

Harm Reduction News

Newsletter Focus

SUBSTITUTION THERAPY: OVERCOMING IGNORANCE

by Anna Moshkova

Methadone maintenance treatment (MMT) must be the most researched yet still most controversial treatment available for any medical problem. For reasons that have little to do with patients' health or their right to treatment, replacement therapy is painfully difficult to bring into everyday practice.

Opposition is based on personal beliefs, gossip, moralization, and even outdated and manipulated scientific data. Many doctors view MMT with ambivalence. A lack of financial incentives for health administrators and medical

Decades of experience have shown that methadone maintenance treatment prevents HIV and stabilizes opiate-dependent people. But policymakers and health care providers ignore the facts.

providers creates an enormous barrier for MMT despite the Hippocratic oath to use every available modality of treatment and care on patients' behalf. The transformation of people on maintenance therapy is often so dramatic that some health professionals feel threatened and sidelined by this simple-to-establish, effective treatment. Law enforcement officials affiliated with organized crime see state regulated MMT as a threat to their source of illegal income.

Availability of MMT is a political issue in countries of Central and Eastern Europe and the former Soviet Union (CEE/fSU) in which treatment is legal but not yet established. Most governments in the region have chosen to adopt and implement repressive laws and deny drug users

basic treatment and care in spite of the negative impact on the HIV epidemic. It is often claimed that HIV infected drug users should not be treated because they are not compliant, and scarce resources should not be wasted on society's "outcasts."

Decades of experience in Western Europe and the United States have shown that MMT prevents HIV and stabilizes opiate-dependent people. But policymakers and health care providers ignore the facts. Tragically, the most common response to the dual epidemics of drug use and HIV in CEE/fSU is incarceration of drug users instead of treatment and prevention. Rates of HIV infection are dramatically increasing in overcrowded prisons where harm reduction services such as needle exchange, condom distribution, and MMT are rarely available.

In countries where substitution treatment is available, such as Bulgaria, Macedonia, Romania, Slovakia, and the Baltics, the expansion of methadone treatment has been a slow process. A lack of resources and political will—not weak demand from clients—are preventing expansion. Many countries report that drug users are put on MMT waiting lists for months and even years.

The articles in this issue of *Harm Reduction News* consider the various stages of development of substitution treatment in CEE/fSU. The impassioned words of drug users, their parents, and health workers directly involved with MMT reveal that opposition to substitution treatment by politicians and the public appears to be a heartless and, frankly, unthinking response to a proven course of treatment that could easily break the cycle of destruction and misery.

Anna Moshkova is a program officer at IHRD.



Drug Users Need HIV Treatment Too... page 7

INSIDE

One Mother's Advocacy	3
Treating Opiate Dependence as a <i>Real Disease</i>	4
Region: Accepting Maintenance Treatment	6
Drug Users Need HIV Treatment Too	7
The Success of Methadone in Kyrgyzstan	8
Methadone Myths and Facts	10
Public Health Needed in Prisons	11
Russia: At the Beginning of the Road	12
Substitution Therapy in South Eastern Europe	14
Methadone Thriving in Slovenia	15
Methadone, Pregnancy, and Fear	16
Substitution Therapy's Little Known Benefit	17
Finding Alternative Substitutes	18
Methadone, Where Are You Heading?!	19
NewsBriefs	20
Zahari Nikolov	22



OPEN SOCIETY INSTITUTE

Open Society Institute-New York

Chairman
George Soros

President
Aryeh Neier

400 West 59th Street
New York, NY 10019 USA
Tel: 1.212.548.0600
Fax: 1.212.548.4679
www.soros.org

International Harm Reduction
Development Program

Director
Kasia Malinowska-Sempruch

Associate Director
Sue Simon

Program Officer
Anna Moshkova

Program Officer (Budapest)
Monica Ciupagea

Program Officer (Budapest)
Konstantin Lezhentsev

Program Coordinator
Jennifer Traska Gibson

Program Coordinator
Matthew Curtis

Program Coordinator
Yulia McCutcheon

Training Coordinator
Magdalena Sklarski

IHRD New York:
Tel: 1.212.548.0600
Fax: 1.212.548.4617
e-mail: IHRD@sorosny.org
www.soros.org/harm-reduction

IHRD Budapest:
H-1051 Budapest,
Nador u. 11 Hungary
Tel: 361.235.6199
Fax: 361.327.3864

Editor
Rebecca Foster

Methadone Issue Advisor
Holly Catania

Newsletter Design
Michael Winikoff

Printed with soy-based inks on recycled paper.



