | 25 |
| Czech Republic | 2,500 | 24 |
| Romania | 2,500 | 11 |
| Poland | 3,500 | 9 |
| Bulgaria | 500 | 6 |
| Slovakia | 200 | 4 |

*Source: UNAIDS , http://www.unaids.org/*

According to expert forecasts, if current trends continue, the number of HIV-positive could reach almost 1.5mn individuals and the number of new cases of AIDS could be 95,000 by 2010. Meanwhile, up to 90,000 Ukrainians could die from this disease in that same year. Moreover, those who die from AIDS in 2010 will represent about 10% of all Ukrainians who died from it, and the majority of AIDS victims will be under 40.[7]

Assuming that government policy does not become any more effective than it is today, by 2010, Ukraine will have to spend more than UAH 500mn every year just to treat and take care of people living with HIV/AIDS (PLHA).[8]

From 1994–1995 on, injecting drugs have been the key channel for spreading HIV in Ukraine. The reason is the risky behavior of IDUs, which, in turn, is one of the symptoms of drug addiction. As a result, HIV/AIDS is beginning to spread among other groups who have contact with IDUs.

In addition to HIV/AIDS, the risky behavior of drug addicts also contributes to the spread

[7] O. Balakiryeva, Y. Galustian, O. Yaremenko, and others. The social and economic consequences of the HIV/AIDS epidemic in Ukraine: New forecasts. Kyiv. 2003.

[8] According to estimates of the Ukrainian Center for Preventing and Combating AIDS, Ministry of Health of Ukraine.

of other contagious diseases, such as hepatitis B and C and sexually transmitted diseases (STDs). Additional social consequences are: the destruction of family ties and friendships, the growing rate of drug-related crime, high costs for treating both drug addiction and contagious diseases, growing numbers of unemployable young people, the violation of human rights, and violence towards drug addicts. These harmful consequences can be seen every day in Ukraine and affect a growing circle of Ukrainians.

By the end of 2003, Ukrainian police had registered 119,965 drug users, including 82,836 who were suffering from addiction. However, official statistical data does not reflect the real situation. According to expert estimates, the real number of drug users stands at 560,000.[9] The spread of the epidemic among this group requires urgent harm reduction steps in the IDU environment.

Injecting drug users constitute nearly 70%[10] of all HIV-positive. According to statistical data, the share of IDUs among new instances of HIV has been slowly declining,[11] although the actual number of new cases of HIV among IDUs continues to grow (see **Figure 1**).

According to a study carried out jointly by the Ukrainian Center for Preventing and Combating AIDS and UNAIDS in Odesa oblast over 1998–2002, IDUs constituted more than 70% of all individuals who transmitted HIV through heterosexual relations.[12] IDUs involved in the sex business also play a major role in sexual transmission of HIV.

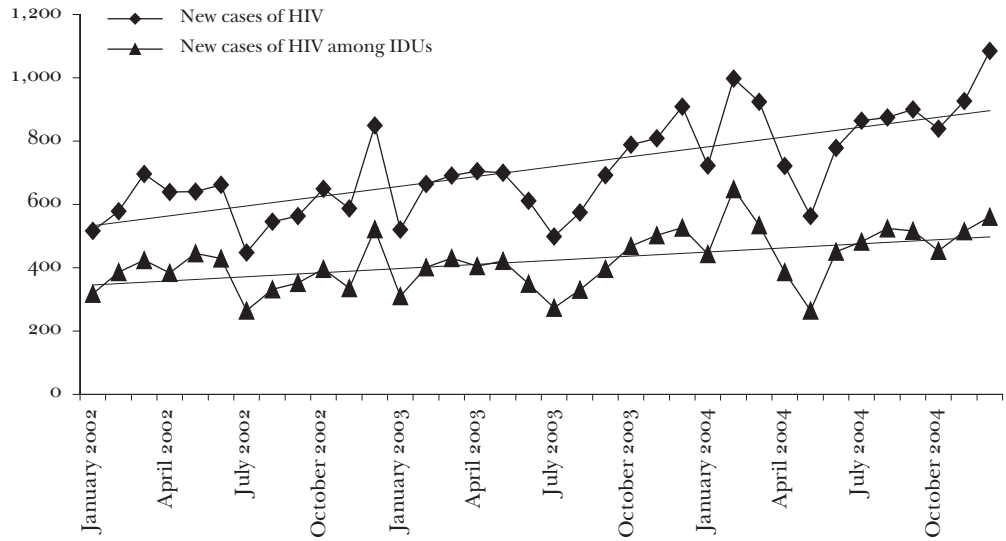
[9] According to data provided by the Social Monitoring Center and UNICEF in a publication called Evaluating the possibility of developing programs to prevent HIV among IDUs, the number of IDUs in Ukraine is growing steadily: the government had 31,080 registered addicts in 1991; by 2003, this number was 119,965. As a rule, the government registers individuals brought in by the police and turned over for mandatory medical examinations. In this case, the difference in numbers is explained by police statistics that divide drug addicts into two categories: (1) those diagnosed with drug addiction; and (2) those who allow non-medical use of narcotics.

[10] Op. cit., Ukrainian Center for Preventing and Combating AIDS.

[11] Among 10,198 officially registered new cases of HIV-positive adults in 2004, 5,778 or 57% were IDUs.

[12] Ukraine and HIV/AIDS: Time to Act. Ukraine Human Development Report for 2003, Special Report, UNDP, 2003, Kyiv, Ukraine, p. 8–9.

*Figure 1. Officially registered new cases of HIV, per month*




# Why is state policy so ineffective?

The extremely high pace at which HIV/AIDS is spreading among IDUs and to the rest of the population is evidence that the government has not adequately responded to the threat of this epidemic. Although, IDUs have been the main vehicle for spreading HIV since 1995, government measures to combat the drug trafficking and prevent HIV remain incompatible, resulting in a widespread epidemic today. According to participants in the debate, anti-HIV efforts will have little or no impact without a consistent harm reduction policy.

The current system for making and instituting policies allows the Government to make decisions that are not underpinned by resources and clearly will not be implemented. In terms of harm reduction, this is particularly true of decisions to provide access to treatment and preventive measures, to introduce drug replacement therapy, to publish social advertising related to HIV/AIDS, and so on. Moreover, there are no effective mechanisms for overseeing the decision-making process and the implementation of this policy by the Government, the Verkhovna Rada or the general public.

The results of the study carried out as part of this project and discussions with stakeholders make it clear that Ukraine does not have a consistent and well-thought drug policy. Legislation pieces and regulations often are largely declarative and are unsupported by resources, containing elements of different—sometimes even contradictory—approaches to illicit use of drugs and, thus, cannot possibly have a real impact on the problem.

In short, the main reasons why HIV/AIDS prevention programs remain largely ineffective are:

- **Incompatible anti-drug and HIV prevention policies.** The emphasis in the current policy on primary preventive measures—prohibition and prosecution aimed at increasing fear of using drugs—

leads to distrust in harm reduction programs. IDUs fail to take advantage of such programs for fear of prosecution. Yet criminal prosecution of drug addicts does little to help them recover, at the same time as it interferes in the proper implementation of harm reduction programs.

- **Insufficient funding for prevention.** According to UNICEF estimates, the state needs about UAH 80mn per year for preventive measures among vulnerable groups.[13] The 5th National Program to combat HIV sets about UAH 20mn per year for this purpose, which only support existing programs, which cover only 15–20% of the target group.

- **No government coordination or oversight.** This is true both at the level of identifying priorities and at the level of implementing and monitoring programs. With different sources of financing and a broad base of NGOs implementing harm reduction programs, coordination and oversight are clearly needed. The lack of these at the central and local levels leads to:

  - a large portion of resources concentrated in "priority" regions and not enough is channeled to "non-priority" regions;

  - harm reduction programs planned according to available donor funds rather than proceeding from real needs;

  - poor coordination among programs of various donor organizations, leading to duplication of efforts in some regions and areas—and lack of support in others;

  - poor coordination among various agencies during implementation, leading to the reduced effectiveness of harm reduction programs.

- **Drug replacement therapy on hold.** DRT is an integral part of any harm reduction strategy and is needed to lower the risk of contracting infections transmitted through the blood, to reduce the crime rate, and to foster the return of drug addicts to their communities. Without DRT, it will be impossible to overcome the epidemic among IDUs. Resistance on the part of the police, which has little professional basis, is the main obstacle to DRT.

- **Medical and social services unaffordable and inaccessible.** This makes it impossible to take preventive measures among this target group. This is happening because there is no comprehensive government program to provide such services for drug addicts, existing rehabilitation services cost too much, and stigmatization leads IDUs to reject these services.

- **No effective oversight of preparation and implementation.** There is no full-fledged system to monitor the situation or the efficiency and effectiveness of measures taken within the framework of state programs. None of the national HIV preventive programs contains goals expressed in specific figures and none was based on an analysis of previous efforts.

