KYIV, ODESSA, AND DNIPROPETROVSK, UKRAINE; MOSCOW AND ST. PETERSBURG, RUSSIA—On Easter Sunday, Sergey Nenov, along with hordes of other people in Odessa, took a basket filled with sprinkle-covered frosted cake, cookies, and other offerings to a gold-domed Orthodox church and lit candles in prayer. But when Nenov came to a gilded painting of the Madonna and Child, he separated himself from the crowd by pressing his lips to glass that protected the Christian icon. Nenov had reason to be grateful this year. He is one of 4300 opiate addicts in the country to receive methadone, a substitution treatment that has freed him from his dependency, allowing him to stop having run-ins with the law and, at long last, begin to tackle his dual infections with HIV and tuberculosis (TB).

Nenov, who lives at a TB hospital in the city that dispenses his daily dose of methadol—a pill form of methadone—started injecting chernaya, an opiate made from liquid poppy straw (see p. 161), in 1988. He is astonished that he survived long enough to see the substitute opiate come to Ukraine; importing it was illegal until December 2007. “Before, we would watch TV reports about these Dutch substitution treatment programs and say, ‘It will never happen in our country,’ ” says Nenov.

Opiate substitutes are one component of harm reduction, an international movement that promotes treatment rather than arrest and incarceration of injecting drug users (IDUs). The harm-reduction “package,” which aims to protect IDUs from infections and other health risks, also includes clean needles, counseling, HIV testing, and education. In a 2005 position paper, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization, and the United Nations Office on Drugs and Crime explicitly backed opiate substitutes to prevent HIV’s spread. An expert committee convened by the U.S. Institute of Medicine in 2007 cited “strong evidence” that methadone and another popular substitute, buprenorphine—now used by only 800 others in Ukraine—reduced illicit drug use and HIV-risk behaviors such as sharing injecting equipment. It recommended that they “be made widely available, where feasible.”

Although Ukraine, Russia, and other countries in the former Soviet Union have IDU-driven HIV/AIDS epidemics that are increasingly spreading into the broader population through sex, harm reduction remains spotty throughout the region. Even the Ukrainian government has not fully embraced harm reduction, which is largely delivered by nongovernmental organizations (NGOs) that receive support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ukraine’s 2010 HIV/AIDS progress report to the United Nations, endorsed by the minister of health, acknowledges the shortcomings: “The scope, scale, quality and intensity of HIV prevention activities among the most vulnerable population groups remain insufficient to stop HIV spreading in these groups and limit the potential spread of HIV among the general population.”

Russian roulette

In comparison, the Russian Federation seems outright hostile toward harm reduction, to the outrage of researchers, public-health specialists, and activists. The banning of opiate-substitution treatment (OST) has evoked the sharpest criticism. “OST does not exist in Russia, and it’s the place where it’s most needed,” says UNAIDS’s Denis Broun, the Moscow-based regional director for Europe and Central Asia. The government does offer treatment at “narco-clinic” clinics, but one recent study found a 90% relapse within a year among nearly 1000 users who sought help.

Unlike in Ukraine, the Russian government pays no heed to civil society’s input, charges Anya Sarang, who specializes in drug policy and runs the Andrey Rylkov Foundation for Health and Social Justice in Moscow. “The government on every level—federal, city, oblast—they’re never interested in listening to the community,” Sarang says. “All the decisions here are totally
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political and unsupported by evidence. They don’t make any effort to find out what’s going on in the world.”

Adding to the lack of knowledge about the benefits of harm reduction, there’s a “huge stigma” toward drug users, notes psychologist Alla Shaboltas, who studies IDUs at the Biomedical Center in St. Petersburg. “They’ve never been considered normal people who deserve treatment,” says Shaboltas. “They’re considered criminals who should die.”

Several Russian public-health officials and politicians did not reply to Science’s request for interviews over several months, but Alexey Mazus, head of the city-sponsored Moscow Centre for HIV/AIDS Prevention and Treatment, articulates the government position—which he shares—and makes it clear that he strongly objects to other countries criticizing his country’s stance toward harm reduction. “It’s not their business what’s going on in the Russian Federation,” says Mazus.

In his view, the evidence that OST and other harm-reduction interventions worked in some countries has no bearing on Russia. “Take into consideration whether people are the same in terms of culture and psychology,” Mazus says, stressing that injection drugs like heroin are new to his conservative country. Giving a heroin user methadone, he says, is “like a doctor who tries to treat an alcoholic and gives the patient alcohol.”

Similarly, he thinks that needle exchange—which is not allowed in Moscow—would “energize drug using. What is more, it will show that our government tolerates using drugs—and they’re firmly against it, just like the whole society.”

Russia has allowed a consortium of NGOs known as GLOBUS to run harm-reduction projects, which include needle exchange in many locales, with money from the Global Fund, but the government recently reneged on a promise to bankroll those efforts itself (see p. 168). “The Russian government says it’s doing this because of lack of effectiveness,” says Charles Vitek, head of the Global AIDS Program in Moscow for the U.S. Centers for Disease Control and Prevention (CDC). “It’s hard to say what type of evidence would be sufficient to change the government’s stance.”