The International Harm Reduction Development program (IHRD) supports local, national, and regional initiatives in Central and Eastern Europe, the Russian Federation, and Central Asia that address drug problems through innovative measures based on the philosophy of harm reduction. Harm reduction is a pragmatic and humanistic approach to diminishing the individual and social harms associated with drug use—especially the risk of HIV infection. The approach places an emphasis on human rights, common sense, and public health. In practice, harm reduction encompasses a wide range of drug user services including needle and syringe exchange, methadone treatment, health education, medical referrals, and support services.

IHRD REDUCES DRUG RELATED HARM BY:

Providing grants and technical support to local direct service providers. IHRD supports over 180 harm reduction projects in more than 20 countries of Eastern Europe and the former Soviet Union. While all interventions are tailored to local conditions and client needs, most projects include a needle exchange component. Making clean needles available to injection drug users has proven effective as an HIV prevention strategy.

Supporting regional, population-based, and topic-specific initiatives. IHRD supports regional conferences, trainings, and direct services on issues such as street kids, HIV prevention in prisons, ethnic minorities (such as Roma communities), methadone treatment, and sex workers.

Promoting local and regional capacity-building. IHRD builds capacity by funding and organizing trainings, workshops, and conferences for a variety of harm reduction stakeholders including NGO staff, government officials, policy officers, prison workers, and health care providers.

Creating an enabling public policy atmosphere. IHRD works to support more progressive and human rights oriented national-level drug policies and practices by sponsoring advocacy efforts, research, conferences, and decision-maker study tours.

IHRD is one of OSI's Network Public Health Programs and works in close cooperation with the local Soros foundations network and the Drug Policy Alliance.

OSI MISSION

THE OPEN SOCIETY INSTITUTE (OSI), a private operating and grantmaking foundation based in New York City, implements a range of initiatives to promote open society by shaping government policy and supporting education, media, public health, and human and women's rights, as well as social, legal, and economic reform. To foster open society on a global level, OSI aims to bring together a larger Open Society Network of other nongovernmental organizations, international institutions, and government agencies. OSI was created in 1993 by investor and philanthropist George Soros to support his foundations in Central and Eastern Europe and the former Soviet Union. Those foundations were established, starting in 1984, to help former communist countries in their transition to democracy. OSI has expanded the activities of the Soros foundations network to other areas of the world where the transition to democracy is of particular concern. The network encompasses more than 50 countries with initiatives in Africa, Central Asia and the Caucasus, Latin America, and Southeast Asia, as well as in Haiti, Mongolia, and Turkey. OSI also supports programs in the United States and selected projects elsewhere in the world.

ONE MOTHER'S ADVOCACY

My son was accepted into methadone treatment. The change was unimaginable. His health improved amazingly. He once again had hope and plans.

by Dorothea Klieber

Many countries in Central and Eastern Europe and the former Soviet Union (CEE/fSU) are today where Germany was 15 years ago: antagonistic to methadone treatment. If it could overcome this antagonism, CEE/fSU could avoid unnecessary human losses such as the one described by Dorothea Klieber, who created the first advocacy group for parents and friends of drug users in Germany. The group was influential in getting methadone treatment legalized shortly after her son's death in 1988. Her leadership gave rise to several parent support groups throughout the country and a national day of recognition for victims of drug prohibition that is observed annually on July 22. More than 65,000 people now receive methadone maintenance treatment in Germany. Most patients are cared for by their general physicians in private, community-based offices. In April 2002 Klieber received the Medal of Honor of the President of Germany. The following excerpts come from Klieber's presentation at a conference on AIDS and Drug Addiction on November 30, 1987.

How much longer will we refuse humane help for addicts in our country? I am the mother of a son who has been opiate dependent for more than 15 years. I have shared and suffered with him all the inescapable stages of the disease.

- One and a half years in a juvenile detention center for possession of a half-gram of heroin;
- Eleven long-term drug-free therapy experiences, two of which were continued until treatment was completed;
- Sixteen hospitalizations in psychiatric institutions;
- About 30 cold turkey detoxes; and
- Ambulatory treatment and counseling again and again.

I don't know how my son was able to tolerate this, and I don't know how I was able to tolerate it. My husband died as a result of it.