- **Policy not based on reliable statistical data.** According to many specialists, official statistics on the number of HIV-positive individuals and the incidence of HIV/AIDS do not reflect the real situation. Moreover, different official sources give completely different data on the number of drug addicts. As a result, the Government does not have the full picture about trends in the epidemic or

[13] Op. cit., UNICEF.

information to evaluate the consequences of decisions it makes.

- **Poor HIV-related awareness and know-how.** Not only is the public ill-informed, but the knowledge and skills to prevent illegal drug use and HIV-risking behavior are lacking among specialists. During public debates, even specialists admitted that they were poorly informed about the principles and methods of harm reduction programs.

# A six-step program

Analysis and debates with stakeholders show that Ukraine is facing two extremely urgent problems: the epidemic of HIV/AIDS and the growing spread of drug addiction. These are two different problems that happen to intersect. Harm reduction strategy is an effective tool to achieve both anti-drug policy goals and healthcare goals. But while the solution to these two problems includes this strategy, it cannot be not limited to it. The set of measures proposed in this paper is based on an understanding of the role of injecting drugs in the spread of HIV/AIDS and should be included in both the state anti-drug policy and its programs to prevent HIV and combat AIDS.

This strategy aims to:

- Provide drug addicts with more opportunities to control their health;
- Reduce the number of deaths related to illicit drug use;
- Limit the negative consequences of the drug trafficking for society, such as the spread of HIV, hepatitis B and C, and tuberculosis.

The harm reduction approach proceeds from the realization that it is virtually impossible for a society to completely get rid of drug addiction, regardless of the means, and the understanding that the harm to the community and society need to be minimized. To implement this strategy in full, six sets of objectives need to be met in Ukraine:

- To radically change information policy;
- To fully implement all elements of a harm reduction policy;
- To develop a system for the rehabilitation and social re-integration of drug addicts;
- To make anti-drug and HIV prevention policies compatible by removing barriers to the implementation of harm reduction measures;
- To take steps to overcome the stigmatization of drug addicts and PLHAs;
- To improve the overall system for developing, adopting and implementing policies in this area.

## Information policy

**Goals:**

- To raise public awareness of the modes of HIV transmission and ways to prevent infection;
- To form a compassionate attitude in the society towards the HIV-positive and IDUs;
- To increase the level of informedness among specialists working with and contacting the HIV-positive and IDUs.

**Arguments:**

During the public debates, participants noted the low level of public awareness work in practically all aspects of HIV/AIDS and drug addiction as the №1 problem in Ukraine. Ukrainian citizens in general and even specialists are poorly informed of the issues, appropriate behaviors, available programs and approaches. Many medical workers are not psychologically prepared to work with HIV-positive IDUs.

This key component in the effort to prevent the spread of the epidemic has not been given enough attention. This is particularly evident in the reluctance of the Government to fund such important preventive steps as information campaigns, education and communication. The overwhelming majority of resources are spent on purchasing testing systems and medications.

But in addition to limited resources, another issue is ineffective allocation. Despite all the existing public awareness campaigns (see **Table 2**), which have different sources of financing, goals are not being reached. This was confirmed by a survey carried out by state social services among different population groups, including young people and children.[14]

*Table 2. Informational support for HIV/AIDS issues during state air-time (2004)*

| State-run company | # of information items | Length of information items (in hours) |
|---|---|---|
| National Radio | 3,412 | 80 |
| National Television | 323 (218 social ads) | 6.2 (1.2 of social ads) |
| Oblast and regional state television | 2,817 | 183.5 |

*Source: National Report on Implementing the Declaration on the Commitment to Combat HIV/AIDS, 2004*

The main conclusion is that neither social advertising, nor special programs on television nor publications in the press are targeted for a specific audience or target group. Setting up a system to influence various consumer groups informationally and properly considering their need for information and education programs could, within a short period of time, form the necessary public attitudes on key issues and affect decision-making by politicians.

**Recommendations:**

- Develop targeted social advertising on avoiding HIV/AIDS and preventing people from getting into drugs. This also means broad-based educational campaigns to reduce the stigmatization of high-risk groups and form a more compassionate attitude in the society towards PLHAs and drug addicts;

- Introduce a subject called "Prevention of Drug Addiction and HIV/AIDS" into the public school curriculum or improve the delivery of the subject of health and healthy lifestyles in schools and medicine in post-secondary institutions. This effort should broadly involve NGOs involved in harm reduction and the prevention of HIV/AIDS, as well as self-help groups for drug addicts and PLHAs;

- Carry out a public awareness campaign in the media to cover the global fight against the epidemic;

[14] According to a poll carried out for the National Report on Implementing the Declaration on the Commitment to Combat HIV/AIDS, only 14.1% of young people aged 15–24 can properly describe ways to prevent the sexual transmission of HIV/AIDS and know how HIV is not transmitted.

- Develop and implement specific professional social campaigns on preventing the spread of the HIV/AIDS epidemic and harm reduction strategies for workers of government bodies at all levels, the police and educational facilities;
- Develop and provide training for journalists to help them properly understand the issues of drug addiction and HIV/AIDS and produce high-quality informational products.

# Harm reduction programs

All elements of a harm reduction strategy were included in three National HIV/AIDS Prevention Programs. Yet, understanding of the priority of this approach for Ukraine remains strictly declarative and it is not being fully implemented. We propose a number of steps to change this situation.

## *1. Provide IDUs with sterile syringes and disinfectants*

**Goals:**

- To stop the transmission of contagious diseases through sharing injection equipment;
- To expand the coverage of target groups through existing prevention services.

**Arguments:**

No oblast in Ukraine has a network of points that can meet the needs of IDUs with suitable medical instruments.[15] Currently, needle exchange programs and outreach activities cover 15–20% of IDUs, but a minimum of 60% need to be reached to affect the epidemic. This part of the harm reduction strategy is handled mostly by NGOs, as well as by Dovira counseling centers set up under the state–run network of Youth Services Centers. Financing is provided by donor organizations and local budgets, with donor funding prevailing. Although it is possible to get State Budget funds allocated for these services, this is not being done on a large enough scale.[16]

The main goal of this activity is to counteract the spread of infections transmitted through the blood and the sharing of syringes by drug addicts among IDUs. Such infections include HIV/AIDS, hepatitis B and C and STDs. Needle exchange points provide drug addicts with sterile syringes in exchange for used ones, as well as disinfectants and contraceptives. They also provide information and counseling. Drug addicts can also consult a psychologist, a medical worker or a lawyer to get information on issues that interest them and references for medical examinations or for treatment in a drug rehabilitation facility, a local state-run HIV/AIDS prevention center or an STD center.

Outreach services provide prevention in places visited by IDUs on a peer-to-peer basis. Outreach workers are, as a rule, former or even current drug addicts who are insiders with the addict population and are familiar with the drug sub-culture. They provide basic consultations to members of such communities on how to lower the risk of con-

[15] For example, there is only one needle exchange point in Kyiv. There are three needle exchange points under Youth Services Centers in Odesa oblast, although a minimum of 15 stations is needed. There are an additional one or two stations under civic organizations in the city of Odesa, which is not enough to cover even 15% of IDUs.

[16] Executive bodies can only procure social services on the basis of legislation governing social services, in particular the 29 April 2004 Cabinet Resolution №559 "Approving the rules for organizing and carrying out tenders to allocate State Budget funds for providing social services."

tracting HIV and other infectious diseases, they disseminate hand-outs and sterile medical equipment, and they keep this community informed about opportunities to receive social, psychological or medical assistance from community and state-run organizations.

The practical effectiveness of needle exchange programs has been confirmed by many studies. In particular, one study commissioned by the Australian Department of Health analyzed data from 103 cities of 24 countries worldwide and showed convincing results: the spread of HIV dropped an average of 18.6% per year in 36 cities that introduced needle exchange programs and grew 8.1% per year on average in other 76 cities that did not introduce such programs.[17]

**Recommendations:**

For this component to be properly and effectively introduced, needle exchange programs must cover around 60% of IDUs. In Ukraine, this means quadrupling efforts in this area:

- Develop a set of standards for this work and indicators for monitoring purposes; organize regular monitoring and development of recommendations to raise the effectiveness of these efforts. Monitoring should not violate the principle of client confidentiality. This work can be carried out by the All-Ukrainian Harm Reduction Association;

- Define the legal status of needle exchange programs at the state level: are they a social service or charitable assistance? A definition is necessary to allocate Budget funding;

- Analyze the need for new needle exchange points in each region based on: (1) realistic estimates of IDUs numbers and projected coverage; and (2) realistic extrapolations of IDU needs for syringes, condoms and disinfectants;

- Open new needle exchange points based on the needs and characteristics of each specific region, including permanent locations, mobile units, outreach activities through AIDS centers, TB and drug dispensaries, clinics, and pharmacies;

- Coordinate needle exchange points operating under various organizations at the regional level;

- Carry out targeted public awareness campaigns at the local level before opening needle exchange points and during their operation in order to (1) inform potential clients; (2) prevent a hostile reaction of local residents; and (3) form a compassionate attitude towards this activity;

- Expand the range of services under needle exchange programs: a system of referrals to specialists, consultations of an addiction specialist and psychologists, free HIV tests, active cooperation with other medical specialists;

- Eliminate external barriers to this area of activity, especially the behavior of police officers towards the target group.