Alexey Bobrik of the Open Health Institute in Moscow, who heads GLOBUS, says harm reduction, and in particular OST, is essentially an ideological issue. “In Russian culture, science almost doesn’t matter,” says Bobrik. “It’s similar to the Soviet Union and questioning the superiority of socialism. Regardless of whether you could support your argument with data, you’d be labeled as insane, an unnecessary person. The same with OST now.” But if someone in a high enough position decides to back OST, the opinions of drug-control specialists and HIV experts won’t matter. “If Putin says we should try OST,” says Bobrik, “it will be done.”

Ukraine’s gains and pains

In the industrial city of Dnipropetrovsk, the City Clinical Hospital No. 21, built in 1908, looks its age. The sprawling institution sits on a steep hill and houses clinics in several low-slung buildings with corrugated tin roofs and heavy steel doors that are shielded by ornate awnings, some buckled with rust. Windows are boarded in places, and gates tilt on their hinges. It seems an unlikely place for one of the country’s most modern and ambitious programs for HIV-infected IDUs, offering them OST, TB treatment, and antiretroviral drugs (ARVs) all at the same facility.

Each morning, the 48 IDUs in the program, which started in July 2008, gather at the OST clinic for their daily dose of methadol. They hang out on the front steps and smoke cigarettes while they wait their turn, and though some grumble about the drug killing their sex drive and the hassle of making daily visits to the clinic, there’s widespread agreement that the methadol is helping them lead what several refer to as “normal” lives. “The program is great,” says Vlad, 45, on a drizzly and drab April morning. “I don’t have to steal or hide from the police. Everything is cool.”

Vlad and his wife, Natasha, 49, walk into the clinic and enter a small, tidy room at the front. After they sign in and a nurse checks their names off her own list, Alonya Lesnichaya, the doctor who runs the program, places their individual doses of methadol pills into plastic cups and pestles them into tiny chunks. One after the other, they toss the medicine into their mouths, chase it down with a sip of soda, and then open wide to show Lesnichaya that they have swallowed everything. The elaborate ritual has less to do with making sure that they received the methadol than the concern that they might hide it in their gums and later spit it out and sell it on the black market.

The potential “diversion” of substitute opiates is one of several reasons that...
Lesnichaya says many doctors on the staff did not initially support the idea of opening the OST clinic here, which is supported by the Clinton Health Access Initiative and a Global Fund grant monitored by the International HIV/AIDS Alliance in Ukraine. “Mainly, they were afraid it would turn out to be a drug-dealing place,” says Liudmila Timoffeva, the director of the hospital. Lesnichaya adds that they also had to confront unease from other patients. “We didn’t want to frighten people, and we worried that our society was not ready.” But “we made it work,” she adds, establishing “a very close, integrated link between the different specialists.”

The clinic currently helps just a tiny number of people in Dnipropetrovsk, one of the cities hardest hit by HIV in the country, and there is only one other OST program operating here. And progressive as this program may be, it accepts only HIV-infected IDUs. Lesnischaya says they were put first in line because when they’re using or preoccupied with trying to score and avoid withdrawal, they have great difficulty remembering to take their ARVs on time or even where they put them. But that shuts out IDUs like Sasha, who badly wants into the program.

A 35-year-old carpenter who lives with his mother in a nine-story tenement on the outskirts of the city, Sasha began using when he was 17. Now estranged from his wife and 1-year-old child, he works with an NGO, Way to Life, that also provides counselors to the program at City Clinical Hospital No. 21. Representatives from Way to Life come to visit him to drop off bags filled with clean needles, which he will then distribute to other users. He becomes sullen and angry when the Way to Life outreach workers explain that the OST program cannot take him because he is not infected with HIV.

Sasha carries the bags of needles into his bedroom and places them on a vanity next to a copy of the Bible. On the mirror, he has taped up a little prayer that reads, in part, “My God, I don’t want to be dependent.” He takes a long look at the floor. “I pray, and it doesn’t help,” he says.

**Future prescriptions**
The IDUs in Ukraine and their advocates have begun pushing to expand OST—which the Global Fund estimates now reaches only about 10% of the IDUs in need—and improve it. “Substitution treatment has a huge number of problems,” says Iryna Borushek, a leader of the All-Ukrainian Network of People Living with HIV who sits on the country’s coordinating mechanism that prepares and oversees Global Fund grants for the country. Borushek, a buprenorphine recipient herself, says at the top of the agenda is doing away with the requirement to make daily trips to an OST clinic. “People are chained to the site,” she says. In all of Ukraine, only six people have prescriptions for OST that allow them to take the drugs without being observed.

Psychologist Olga Belyaeva, who runs an NGO in Dnipropetrovsk that helps IDUs, is one of the six Ukrainians who has a buprenorphine prescription. She and other community activists are lobbying for national regulations that will establish standards of care for substitution treatment, federal funding for it, and more flexible use of different substitution drugs. “We need political will from the new government to change the drug policy more to public health,” says Belyaeva.

Some fear, however, that Ukraine’s new president, Viktor Yanukovych—who was elected in February and has closer ties to Moscow than his predecessor did—will not be receptive to expanding OST. “The legalization of methadone in Ukraine was a hard-fought battle, and like many things, it may be vulnerable because of political changes there,” says CDC’s Vitek, who is relocating to Kyiv in August. “If groups could seize on any evidence of a lack of effectiveness, methadone overdose deaths, or diversion, there’s a continued political risk.”

For Belyaeva and other activists, any rollback of Ukraine’s hard-won policies toward those of Russia would be disastrous. “When I was in Moscow in November,” says Belyaeva, “I came back home and was kissing the ground.”

—JON COHEN