Such a report is not unique. What is special is that my son, after 14 years, finally obtained effective help: He was accepted into methadone treatment. The change was unimaginable. He was no longer faced with the threat of persecution. His health improved amazingly. He once again had hope and plans.

While he was in treatment I came to know other patients. When we parents heard talk of zombies or words like that, we could only stare incomprehensibly. We knew that they couldn't possibly be referring to patients treated with methadone. Nobody could convince us of the alleged disadvantages of substitution treatment. We simply knew better, because we saw the effects of medication-supported therapy on our own children. We founded an organization called "Parental Help for Addicts."

Then, after a very brief period of hope, a catastrophe hit: The physician was arrested, the practice was ended, and roughly 100 patients were kicked back into misery, need, and desperation. My son, no longer seeing any way out, tried to hang himself. I found him in time to cut him down.

After the police forced the closing of the physician's practice, I was drawn even closer to the other parents. Others joined us and we did everything in our power to help the unfortunates. In vain! The only effective help, medical treatment, was impossible. Responsible physicians who



Funeral photograph of an injection drug user. Photo © 2003 John Ranard

were prepared to provide this treatment through a loophole in the legal system were warned that they would share the same fate as the arrested physician.

And thus began for most of the patients a damnable downward spiral: illegal drugs, the needle with all of its health risks, prostitution, criminality, prison, illness, suicide, and death.

I ACCUSE, in the name of thousands of addicts and their relatives, because of the failure to provide help and the refusal to make treatment possible.

I ACCUSE, because of the toleration and the cause of unspeakable misery and damage to the body and soul of thousands of addicts, their relatives, and the physicians who responsibly seek to care for them.

I ACCUSE!

Epilogue: On June 2, 1988, I brought my "report of a mother" to a final conclusion. My son, for 15 years persecuted and hunted, no longer saw any way out, and put an end to his desperate life. Methadone could have been his savior.

TREATING OPIATE DEPENDENCE AS A REAL DISEASE

by Robert Newman

In the field of drug dependence, a great deal of debate focuses on semantic issues. Nothing illustrates this better than the persistent refusal by many to accept the concept—let alone the practice—of "harm reduction." Taken at face value, this position is incomprehensible, since if one is *against* the reduction of harm, what in the world is one *for*? Another issue that generates semantic debate is the nature of drug dependence and its treatment. The question is whether drug dependence is a "disease" and, if so, whether it requires—and merits—medical care.

The unwillingness to accept opiate dependence as a "real" disease seems to rest largely on the observation that some opiate-dependent individuals stop using drugs without medication and, indeed, without any treatment at all. The implication is that if some people can "just say no" and control their dependence through sheer determination, then everyone can. The dichotomy between opiate-dependent individuals who, seemingly at will, can assume drug-free and medication-free lives and those who cannot, also exists with regard to most medical conditions. It is estimated, for example, that as many as 80 percent of adult-onset diabetics *could* control their blood sugar without insulin, through appropriate exercise, diet, stress reduction, smoking cessation, etc. Behavioral modifications can eliminate the need for lifelong medication and restore the health of many patients with hypertension, coronary artery disease, and other illnesses that are accepted as primarily "physical" in etiology.

None of these impressive outcomes among the few, however, justifies either moral condemnation or clinical abandonment of the many. Extrapolating the experience of a handful to the entire opiate-dependent population may be intellectually appealing, but it conflicts with reality.

Almost all chronic diseases are influenced by psychological, behavioral, and social factors in addition to genetic and physiological determinants. Ideally, all should be considered and addressed, as necessary, by the health care provider. In the last analysis, the clinical regimen that is applied must be based on the specific needs and circumstances of the individual patient, and a judgment regarding the degree of compliance that can reasonably and realistically be expected. Put another way, it would be unacceptable for physicians to be slavishly fixated on some academic ideal and deny care to those who cannot or will not share their expectations and cooperate in meeting them. In the real world the predominant focus of providers and patients in all areas of medicine is, in fact, "harm reduction."

Beyond the commonality of therapeutic goals, drug dependence shares other characteristics with chronic diseases. Perhaps the most fundamental is—by definition—that these conditions are incurable. This is not cause for

despair, and certainly no excuse for therapeutic nihilism. As all physicians (and virtually all patients) know, even today's highly sophisticated drugs and surgical, radiological, and endovascular interventions that can do so much to lessen suffering and prolong life, very rarely effectuate cure. Some infectious diseases are exceptions to this generalization. Significantly, even when certain illnesses seem to have been "cured," one can rarely be certain that this is the case; physicians are almost always reluctant to guarantee that relapse will not occur.