## *2. Provide drug replacement therapy for IDUs, especially users of opiates*

**Goals:**

- To abandon injections and reduce risky behavior in terms of contracting HIV, preventing AIDS among IDUs;

[17] Health Outcomes International, Return on investment in needle and syringe programs in Australia. Commonwealth Department of Health and Ageing, 2002. *http://www.health.gov.au/pubhlth/publicat/document/roireport.pdf*

- To reduce the use of illegal opiates and, hence, lower the crime rate;
- To lower the death rate from overdosing and using toxic substances;
- To ensure that HIV-positive IDUs follow their HAART-therapy regimen;
- To lower the incidence of secondary diseases among IDUs;
- To reduce the cost of opiate addiction to drug addicts, their families and the society as a whole, through all the above.

**Arguments:**

Methadone[18] therapy is a widely and well-known method for treating drug addiction. Research and monitoring of assistance have provided convincing data that methadone treatment effectively contributes to lowering the use of prohibited drugs, the death rate and the risk of HIV.

Still, DRT is only one among a number of methods to treat opiate addictions. Applying DRT in no way excludes other methods, including counseling, psychotherapy and other social and psychological approaches, detoxification, treatment with opiate antagonists and other psychopharmacological means.[19] A doctor is responsible for choosing the specific form of treatment. In other words, the proposition is not that all opiate addicts enter DRT. The criteria for applying DRT should be strictly limited to those addicts who have no prospects of recovery through other methods. These are mostly individuals who have been taking such drugs for a long time, have been treated with no success in the past, and are suffering from mental or somatic disorders (HIV/AIDS, tuberculosis, and so on). There are also age restrictions: drug replacement therapy is not recommended for those under 20.

An important point about DRT is that not only drug addicts benefit from it, but also the society, as this therapy tangibly helps lower the pressure of social and economic problems related to drug abuse, such as public funding for hospitals, penitentiaries and the police.

As of 2003, some 600,000 individuals are in drug replacement therapy programs worldwide.[20] From 1998 to 2002, the number of patients who were undergoing methadone treatment grew 34%. In particular, the numbers grew 23.4% in Great Britain, 61% in France, 80.8% in Austria, and 800% in Norway. More recently, buprenorphine therapy has become very widespread: about 200,000 individuals are undergoing buprenorphine therapy in France alone.

The Ukrainian Government and the Verkhovna Rada have understood that drug replacement therapy is a highly effective preventive method. Indeed, provisions to the effect are included in the 3 February 2004 VR Resolution №1426-I "On recommendations of the Verkhovna Rada hearings on 'Social and Economic Problems of HIV/AIDS, Drug Addiction and Alcoholism in Ukraine'" and the 4 March 2004 Cabinet Resolution №264 "Approving the Concept of a Government Action Strategy to prevent the spread of HIV/AIDS until 2011 and the National Program for HIV preven-

[18] Methadone is a synthetic opiate that is usually administered orally in liquid form. This drug is most frequently used in treating heroin addiction. Methadone was included in the list of narcotic substances whose sale is limited according to the 5 May 2000 Cabinet Resolution №770 approving the list of narcotic substances, psychotropic substances and precursors.

[19] On average, about 30% of heroin-dependent patients undergo replacement therapy in EU countries.

[20] About 200,000 were in the US and up to 400,000 in Europe, according to estimates of the European Monitoring Center for Drugs and Drug Addiction, Report for 2003.

## *Studies in many countries confirm that DRT results in a number of positive outcomes:*

- *Slowing the spread of HIV/AIDS through injecting drugs.*
- *Injecting opiate users who are living with AIDS and need HAART can be prepared by stabilizing their social and psychological states. HAART requires discipline and unswerving daily and hourly adherence to all medical instructions from a patient, that is, it requires a patient to be committed to treatment. It is practically impossible to achieve this with a patient who is on a daily hunt to obtain a dose of drugs because of addiction. Thus, to make addicts committed to treating AIDS, first, they need to cope with their craving for drugs. This can be achieved through drug replacement therapy.*
- *Methadone treatment rarely shows negative side effects and usually allows considerable improvement in health indicators. About 75% of those who receive this therapy respond positively.*
- *The death rate among addicts in DRT is 25–33% of the rate among those not involved in such programs. Pregnant women receiving DRT more rarely have complications–both mother and fetus–than those not in this kind of therapy.*
- *DRT is more effective than no treatment, placebo and detox, which is used as a separate form of treatment, in terms of how long addicts stay in treatment and the reduction of their heroin intake.*
- *Very high crime rates were registered among drug users before their involvement in treatment. After one year of methadone treatment, rates went down by almost 50%. The most positive results were registered during the treatment process and right after it ended. But noticeable improvement can be observed for several years after the treatment was stopped. Indicators connected to drug-related criminal behavior appear to shrink significantly.*
- *According to estimates, every dollar invested into addiction treatment programs can help a community save up to US $4–7 based on such factors as lower losses to drug-related criminal behavior, thefts and robberies. Hand-in-hand with this, spending on criminal trials should also decline. If the cost of medical assistance is factored in as well, overall savings can exceed spending at a ratio of 12:1.*
- *Although DRT is viewed as merely a treatment of symptoms that does not eliminate the need for regular doses of a drug,* ***currently there is no effective alternative to such a treatment for long-term addicts****. Medical research has shown that detoxification is absolutely ineffective: afterwards, 100% of addicts return to taking opiates. Rehabilitation programs have a success rate of no more than 25%. Moreover, they are costly, making it difficult to provide them to many addicts.*
- *In addition to preventing HIV and treating drug addiction, replacement therapy programs are an effective method to reduce trafficking by reducing demand for drugs. Thus, if 10,000 individuals whose daily dose is 5–10 ml join a DRT program, their demand for drugs represents about 18,000–36,000 kg per year (0.01 x 10,000 x 365 = 36,500). This is a significant figure, given that the Ministry of Internal Affairs reported that 22,000 kg of illegal narcotic substances were seized from dealers in 2003. Other calculations are also available. A pilot project in drug replacement therapy in Ukraine showed that clients used an average of UAH 100-worth of opiates per day. It is easy to see that one program treating 100 addicts effectively deprives drug dealers of UAH 300,000 per month or UAH 3.6mn per year. It is clear that DRT will certainly find resistance under such conditions.*

tion, assistance for and treatment of the HIV-positive and those suffering from AIDS for 2004–2008." Recently, the Health Minister signed a Decree "On developing and improving drug replacement therapy to prevent HIV/AIDS among IDUs"[21] that envisages the introduction of drug replacement therapy using the drug Yednoc in five oblasts.

Replacement therapy programs have not previously been implemented[22] in Ukraine for a number of reasons. The main one is lack of understanding and resistance to replacement therapy on the part of many narcotics specialists, heads of drug oversight committees, the Interior Ministry, and other government agencies monitoring trafficking in narcotic substances. The idea of financing such programs is not seen as an opportunity to reduce harm from drug abuse for the society as a whole.

Because the issue of drug replacement therapy remains unresolved, centers for preventing and combating HIV/AIDS effectively cannot provide HAART services to active IDUs, since protocol requires that they have at least 30 days of treatment with DRT before the main treatment can commence.

**Recommendations:**

DRT was included in the HIV Prevention Program. Ukraine developed recommendations called "Methadone treatment in the Treatment and Rehabilitation of Addicts of Opiates," which have been approved by the Health Ministry. Research shows that the prescription of key replacement therapy medications is in line with Ukrainian legislation. Moreover, there is now a set of regulations that directly point to the need to introduce DRT. Further steps include:

- Examine the possibility of manufacturing replacement drugs (buprenorphine and methadone) in Ukraine to reduce the cost of treatment and the burden of expenditures shouldered by the society;
- Revise certain Health Ministry regulations intended to track narcotic substances so that they cannot be used as replacements in medical practice;
- Provide information, training and internships for different interest groups: narcotics specialists, doctors from HIV/AIDS centers, and workers in related health departments;
- Develop a mechanism for overseeing and coordinating at the regional level those organizations that implement DRT programs, which would include medical and social facilities and the Interior Ministry;
- Establish conditions for providing DRT at drug addiction centers and offices, HIV/AIDS prevention centers and

[21] The 13 April 2005 Ministry of Health Decree №161.

[22] Replacement therapy programs have been implemented only on a pilot basis to date. A buprenorphine replacement therapy program was introduced at the Poltava oblast drug addiction center. Patients were given the opportunity to use this medication free-of-charge from 1–2 months, a short-term course of treatment, up to 4 months, a medium-term course. Seven patients were involved in this program for one year, a figure that is really insignificant, given the 1,287 registered addicts in the region. A replacement detoxification program in which patients receive buprenorphine to remove withdrawal symptoms for the first 10–15 days proved very popular among IDUs and involved nearly 100 patients for a year. Such programs have also been also implemented in Kremenchuk, Lubny and Luhansk.

infectious diseases hospitals. This means providing licenses to work with narcotic substances; to buy, import and distribute replacement drugs and medications in the necessary amounts;

- Institute the positions of an infectious disease doctor and a narcotics doctor at drug addiction centers and HIV/AIDS prevention centers to dispense medications and replacement drugs for HIV-positive drug addicts in conjunction with HAART;

- Develop a strategy to involve IDUs who meet certain criteria in DRT programs.

## *3. Public awareness campaigns and education*

**Goals:**

- To provide public support for harm reduction;

- To provide information to IDUs and to their closest circles on preventing risky behavior;

- To broadly disseminate information about organizations that work with drug addicts and the HIV-positive and about services that they provide.

**Arguments:**

Disseminating information is the key factor in effective prevention of HIV/AIDS as a whole. The public awareness component plays an important role in any harm reduction strategy by involving the target group in preventive measures. This component also ensures understanding and support for harm reduction among the general public.

**Recommendations:**

- Carry out regular public awareness campaigns in the media to highlight the goals and approaches of harm reduction policy in Ukraine;

- Carry out targeted public awareness campaigns on harm reduction at the local level in order to: (1) inform potential beneficiaries; and (2) form a positive attitude towards such activities;

- Set up a cross-sector database of organizations that work with drug addicts and the HIV-positive and of the services that they provide through the Dovira consultation centers or HIV/AIDS centers. Develop and introduce a mechanism for providing this information.

## *4. Provide easy access to social and medical services*

**Goals:**

- To ensure the right of every individual to receive medical assistance;

- To encourage drug addicts to practice safe behavior.

**Arguments:**

Opiate addictions are frequently accompanied by social problems. The most common are the lack of an official place of residence and wrong or missing documents. The majority of IDUs are unemployed. However, few of them apply to employment centers or receive social unemployment benefits, and most cannot apply for subsidies for residential services. Resolving these problems would significantly reduce the negative consequences of drug addic-

tion. However, Ukraine still lacks accessible social services for IDUs.

Although the country has a network of social facilities[23] that work with IDUs, their number and the quantity of services they provide fail to meet actual needs.

Another serious problem is accessible medical services for IDUs. Quite often, it is very difficult for an IDU or an HIV-positive individual to receive first aid or to have an operation. The reasons for this include stigmatization, negative attitudes and a lack of professionalism among come doctors. The other side of the coin is that IDUs are reluctant to turn for assistance for fear of disclosure and being forced to registered with the police.

Drug addiction services tend to be inaccessible and low quality. This is because funding for drug addiction centers and staffing and specialists at such centers have been cut back since independence. The government allocates only UAH 3 per day for the treatment of a single drug addict, although high quality treatment in a hospital costs UAH 300–400 per day.

One organizational issue is that the system of medical aid for IDUs is isolated, lacking an integrated approach and ties to other centers, especially tuberculosis and HIV centers. Currently addiction services are not components of a comprehensive strategy for the medical, social and economic rehabilitation of drug addicts. Given the seriousness of the HIV epidemic, isolating drug addiction and HIV services in this way has led to a crisis of medical support to IDUs.

On the other hand, access to opiate analgesics, especially for replacement therapy and palliative treatment of drug addiction, HIV/AIDS and TB is very much over-regulated. A complicated system of permits for the use of narcotic analgesics makes medical specialists reluctant to provide access to opiates at their medical facilities. In 2004, among 40 TB and HIV service facilities, only 13 had a license to use narcotic analgesics.

**Recommendations:**

- Introduce a full-ranged system of medical and social assistance for drug addicts that will encompass detoxification, rehabilitation, drug replacement therapy, and psychological and social support programs;
- Analyze the needs of drug addiction centers in each region of Ukraine and match the number of such facilities to actual needs;
- Inform IDUs about medical and social services and access to them, and about their rights;
- Set up a system for regulating the use of narcotic substances in treatment facilities that will make it possible to provide DRT and palliative care in the amounts necessary for treatment purposes;
- Introduce DRT through HIV/AIDS prevention centers and drug addiction centers;
- Ensure equal access to antiretroviral (ARV) treatment for IDUs living with HIV;

[23] Tertiary prevention among risk groups, in particular among IDUs, is provided by the network of Youth Services Centers that have been set up in all oblast centers. With the support of UNICEF, these state-run centers implement the "Preventing HIV/AIDS among Young IDUs" program. The responsibilities of the Dovira counseling points under the YCS are to: (1) provide the necessary knowledge and develop skills related to safe behavior in terms of HIV/AIDS among young IDUs; (2) train social workers, volunteers and leaders of target groups in harm reduction and peer-to-peer strategies; (3) provide young IDUs with individual means of protection, such as syringes, antiseptic towelettes and condoms; and (4) create a social environment that would display a compassionate and unbiased attitude towards IDUs.

- Introduce a complete set of measures to protect social and medical professionals working with IDUs from possible risks when they provide qualified assistance to IDUs and people living with HIV/AIDS;
- Expand insurance programs to include all medical and social services personnel who work with IDUs in case they contract HIV while providing assistance.

# Rehabilitation and re-integration

**Goal:**

- To help addicts give up drugs and return to normal life in their communities.

**Arguments:**

A necessary element of any harm reduction strategy is developing support systems to re-integrate and rehabilitate drug addicts. But rehabilitation programs that cost US $300–1,000 per month deprive many drug users of a chance to give up their addiction. Without developing a rehabilitation system, DRT may not have the desired impact. Yet, despite a Cabinet Resolution giving the green light, the system is at an embryonic stage and is mostly developing through the efforts of NGOs. The standard provision on the Tvoya Peremoha [Your Victory] rehabilitation center never became an effective tool for developing a network of drug rehabilitation centers.

International experience indicates that an individual must participate in a rehab program for up to two years and then the right kind of social services have to support this person from one to three more years. In Ukraine, the rehabilitation of addicts amounts to detoxification and a "psychological adjustment" program at a treatment facility that lasts from two weeks to two months at most. There are no institutions that might take care of addicts for the period when their ties with their families are destroyed and they may be de jure registered as residing somewhere but de facto have neither shelter, food, source of income, nor clothes. With no opportunity for professional support, relatives of drug addicts abandon them in the end. There are numerous instances of family violence towards drug addicts. In short, if this component is not included in government HIV/AIDS policy, an important link will be missing. Without this link, most IDUs will have no alternative except for methadone.

The rehabilitation system is poorly developed because of high costs combined with poor performance. An analysis of the financial requirements to set up a network of rehabilitation centers[24] shows that a single rehab center with a program aimed at complete withdrawal from narcotics can effectively treat an average of only 120–150 individuals per year. Moreover, the cost of this treatment will be at least UAH 2,500–3,000 per patient per month, including daily maintenance, salaries for qualified personnel, equipment, medications, and so on. According to actuarial calculations, 25–30% of patients become indifferent to drugs and do not return to abuse. With some 560,000 drug addicts in Ukraine, this means that at least 40,000–50,000 addicts need to be treated per year. To do so, Ukraine needs at least 300 rehabilitation centers with a total budget of about UAH 1.3bn.

Yet financing such a rehabilitation network is too costly for a healthcare system that was allocated only UAH 12bn in 2004. In short, the State Budget cannot fully cover needs at the state level. Moreover, there is not the necessary number of qualified specialists in Ukraine who can work at such facilities.

[24] Serhiy Dvoryak, A Nutritious Environment for the Virus or Why haven't we started to treat drug addiction with methadone, Replacement Therapy, UNAIDS.