Having stressed some of the key similarities between drug dependence and chronic disease, it is somewhat embarrassing to acknowledge that it really does not matter whether or not drug dependence is considered under the chronic disease rubric. What matters is that the orientation that guides treatment is identical. Applying accepted medical approaches is the answer to the many questions that confront and confound the drug dependence treatment provider and patient alike. For example:

HOW DOES ONE DETERMINE WHICH TREATMENT IS BEST FOR WHICH PATIENT?

AS WITH MANAGEMENT OF ALL ILLNESSES, all treatments should be available that the physician believes might benefit the patient. With regard to methadone and other opiate agonists, there are no concomitant illnesses that preclude their use, and none, such as HIV, that should be considered prerequisites. It is equally irrational to make "eligibility" for a particular therapeutic regimen contingent upon prior "failure" with another, or upon some arbitrary number of years of dependence, or a specific age.

WHAT IS THE OPTIMAL MAINTENANCE DOSE WHEN OPIATE AGONISTS ARE PRESCRIBED?

AS WITH MANAGEMENT OF ALL ILLNESSES, there is absolutely no place for moral judgments that particular dosages are inherently "good" or "bad." General guidelines, based on empirical and scientific evidence, are reported in the professional literature, but the ultimate decision must be individualized, based on each patient's response.



Injection Room, Togliatti, Russia. Photo © 2003 John Ranard

HOW LONG SHOULD TREATMENT BE CONTINUED?

AS WITH MANAGEMENT OF ALL ILLNESSES, treatment (medication-based or drug-free) should be continued as long as it is effective and does not cause significant side effects, and as long as there is reason to believe that its termination would be associated with risks to the patient. Generally, the safest approach is to continue treatment indefinitely. If this sounds excessively conservative, consider what an Alcoholics Anonymous advocate would say if told AA meetings were no longer available to the abstinent alcoholic.

WHAT SUPPORTIVE SERVICES SHOULD OR MUST BE PROVIDED?

AS WITH MANAGEMENT OF ALL ILLNESSES, drug dependence treatment should have available a wide range of services for concomitant medical, social, legal, and other problems patients may have. It is wrong, however, to make the availability of such services and their acceptance by all patients a prerequisite to offering life-and-death services to a person who is opiate dependent.

WHAT IS THE ROLE OF URINE TESTS?

AS WITH MANAGEMENT OF ALL ILLNESSES, a variety of laboratory tests may be helpful. The frequency of such tests and, even more important, the conclusions and consequences to be drawn from the results, must be left to the individual provider. It is absurd (though tragically common in the case of drug users) to make unfavorable test results grounds for terminating treatment; this is analogous to punishing by termination of care the epileptic who continues to have seizures, the cardiac patient whose angina persists, or the diabetic whose blood sugar concentration remains elevated.

WHAT SHOULD BE DONE TO/FOR THE "NONCOMPLIANT" PATIENT?

AS WITH MANAGEMENT OF ALL ILLNESSES, compliance by patients with the treatment regimen is a major challenge for the clinician. There are no easy responses, but threats of "punishment" are rarely either ethical or effective. Patience and persistence in seeking to overcome or lessen noncompliance are essential and among the most important attributes of any successful health care provider, in any specialty.

For those committed to addressing the complex challenge of drug dependence, it is helpful to be guided by one fundamental principle: to view the challenges in this field in a manner consistent with that applicable to all diseases. Providing treatment for the opiate-dependent patient is difficult, but it is also a great privilege, and enormously gratifying! It is fine to dream of "the best," but meanwhile we must seize the opportunity that exists today to provide "the good" to every single person who needs and wants help, and who may well die without it. This is precisely what is meant by "harm reduction," and it is applied as a matter of course to every other area of medicine.

Robert Newman is the director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center in New York City. Part of this article was adapted from "Methadone Treatment: Common Questions, A Common Answer," by R.G. Newman in *Annales de Médecine Interne* (2001).