**Recommendations:**

Because of high costs, the government currently cannot support rehabilitation programs that aim at complete withdrawal from narcotics at a level that will make them affordable for all who need them. This means it will have to focus on other tasks first:

- Set up an environment to encourage the development of non-government rehabilitation centers. This includes providing state support, ensuring the conditions for sustainability (social services enterprises) and partnering with private capital;
- Provide independent evaluations and oversight of the quality of rehabilitation services;
- Develop recommendations for the approach to developing rehab centers based on the experience of different types of rehab programs, especially 12-Step Programs, Narcotics Anonymous—the regulations on these centers, how they operation, staffing);
- Establish licensing for rehab programs to provide social services so that local government bodies can legitimately use State Budget resources to finance rehab programs;
- Set up a register of rehab centers with a description of their services and a system under which a doctor can prescribe treatment in such centers or at least provide information about them;
- Analyze possible forms of public, private and donor capital to fund the rehabilitation system, and to develop appropriate recommendations.
- Set up special shelters for drug addicts where they could find temporary protection and receive certain kinds of assistance;
- Develop educational programs and teaching materials for training rehabilitation specialists at post-graduate educational facilities;
- Organize workshops for decision-makers, social workers and various specialists in drug addiction and HIV/AIDS.

# Harmonizing HIV prevention and anti-drug policies

**Goals:**

- To reduce the number of cases when individuals who are addicted to drugs are unreasonably fined or sentenced for violations;
- To return the confidence of vulnerable population groups in government bodies, especially in the police, to improve access of such groups to prevention, treatment and support and to raise the effectiveness of these activities;
- To reduce high caseloads of courts and sentence enforcement agencies;
- To make the police more effective in combating established organized crime rings engaged in drug trafficking;
- To enforce adherence to the law in the activity of the police itself and to reduce violations of human rights, especially with vulnerable groups.

## *1. Changing the grounds for criminal prosecution*

**Arguments:**

IDUs suffering from addiction have a strong psychological and physiological need for drugs. Because of their sickness, they will continue to take narcotic or psychotropic substances on a regular basis, regardless of any threat of punishment. They need at least a minimum dose to avoid withdrawal symptoms, which cause terrible physical and psychological suffering.

The Criminal Code of Ukraine does not anticipate liability for drug abuse. Yet, official statistics indicate that about 70% of criminal cases on sales of illegal drug are filed under Art. 309, which refers to the storage of such drugs without the intent of selling. More than 90% of those accused under this Article are registered with drug addiction centers. In other words, these cases involve the storage of several grams or several cc's of a drug although these amount to no more than an individual dose. Cases involving the storage of especially large quantities of illegal drugs constitute a miniscule portion in the total number of criminal cases.

Prosecuting individuals who suffer from drug addiction for such a minor offence does little in terms of prevention but only worsens the condition of these addicts.

**Recommendations:**

- Amend the definition of the lower limits in the table of illicit drugs that lists "small," "large" and "especially large" amounts of narcotic or psychotropic substances or precursors approved by the 1 August 2002 Ministry of Health Decree №188. This applies specifically to individual doses for addicts, which should be determined by a competent drug commission.

## *2. Reducing penalties for activities involving drugs without the intent of selling*

**Arguments:**

Today, Ukraine still uses the long-outdated practice of holding a person criminally responsible under Sec. 1 of Art. 309 of the Criminal Code, pertaining to illegal production, purchase, possession or other activity involving a relatively small amount of drugs without the intent of selling, and according to Sec. 2 of the same 309, pertaining to "especially dangerous substances" without the intent of selling. Thus, under current legislation, simple possession of more than 5 gm of hemp or 10 gm of opium poppy stems ("straws") is sufficient grounds to land an individual in prison for up to three years. Yet the vast majority of those pursued under this Article are drug addicts who, according to the EU position, are victims of drug-related organized crime. As a rule, such individuals cannot adequately defend their rights.

In 2004, Ukrainian police uncovered 65,740 drug-related crimes, a 14.5% increase on the 57,435 offences registered in 2003. At the same time, the number of documented drug deals grew only 1.5%, from 17,502 to 17,768. In other words, the "growth" of these indicators came as a result of holding ordinary users criminally responsible for possessing drugs for personal use. Statistically, for every two drug addicts officially registered in Ukraine (124,800 individuals), one criminal case was launched in 2004. In some oblasts—Cherkasy, Kharkiv, L'viv, Poltava, Zakarpattia, and Zhytomyr—, the number of trafficking cases launched in 2004 was equivalent to or even higher than the number of registered addicts.

As for "priority drug-related crimes," in 2004, the relative weight of documented drug deals was 27%, vs 30.5% in 2003, while the share of "qualified drug-related

crimes"—drug deals, loitering in hangouts, inducing into drug addiction, drug theft, organizing drug laboratories, and laundering drug-related money—dropped from 37% to 33.5%.[25]

**Recommendations:**

- Draft and submit to the Verkhovna Rada a bill to amend Sec. 1 of Art. 309 of the Criminal Code by removing sentencing in the form of imprisonment and replacing it by sentencing in the form of community work. Also supplement Art. 309 to state that such alternative sentencing can be for a period longer than currently permitted under Sec. 1 of Art. 309 and to identify drug addicts as subject to this alternative form of punishment;

- Introduce alternative forms of punishment, such as free community work or other alternatives. Consider the possibility of instituting mandatory participation in the 12-Step program or other rehabilitation programs.

## *3. Improving the police performance evaluation system*

**Arguments:**

The participants concluded that police work to combat drug addiction is ineffective because it focuses too much on drug users and addicts alone. The vast majority of criminal cases to combat drugs involve holding addicts criminally responsible for possessing or producing drugs for personal use. This kind of policy does little to treat drug addiction: it only makes addicts fearful and distrustful of government institutions, marginalizes them even more, and puts them beyond the reach of preventive efforts. Of course, law enforcement agencies are of a different opinion: they see the fight against drug users as one of their priorities because addicts are the most likely to commit crimes. According to police officials, drug users are the main channel for dealing in drugs and spreading drug abuse, so they see a policy of prohibition and enforcement as the most appropriate in this area. Still, this approach fails to consider medical aspects of the problem.

Current regulations include a requirement that police agencies submit regular reports on a number of indicators. One of these indicators is the number of criminal cases launched with regard to drug trafficking. As a result, police officers are motivated to increase the number of new cases. Similarly, investigative agencies want to avoid fines for failing to produce the necessary numbers and sometimes will launch criminal investigations without proper grounds. Built on little hard evidence, such cases easily fall to pieces at first court session and the judge generally decides that no guilt has been proven and the defendants are released. Of course, this does not concern the investigative agency, since it has "fulfilled" its "task"—producing the necessary performance numbers.

The ineffectiveness of the current system of using performance indicators that lead to ordinary drug addicts being prosecuted is confirmed by the number of sting operations carried out, where the deliveries and sales of drugs are done by undercover cops.

For instance, in 2003, the police carried out more than 5,100 undercover purchases and 224 deliveries of drugs, about 10% of the total number of drug-related crimes. In Ukrainian anti-drug legislation and world practice, however, these two methods to combat drug trafficking are normally used to infiltrate drug traffickers, especially organized rings. As a result, the number of undercover operations in the US and EU countries is quite limited, not in the thousands. By contrast, Ukraine uses these oper-

[25] Statistics from the Department for Combating Drug Trafficking, Ministry of Internal Affairs.

ations to entrap mostly ordinary users who are in possession of or selling a few grams of a drug.

Significantly, the police do not keep appropriate statistics on the "quality" of criminal cases in this category.

**Recommendations:**

- Gradually change the police performance evaluation system. During the first phase, stop launching of criminal cases under Art. 309, possession or use without the intention to sell, from police performance indicators. During the second phase, develop and institute a performance evaluation system that is appropriate to combating serious drug trafficking.

- Shift the accent to exposing crimes related to trafficking—especially importing onto Ukrainian territory—, manufacturing and wholesale production, and the inducement of minors to use drugs, away from private use. In this way, the government will shift police efforts away from individuals who use drugs to the criminals and rings who deal in drugs and foster drug addiction in Ukrainian society.

## *4. Improving police regulation and practices*

**Arguments:**

Ukraine has committed itself to protecting the rights of the HIV-positive and drug addicts and to providing them with social support. But actual police practice is narrowly focused on detaining drug addicts, seizing narcotic substances, registering addicts, and determining whether to prosecute or merely fine them.

Currently, the community and charity organizations that implement harm reduction programs provide the lion's share of preventive measures and support for IDUs. It is hard to overestimate how important it is that the police not only not counteract needle exchange points and outreach activities but actively support such critical efforts. Another important element is effective cooperation between police officers and NGOs running harm reduction programs in jointly organizing public awareness and education campaigns on preventing HIV/AIDS and other infectious diseases in the IDU environment, personal prevention and health protection to keep medical and other staff from contracting HIV while fulfilling their professional duties.