ACCEPTING MAINTENANCE TREATMENT

by Emilis Subata

In Eastern Europe and Central Asia, injection drug use has been directly associated with the increasing number of HIV/AIDS cases over the last six to seven years. A recent survey conducted by the Central and Eastern European Harm Reduction Network (CEEHRN) showed that in many countries injection drug users (IDUs) account for more than 50 percent of registered HIV/AIDS cases, while in the Baltic States and the Newly Independent States they account for more than 80 percent. Yet access to maintenance treatment, which can slow or even stop injection drug use, remains extremely limited.

It is difficult for post-Soviet countries to accept the principles behind substitution treatment. Narcologists, trained in the methods of the Soviet treatment system that was developed in 1976 in response to alcohol abuse problems, generally focus on abstinence treatment goals rather than substitution. The kind of substitution treatment practices found in Western countries, such as prescriptions issued by general practitioners (GPs) and distribution of methadone through pharmacies, are hardly applicable in the post-Soviet context. The absence of culturally sensitive national guidelines, manuals, and protocols compound the misunderstandings about the goals and practices of substitution treatment. Further, because salaries are comparatively low among medical professionals, there is a fear that methadone will be diverted for sale on the black market. Some people also fear that organized criminal structures could ultimately take control of methadone programs. Many ministries of justice and interior cite this as a reason not to support such programs.

Nevertheless, according to Natalya Dolzhanskaya of the Research Institute on Addictions in Russia's Ministry of Health, the percentage of narcologists with negative attitudes toward methadone maintenance treatment (MMT) in Russia dropped from 86 in 1993 to 40 in 1995 to 26 in 2001. The HIV/AIDS epidemic among IDUs, which hit Russia in 1995, was one of the key factors in changing this attitude. Due to the rapid increase of heroin use and HIV transmission among IDUs in post-Soviet countries there is an urgent need to make different treatment programs, including MMT, an integral part of medical services. Consensus building among medical professionals in the region is essential for the introduction and development of such treatment.

Several successful MMT programs have been implemented in the region. Programs in the Baltic countries provide a model of how substitution treatment can be established within a post-Soviet reality. In Vilnius, Lithuania, three primary health care centers have dispensed methadone since 1996-98. GPs, in cooperation with a specialized center, are responsible for treatment. Cooperation with GPs in the primary health care center seems to be an especially effective tool in reaching the marginalized Romani minority. The integration of MMT into mainstream medical and social services at the Druskininkai Primary Health Care Center and the Substance Abuse Treatment Center was included as a "best practice model" in the 2001 United Nations ODCCP and UNAIDS case studies booklet for Central and Eastern Europe and the Central Asian States.

HIV/AIDS, IDUs, and maintenance treatment in Caucasus/ Central Asia, Baltic States, and Newly Independent States, May 2002 (CEEHRN), updated by IHRD June 2003.

	Registered HIV/AIDS cases	IDUs among registered HIV/AIDS cases (%)	Legal status of maintenance treatment with methadone or buprenorphine	Total # receiving maintenance treatment with either substance
Caucasus/ Central Asia				
Armenia	189	49.2		0
Azerbaijan	389	47.9	Methadone (registered 2003)	0
Georgia	316	70.9	Methadone (registered 2003)	0
Kazakhstan	2,870	87.1		0
Kyrgyzstan	825	82.0	Methadone	11
Tajikistan	45	75.6		0
Turkmenistan	2	0.0		0
Uzbekistan	1,120	60.0		0
Baltic States				
Estonia	2,297	85.0	Methadone	0
Latvia	2,035	76.3	Methadone	85
Lithuania	448	72.3	Methadone	400
NIS				
Belarus	4,344	78.0		0
Moldova	1,570	83.0	Buprenorphine	22
Russia	197,497	92.7		0
Ukraine	46,800	69.4	Buprenorphine Methadone (registered 2003)	200 0

In Russia, federal law explicitly prohibits the treatment of drug dependence with opiate-containing medicines, such as methadone and buprenorphine. In 2001-2002 Tramadol-retard, a synthetic pain-killer opiate, was used on a trial basis by government treatment centers in two cities with the support of Médecins du Monde. Preliminary findings showed improved contact between drug treatment services and patients, as well as a reduction of illegal opiates consumed and a reduced risk of HIV/AIDS transmission. (See article on page 18.)

While much work remains ahead, these recent successes indicate that persistent introduction of trial projects and better evaluation of existing programs is contributing to the gradual acceptance of substitution treatment principles in post-Soviet countries.

Emilis Subata is director of the Vilnius Substance Abuse Treatment Center, Lithuania.

DRUG USERS NEED HIV TREATMENT TOO



TB patient in Novokuznetsk detention center, Russia, taking HIV test. Photo © 2003 Alexander Glyadyelov

An interview with Marek Beniowski, director of the Center for AIDS Diagnostics and Therapy for Katowice District, Poland

What effect does substitution treatment have on heroin injecting, needle sharing, and therefore the spread of infectious diseases such as HIV?

Substitution treatment decreases the craving for drugs and leads to changes in how drugs are used. Switching, as most program participants do, from injecting to oral administration of a drug leads to a decrease in incidence of blood borne infections and, consequently, hepatitis B and C viruses and HIV. And even if some substitution program patients still inject, the information they get on safer injecting practices encourages them to decrease needle sharing.

Drug dependence is a complex disorder that has many non-medical influences. Thus the treatment of drug dependence should address as many

factors as possible. Substitution treatment makes this possible. The simple action of filling up the brain receptors allows drug users to see the light, to make wise decisions about their lives, to take care of themselves and their families. I would call substitution treatment the harm reduction approach of the highest rank because it makes reconciliation of drug dependence with a normal life possible.

What kind of access exists in the countries of Central and Eastern Europe and the former Soviet Union to treatment for the dual epidemics of HIV/AIDS and injection drug use?

The survey done by the Central and Eastern European Harm Reduction Network in 2002 provided alarming data: In the whole region only 2

percent of the people living with HIV/AIDS (PLWHA) were treated with antiretrovirals (ARV), with drug users accounting for no more than 25 percent of them. In countries hit hardest by the dual epidemics—Russia and Ukraine—drug users account for no more than 13 percent of all treated PLWHA, even when the number of drug users in these countries is enormous, about 2 percent of the whole population. Drug dependency treatment options are very limited, with methadone on the list of prohibited drugs in most countries of the region. Use of other drugs for substitution treatment in the whole region is marginal. Wider access to substitution treatment occurs in some countries in South Eastern Europe, such as Slovenia and Croatia.

THE SUCCESS OF METHADONE IN KYRGYZSTAN

The lessons we learned might be useful to others planning or starting an MMT program.

by Tynchtykbek Asanov

In just one year, it is clear that methadone maintenance treatment (MMT) in Kyrgyzstan has been a success. Since the first MMT programs in the cities of Bishkek and Osh for opioid dependent people were launched in April 2002 almost 90 percent of the 155 participants have attended the programs continuously.

successful in positively changing the lifestyles of the majority of the program participants. At the same time, those of us running the program gained valuable professional experience and learned lessons that might be useful to others planning or starting an MMT program.

a chronic disease with frequent relapses, but at the same time it demanded that patients become drug free in a very short time. These old approaches die hard. Today's more knowledgeable approach is based on a philosophy of tolerance. In order to implement MMT successfully, it is important to advocate for MMT among medical professionals and help them change their approach to drug treatment and the evaluation of its effectiveness.

A second lesson learned is that achieving good results required us to work closely with our clients for a rather long period of time—one whole year! We agreed to working long hours, learned to be tolerant when waiting for abstinence, and enjoyed even the slightest positive changes. Our experience also demonstrates that methadone is only a small part of changing a client's behavior. Treatment includes the influence of doctors and medical professionals, as well as other program participants. We found that clients responded more positively when staff members were disciplined about treatment rules.

Lowering the entry threshold for the MMT program provided a third lesson. A lower threshold resulted in the enrollment of many clients with mental disorders. They turned out to be the most difficult to work with. They would often be late for their appointments or miss them altogether, continue to use drugs or psychotropic substances, commit crimes, and leave the program. Such clients need additional psychiatric care and psychotropic medications, which we were unable to provide due to our financial constraints, and which they could not afford themselves. Therapy for people with mental disorders needs to be piloted and developed, especially since we will be lowering the threshold in the near future and have already started the program's expansion.

continued on the next page



Giving Methadone in Bishkek, Kyrgyzstan. Photo by Diljara Shakirova

Our survey results show that 88 percent of the clients felt physically better after one year and 93 percent noted positive changes in the way they use their free time. Twenty-two percent were able to obtain employment and 86 percent rated their financial status as "satisfactory." Four people returned to universities or colleges, and about the same number were able to go back to their families. Unfortunately, we found one case of HIV infection among the project participants. Over 90 percent of the participants who continue with the therapy regard their participation in MMT as a positive experience.