**Recommendations:**

- Analyze legislation that regulates the proper action of police officers towards drug addicts, identify regulations that contradict other Ukrainian laws and international human rights and anti-HIV/AIDS commitments, in particular in terms of these types of activity. Amend these regulations or cancel them. Harmonize Interior Ministry regulations with EU standards, which is also important in the context of eventual integration into the EU;

- Based on specific decisions, develop amendments to relevant regulations or new regulations that of necessity reflect Ukraine's laws and international human rights commitments. These should include: a mechanism for the Ministry of Internal Affairs to participate in an appropriate fashion in developing and implementing state programs to combat the spread of drug addiction and HIV/AIDS; a mechanism that obliges the police to cooperate with executive agencies and civic organizations that work in this area at both the national and local levels; and the commitment of the police not to interfere in the activities of such organizations. For example, this can take the form of a principled agreement not to organize raids on drug addicts around needle exchange points

or to set up police ambushes around such stations, as has been the practice, and the commitment of police officers not to prosecute or detain outreach workers—which often happens in reality—but to support their important work;

- Forms of cooperation should include: exchanging information; organizing seminars and workshops for employees of police agencies by specialized NGOs; involving qualified medical personnel to cover issues related to the modes of transmitting HIV and other dangerous diseases in the IDU environment, the methods for individual prevention and for the protection of personnel from contracting HIV the line of duty; distributing specialized hand-outs on preventive methods among police personnel, and encouraging their further dissemination by police officers in preventive work with drug addicts. The staff of such police departments can refer IDUs to local NGOs that are carrying out harm reduction program, to be registered and receive counseling on preventive measures, and to obtain social and rehabilitation services.

# The war on stigmatization

**Goals:**

- To protect rights of IDUs and people living with HIV/AIDS (PLHA);

- To form a compassionate attitude towards those HIV-positive and IDUs in Ukrainian society.

**Arguments:**

To eliminate the discrimination against IDUs and PLHAs that exists in Ukraine today, a complex policy aimed at two key objectives should be instituted:

- Raising the level of informedness among the general population about drug addiction and HIV/AIDS and the way they are propagated;

- Establishing liability for violating the rights of drug addicts and HIV-positive individuals, especially if such violations are based on discrimination against them.

The enforcement of such liability and public reports about it should ensure that individuals guilty of discrimination against IDUs and the HIV-positive will be loath to violate their rights for fear of incurring negative consequences themselves. The result of this should be a lower level of discrimination against IDUs and PLHAs. Services providing appropriate legal aid can be set up under NGOs that implement harm reduction strategies, HIV-service organizations, and self-help organizations for drug addicts and PLHAs.

**Recommendations:**

- Carry out broad-based public awareness campaigns in the media to inform people about these issues and provide specialized courses in public schools and post-secondary institutions;

- Develop and implement a series of workshops for employees of police departments across all levels. The aim is to provide explanations and information that might help develop a more compassionate attitude towards IDUs, drug addicts and people living with HIV/AIDS;

- Hold workshops for police department staff to improve their level of informedness on harm reduction;

- Set up a network of services providing free legal aid to drug addicts and the HIV-positive, who belong to the most vulnerable social groups. The aim should be to provide IDUs and PLHAs

with effective assistance in protecting their rights and legal interests and to establish the liability of those guilty of violating the rights of such individuals. This legal aid operation should involve domestic security services from the Interior Ministry, Prosecutors' Offices, the Office of the Ombudsman, relevant Government and Verkhovna Rada committees, and the media.

# Political leadership

**Goal:**

- To increase the effectiveness of government policies by improving procedures for developing, adopting, implementing, and monitoring policies in this specific area.

**Arguments:**

All the recommended government policy components are interdependent in the current situation. That is, if the police stop prosecuting drug addicts, it will not have the desired overall impact, unless there is an active network of social facilities and centers where drug addicts can receive medical and social assistance. Conversely, all efforts to provide rehabilitation and re-integration for drug addicts will fail if IDUs are afraid to turn to state-run facilities for fear of arrest.

To effectively implement the new state policy, first of all, the process of making and implementing policy needs to be revised. This must be done fairly urgently, especially because this kind of work has to be cross-sector and program-based.

**Recommendations:**

- Improve informational and analytical support for the development and institution of national and regional HIV prevention programs through:
  - obligatory analysis of the progress of the situation, its roots, and the results of previous programs;
  - analysis of available resources and barriers and impact analysis;
  - analysis of possible alternatives for achieving stated goals and analysis of current concerns and consultations with stakeholders;
- Revise the system for coordinating activities and establish a single mechanism to fulfill three key tasks:
  - to agree state policy for preventing HIV/AIDS in the medical, social and education spheres, and for combating the spread of drugs;
  - to ensure effective public participation in formulating policy in this area;
  - to coordinate priorities, programs and the amounts of donor assistance used in this area.
- Provide the regulatory, methodological and logistical base to run a unified coordination mechanism;
- Set up a single coordination agency in the regions that will manage funds from all sources of financing: the State and local budgets, charitable organizations, and donors. This agency would take in, distribute and oversee that money is spent for designated program purposes. It would also be responsible for making sure that the goals, numbers and indicators set in a given program are reached. The performance of this agency should be reviewed by both government bodies and independent auditors appointed by the donors. The agency should include appropriate representatives of government bodies and

services, as well as NGOs with regional experience;

- Adopt a State Concept for an Anti-Drug Policy that is consistent with HIV/AIDS prevention policy and includes a harm reduction strategy:
  - organize debates and consultations with stakeholders on the concepts of anti-drug and HIV prevention policies;
  - make current government programs consistent with the approved concepts of anti-drug and HIV prevention policies.
- Improve the quality of statistical data by updating the methods for tracking drug addicts and the HIV-positive and for carrying out research, specifically by applying the monitoring and evaluation methods proposed by the UN;
- Approve the list of statistical indicators necessary to monitor the application of preventive measures and the provision of assistance and treatment to the HIV-positive and PLHAs, and relevant models and procedures for monitoring;
- Institute a full-scale program-oriented method for Budget financing of government programs in this area.

# Appendix 1. The results of public debates

## The first round, January–February 2005

Over 18 January–9 February 2005, the International Centre for Policy Studies (ICPS), jointly with the All-Ukrainian Harm Reduction Association (AUHRA), held a series of public debates called "A New Harm Reduction Policy" under the "Policy Campaign for Harm Reduction" project in Kyiv and 10 other Ukrainian cities. The goal of these debates was to develop a common vision of harm reduction policy and to identify the positions of different stakeholders regarding problems and their solutions. Participants also considered at a Green Paper prepared by AUHRA and ICPS specialists with the assistance of outside experts from the project. The events were organized by regional organizations that are members of AUHRA.

The schedule of the first round of debates:

18 January—Luhansk, Poltava, 20 January—Dnipropetrovsk, Znamianka, 25 January—Odesa, 27 January—Chernivtsi, Mykolayiv, 28 January—Simferopol, 1 February—L'viv, Uzhorod, 9 February—Kyiv,

All debates followed the same format: the presentation of the Green Paper, presentations by experts, and group work on issues proposed by the organizers. Depending on the number of stakeholders participating, groups were formed using different principles in different cities. Where there were more than three representatives of the police and social agencies such as the Ministry of Family and Youth, the Ministry of Labor and Social Policy, the State Center for Youth Social Services, they worked in separate groups. Otherwise, they were mixed in with other officials in a group called "government representatives." The group called "doctors" was mostly staff at AIDS centers and drug addiction centers. The "community organizations" group included representatives of NGOs and of the target group: current or former drug addicts, their relatives and PLHAs. Each event was attended by 25 to 35 individuals.

The first round of debates identified the positions of the main stakeholders:

- Government;
- Doctors;
- Police officers;
- Social workers;
- Community organizations.

Participants in each group were asked to consider six key questions:

- What should be the goals and priorities of government HIV prevention policy? What indicators can confirm the success of policy in this area?
- Why is HIV prevention among drug users not working?
- What are the pros and cons of continuing with the current policy?
- What are the pros and cons of increasing prosecution for drug use?
- What are the pros and cons of instituting a harm reduction policy?
- What are other HIV prevention policy options?

# Common ground

According to most participants, the key priorities of a policy towards IDUs are to reduce the spread of HIV and other diseases and to change the government approach towards IDUs from prosecution to prevention, treatment and rehabilitation. The most frequently mentioned goals were: to cover 60% of IDUs through harm reduction programs, to expand harm reduction programs to small towns and villages, to ensure a high-quality and affordable rehabilitation system for drug addicts, and to improve the quality of public awareness campaigns. Much was said about the importance of improving primary measures to prevent drug addiction in Ukrainian society, especially among young people, of coordinating policies and of providing appropriate financing.

In the opinion of participants, the success of a given policy might be confirmed by five key indicators: stabilized/reduced rate of spread of HIV, falling numbers of IDUs, the numbers of IDUs reached by harm reduction services, the quality and affordability of such services, and the stability and funding volumes provided for harm reduction programs.

Participants singled out two main reasons for the ineffectiveness of HIV prevention among IDUs: inadequate funding and lack of coordination of efforts among various agencies and NGOs. As a result, the amount and quality of preventive measures are not enough to have any real impact on the situation. The majority of participants mentioned the poor quality of primary preventive measures against drug addiction because of the low quality of public awareness campaigns and educational programs on this subject.

Representatives of government and NGOs singled out another problem: the lack of trust in government agencies and in medical and social facilities. As a result, the target group for harm reduction programs does not use the existing services and programs, which reduces the effectiveness of preventive measures that much more. The majority of groups also mentioned a related problem that needs to be tackled—stigmatization.

Stakeholders repeatedly mentioned the low level of informedness about this issue among the general public and the role of the community in dealing with it. This is among the most important gaps in the current policy.

Participants mentioned other drawbacks in the existing policy: its declarative character and the lack of funding. Specifically, participants spoke about the lack of proper state rehabilitation programs for drug addicts and replacement therapy programs, albeit these were announced by the government. Without such programs, it will be impossible to have any impact on drug addiction and the spread of HIV. Participants gave mostly negative assessments to the approach to combating drug trafficking currently taken by the police, who mostly hunt drug addicts, instead of drug dealers. Such an approach, noted participants, not only failed to contribute to the fight against drug trafficking, but actually undermined medical efforts to prevent HIV.

Positive aspects of the current policy include the government's recognition of harm reduction programs, however nominally. Participants also mentioned evidence of cooperation between NGOs and government bodies and the beginnings of proper understanding of the problem among government officials.

The prospect of increased police pressure on IDUs had a very negative reception from participants. Although such an approach can indeed isolate IDUs from society somewhat and serve as an incentive to quit drugs for some users, it will nevertheless push the problem even further into the shadows, strengthen criminal activity,

and make the prevention of diseases in this extremely vulnerable group virtually impossible.

The main advantages of expanding harm reduction programs, according to participants, were the possibility of having a real impact on the spread of HIV and related diseases, improving contact with the target group, the possibility of returning IDUs to normal community life and of motivating them to give up drugs. In the opinion of participants, the risks of implementing harm reduction programs include: negative reaction among the general public, delayed introduction given the current epidemic situation, the lack of specialists, and insufficient and unreliable funding.

In addition to harm reduction programs, participants said that a great deal more attention needed to be paid to primary preventive measures for both HIV and drug addiction in a number of ways: targeted public awareness campaigns for various groups of the population, better preventive activities in schools, and the promotion of healthy lifestyles.

# Special accents

The groups of doctors said one problem is that drug replacement therapy (DRT) is unregulated. Although nearly all the doctors from drug therapy services who participated in the debates were prepared to introduce DRT, at the moment there are only a number of pilot projects in this area because the police do not understand the purpose of methadone treatment. At the same time, the majority of drug rehabilitation centers have long been using other narcotics in detox programs and some of them in local pilot DRT programs.

Groups with a mix of doctors and police officers mentioned the risk of trafficking of replacement drugs while DRT was being introduced, opportunities for abuse and corruption, and the possibility that replacement therapy might foster new cases of drug addiction.

Groups of NGOs that are implementing harm reduction programs with the financial support of international donors emphasized the need to gain government support for NGO efforts in HIV prevention, specifically by allowing NGOs to participate in government tenders for providing services in this area. They see stable and reliable state funding of harm reduction efforts implemented by both government and non-government organizations and cooperation between NGOs and government institutions as necessary to stop the HIV epidemic and reduce the extent of drug addiction in Ukrainian society.

Doctors, social workers and NGOs noted that one factor in Ukraine that complicated their work was very little access to drug addicts. Another factor is that they have to get the approval of local police officials in order to be able to carry out preventive measures and treat drug addiction and HIV/AIDS at the local level.

It was clear in the course of the discussions that there was a definite lack of understanding among some participants of the objectives of DRT and the meaning of the term "resocialization." Some government officials seemed to believe that drug replacement therapy programs and social rehabilitation of IDUs were incompatible, although harm reduction work in other countries has shown shows that DRT is one of the first steps to start the process of integrating drug addicts back into their communities. Other officials frankly admitted to knowing nothing about the objectives and approaches used in harm reduction. Doctors noted that, while harm reduction was an important element in fighting the HIV/AIDS epidemic, it could not resolve the overall problem.

## Differences

The main gap in positions was between police representatives and the rest of participants in these debate. Police officials think that making drug users criminally responsible is not overly repressive, as it is aimed mostly against drug dealers. As far as they are concerned, all drug users are also potential criminals and have to be isolated from the rest of society, so prohibition and control are in the public interest.

The rest of participants pointed out that police actions are aimed mainly against drug users, not drug dealers: court statistics show that the overwhelming majority of criminal cases are launched against individual users for storing or making small amounts of narcotic substances for their personal use. The negative consequences of this are reduced effectiveness of preventive work, lack of trust in harm reduction programs among drug addicts, and the waste of law enforcement resources in fighting users rather than professional dealers.

## The second round: April 2005

Over 18–28 April 2005, ICPS and AUHRA held the second series of public debates on harm reduction policy. The goal of this round was to discuss proposed steps to introduce such a policy, to identify the positions of stakeholders as to priority activities and risks, barriers and resources. At the hearings, participants also considered a draft White Paper in all 11 Ukrainian cities.

The schedule of the second round of public debates:

18 April—Kyiv, 20 April—Poltava, Znamianka, 22 April—Dnipropetrovsk, Luhansk, 25 April—Odesa, 26 April—Chernivtsi, 27 April—L'viv, Mykolayiv, 28 April—Simferopol, Uzhhorod.

This debate followed the same format as the first round. Participants were asked to consider four key questions:

1. Are the steps proposed by the White Paper enough to introduce a harm reduction strategy? What steps would you add, remove or change?

2. What should be done first of all and who should do it? Single out three to five steps that are, in your opinion, the top priority.

3. What resources are necessary to implement these steps?

4. What barriers exist to doing this and how can they be eliminated?

Among top priority steps, most groups across all cities most frequently named creating the necessary conditions for a policy to be effectively instituted. These institutional steps include: proper coordination of efforts, adequate funding for harm reduction programs, training for specialists, and oversight of program implementation. Community organizations also emphasized the need to establish the status of harm reduction programs as a social service and involve NGOs in implementing state programs.

At the same time, priority was given to public awareness campaigns to increase informedness among the general population, promote healthy lifestyles, and encourage a compassionate attitude towards drug addicts and PLHAs.

According to participants, another important step was to provide access to treatment for drug addicts. In particular, participants said that the development of rehab centers, social services providers, and access to

drug replacement therapy for those who need it.

Changing the nature of police work with drug users was also mentioned as a priority. Specifically, participants spoke about the need to lower the level of criminal prosecution of drug addicts, to shift accent from arresting drug addicts to going after professional drug dealers.

According to participants, having enough financial and human resources are the key factor to implement harm reduction strategy. The genuine lack of such resources and unregulated status of harm reduction programs are the primary barriers to implementing this strategy. Finally, there is a serious lack of support from the both government workers and the general public.

The major barrier to introducing DRT is lack of support form the public and government officials. The introduction of drug replacement therapy for drug addicts was the main discussion issue. These discussions showed that, first of all, there is no shared understanding of policy goals towards drug addicts. Opponents of DRT mostly believe that drug addicts cannot live in a community, that they should be isolated from society and forced to undergo treatment or be locked in jail. But the majority of participants think that DRT needs to be instituted as it can help deal with both the problem of the HIV epidemic and the problem of crime associated with illicit drug use.

# Appendix 2. International experience in preventing HIV among IDUs

To be effective, government policy in preventing HIV/AIDS among IDUs must meet three conditions:

- be based on up-to-date harm reduction approaches and experience;
- like any other policy, be clearly formulated, define clear goals and a clear implementation plan, and provide a mechanism for coordinating efforts among all executing agencies. It also has to be supported by financial and human resources, to be based on an appropriate infrastructure, and to include instruments for monitoring, evaluating and adjusting goals and implementation instruments;
- be based on reliable data on the current situation, to reflect the actual situation in the country, especially as to drug abuse and the spread of HIV, popular attitudes towards the issue, traditions and approaches to solutions, and existing resources and restrictions.

## International efforts

The main international documents on preventing HIV are the UN International Guidelines on HIV/AIDS and Human Rights[26] and the UN Declaration of Commitment on HIV/AIDS, which are based on long experience with combating the HIV epidemic around the world. These documents recommend states to follow the principle of upholding human rights in fighting the epidemic, as the most vulnerable pockets of any population tend to be marginalized groups such as IDUs, whose rights are most frequently violated. The idea of these recommendations is that upholding human rights, such as the right to non-discrimination, to work, and to accessible medical and social services significantly increases the effectiveness of prevention work.

The fight against drugs and the prevention and reduction of the negative impact of drug addiction are regulated by a number of other international documents as well. The International Convention on Narcotic Drugs of 1961[27] recognizes the social and economic threat to humanity of drug addiction and emphasizes the need to pay special attention to providing drug addicts with medications, support and appropriate treatment.

The UN Declaration on the Guiding Principles of Drug Demand Reduction was adopted in 1998 to focus specifically on the problem of drug addiction. The Declaration emphasizes that programs to reduce demand for illicit drugs should cover all prevention areas: from discouraging the initial use of drugs to reducing the negative social and personal consequences of drug use for a person and the society as a whole.[28]

[26] International Guidelines on HIV/AIDS and Human Rights, Geneva/New York, 1998.

[27] The UN Single Convention on Narcotic Drugs of 1961, Art. 38.

[28] The UN Declaration on the Guiding Principles of Drug Demand Reduction of 1998, Art. 10.

To assist governments in developing and instituting policies for preventing HIV among IDUs, international organizations have developed such documents as the UN Position Paper on Preventing the Transmission of HIV Among Drug Addicts and a program document called the Principles of HIV Prevention in Drug-Using Populations adopted by the World Health Organization Regional Office for Europe. These documents were developed in response to the spread of the HIV/AIDS epidemic among IDUs and contain consistent and detailed strategic approaches to counteracting this epidemic among drug users.

# Key harm reduction policy components

Policy components that, according to WHO recommendations, have a good potential to reduce individual and social harm from drug abuse are:

## *1. Providing IDUs with clean injecting tools and disinfecting substances*

This means access to sterile needles and syringes and disinfecting materials with the help of free needle exchange programs or non-prescription sales at drug stores; access to programs that work actively among drug addicts and other services and institutions; unlimited access to needles, syringes and disinfecting materials for IDUs without any strings attached, such as providing personal identification information. Many studies confirm that such programs are effective at destroying the chain of virus transmission. Such services also serve as points where drug users can be given information and get involved in rehabilitation programs. Needle exchange programs also work to prevent other undesirable consequences of drug abuse, by collecting used needles and syringes, and storing and destroying them safely.

## *2. Offering IDUs the choice to undertake drug replacement therapy*

This is a way to provide medically supervised treatment of opiate addiction by using replacement drugs such as methadone. The main goal of DRT is to reduce illicit drug use, to lower the level of risky behavior, such as using dirty syringes and needles, and, as a result, to reduce the risk of contracting HIV. WHO recommends including methadone or other DRT programs in the general national anti-drug strategy as one of the therapy options, especially in counties where heroin or other opiates are widely used and providing access to methadone programs for people who use opiates, especially intravenously and show risky behavior in terms of HIV transmission. WHO also recommends introducing national rules and recommendations for involving IDUs in DRT programs and organizing such programs in combination with educational programs on HIV to reduce risky behavior in general, providing psychological and social support as a component of DRT programs to improve both the physical and emotional health of patients and thus to improve broader social indicators, such as reducing criminal behavior and increasing employment.

## *3. Ensuring easy access to social and healthcare services*

Offering drug addicts access to social and medical services helps them adapt and stick to HIV-safe behavior, which can lead to significant preventive results. An important point is to provide IDUs living with HIV access to antiretroviral treatment. This component includes access in terms of location and accessibility by public transport; First Aid and crisis intervention services with

minimum restrictions as to hours and days; services that ensure confidentiality and data protection; services for all possible users, regardless of age, sex, race, ethnic origin, culture, ideology, or religious beliefs; services that are not restricted according to the state of mental or physical health of the person, even if they are HIV-positive; services that can be used regardless of financial or employment status; services that don't require a specific legal status of the patient; and services that offer counseling and assistance for preventing HIV among IDUs.

### *4. Working actively among IDUs*

This includes ongoing awareness campaigns among drug addicts to help them change their behavior or avoid dangerous behavior while using drugs. Materials should include information on how dangerous drug use and sharing syringes are, and practical advice on how to behave more safely. Also, contact should be established with hidden populations of drug users and counseling on HIV-risky behavior provided, including information about safer sex and safer methods of drug use. Sterile needles, syringes, disinfecting substances, and condoms should be distributed among high-risk groups, and used injecting instruments and instruments for producing drugs should be collected. Special services are needed for drug addicts in terms of problems with accommodations, legal issues, finances, family issues, HIV, HIV testing, and so on. Some programs should be aimed at special population groups, such as sex workers who use drugs. Meanwhile, close contacts should be established with appropriate community groups and services so that they can help with the integration of drug addicts into the local community.

### *5. Public awareness campaigns and education*

This includes education for the general population to reduce the stigmatization of high-risk groups; identifying high-risk groups; information-sharing work among IDUs and their immediate environment to prevent risky behavior; training personnel from medical and social services facilities with an emphasis on primary medical assistance.

## Conditions for effective harm reduction work

For harm reduction policy to work effectively, the human rights of IDUs need to be respected and active steps taken to reduce the marginalization and prosecution of HIV-vulnerable groups. The criminal prosecution and stigmatization of drug addicts by society only increases their marginalization, making them unavailable to preventive efforts and rendering harm reduction policy ineffective.

Protecting IDUs from discrimination and establishing an open and friendly environment, respectful and understanding attitudes, good access to treatment and support make it more reasonable to expect that IDUs will use the services offered by harm reduction programs and will have incentive to change their behavior to be less risky. The first step to establishing these conditions has to be that harm reduction policy reduces or stops criminal prosecution for personal drug use and institutes measures to reduce the stigmatization of IDUs.

## *Case study: Harm reduction in Poland*

*Talk of harm reduction strategies began in Poland back in 1986–7. However, the first needle exchange programs financed by the Ministry of Health and Social Welfare were launched in 1988, after HIV began to spread among IDUs. The program was carried out through counseling stations run by MONAR, an NGO. The first outreach programs were launched in 1993. The first needle and needle exchange program that was not limited to distribution, was initiated by MONAR in Krakow in 1995. Nowadays, these programs are financed by the National Bureau for the Prevention of Drugs Addiction or international donors. They are now available in all major centers where there are drug addicts in Poland. In addition to injecting equipment, these programs distribute condoms and information about the dangers of injecting drugs and safer sex. They also do public awareness campaigns to spur drug addicts to undergo drug addiction treatment.*

*Methadone replacement treatment was launched in Warsaw at the Institute of Psychiatry and Neurology in 1992 as a pilot program for 40 patients. Over the next years, similar programs were launched in Krakow, Lublin, Poznan, and other cities, once the Sejm, Poland's legislature, adopted a Law on counteracting drug addiction in 1997.*

*By late 2003, 850 people were participating in methadone replacement programs. Currently, new programs are being prepared to launch in different parts of Poland.*[29]

*Because these measures were taken in time, the number of people living with HIV in Poland, according to unofficial estimates, is only about 20,000, whereas similar estimates for Ukraine are as high as 400,000.*

[29] Source: National AIDS Center of Poland, *http://www.aids.gov.pl/*.

# Appendix 3. The European context

According to the European Commission's Coordinated and Integrated Approach To Combat HIV/AIDS,[30] the Council of the EU's recommendations on the prevention and reduction of health-related harm associated with drug dependence,[31] and the UN and WHO, harm reduction programs are an effective tool to combat drugs and prevent infectious diseases. Clearly, such programs should be expanded.

European Union countries view harm reduction as a part of anti-drug policy[32] aimed at reducing demand for drugs and the negative consequences of drug addiction for the society as a whole. Although there is no evidence that the expansion of illicit drug use declined, full-scale implementation of harm reduction measures in European Union states has helped reduce health risks and the rate of drug-related deaths.[33] EU policy presents harm reduction as a set of steps that includes:[34]

- informing and counseling to drug users to promote risk reduction and to facilitate access to appropriate services;
- involving local communities and families in the prevention and reduction of health risks associated with drug dependence;
- emphasizing outreach work methodologies to involve groups that are beyond the reach of existing program;
- providing replacement therapy in combination with psychological and social support, with the understanding that a wide variety of different treatment options should be provided to drug abusers;
- providing imprisoned drug addicts with services similar to those offered outside the prison system;
- distributing and exchanging syringes, condoms, and disinfecting materials, including setting up programs and needle exchange points;
- arranging emergency services to handle overdoses;
- integrating health and social services;
- training for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

[30] Coordinated and Integrated Approach To Combat HIV/AIDS Within The European Union and in its Neighborhood, European Commission, Brussels, 8.9.2004 C (2004) 3414.

[31] Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence, OJ L 165, 03/07/2003, p. 31.

[32] EU Drugs Strategy 2000–2004, EU Drugs Strategy 2005–2012.

[33] EU Drugs Strategy 2005–2012, Brussels, 22 November 2004, p. 4.

[34] Ibid, Council Recommendation.