Based on the survey results, we consider the first year of our program

The first lesson is that it is wrong to think that skepticism toward MMT can be totally overcome in a year, even with clear and positive results from a program such as ours. In Kyrgyzstan, a lot of narcologists and public health professionals still hold to the positions of therapeutic maximalism and moralization. They believe that total abstinence from drugs is the only form of success, and that the use of drugs for "medical purposes" is amoral and should be prohibited.

The skepticism of those opposed to MMT is rooted in the philosophy of narcological aid that was used in the countries of the former Soviet Union. The old medical strategy was based on the realization that drug dependence is

continued from the previous page

A fourth lesson concerned the difficulty of preventing methadone from getting into the illegal drug market. Under conditions of economic hardship, the medical staff of the projects might be tempted to sell methadone on the side illegally. These concerns turned out to be exaggerated. If the work is set up properly this risk is minimal. The concern about very close attention and control by the police did not materialize either.

The fifth lesson we learned was that MMT can be used to increase the trust of drug users towards the state narcological system and narcological institutions. The first participants, for example, may have been suspicious about not being able to participate in the MMT program anonymously. After some time they accepted this condition because they saw that there were no negative social consequences for their peers, as there would have been previously.

Through our MMT programs we were able to expand the spectrum of services provided for injection drug users in Kyrgyzstan and ensure their trust in the national narcological institutions. Such trust is key to prevention interventions, especially in the era of HIV/AIDS.

Tynchtykbek Asanov is the director of the Republican Narcology Center and the chief narcologist of Kyrgyzstan's Ministry of Health.

DRUG USERS NEED HIV TREATMENT TOO (CONTINUED FROM PAGE 7)

There are a lot of convincing data that active drug users can benefit in the same way from HIV treatment as non-drug users.

How is the medical profession responding to the dual epidemics? If it is responding inadequately, how should it respond?

Usually the link between the system of care for drug users and the system of care for PLWHA is weak, at best. Psychiatrists, who are in theory responsible for drug dependence treatment issues, are not skillful enough in their care for HIV infected people. And infectious disease specialists are often helpless in the face of drug dependency problems. Neither is prepared to deal with their patients' non-medical problems. The system of care for HIV infected drug users should be built upon teams of medical specialists—psychiatrists or narcologists, infectious diseases specialists, social workers, and psychologists. Such a comprehensive approach addresses the medical and psychosocial needs of the patients in the most appropriate way.

Describe the problem drug users have getting equal treatment for HIV/AIDS, and why.

Drug users are stigmatized all over the world. An image of a drug user conjures up an image of a dirty, smelly, intoxicated person who is totally irresponsible and has a chaotic lifestyle. It is often said that such a person cannot benefit from HIV infection treatment, especially when antiretroviral treatment is involved, because inadequate consumption of ARV drugs can be harmful if it enables HIV strains resistant to those drugs to develop. But drug users are all different. Many people in this group could improve their lives if adequate help and care were provided—not only after they are totally abstinent. The problem is the lack of institutions that do outreach and actively seek clients. Outreach has proven to be an effective public health approach in the provision of care for hard to reach populations. There are a lot of convincing data showing that active drug users, if properly approached and adequately followed, can benefit in the same way from HIV treatment as non-drug users. The issue of the development of drug resistance in this group of patients is often overestimated.



Outreach worker in Volograd, Russia. Photo © 2003 John Ranard

My experience has been that severe health problems are more frequent among HIV infected drug users than other HIV infected persons. This can lead to burn out among medical personnel working with drug users. It's hard to face your patient who was successfully treated for a severe opportunistic infection, for instance, but who now shows up in bad condition because he returned to active drug use. It is difficult and depressing. But this is no excuse for disregarding such patients as human beings or denying them treatment. Doctors do not disqualify coronary artery disease patients from treatment because they smoke cigarettes...

I think that the weak position of PLWHAs in society is going to change. A homophobic and "narcophobic" society simply has to become more forgiving and embracing. It takes time and needs a lot of energy and positive thinking. But it is happening.

METHADONE MYTHS AND FACTS

by Sharon Stancliff, Peter Vanderkloot, and Holly Catania

Although it has been successfully used in the treatment of opiate dependence for more than 35 years, methadone remains one of the most misunderstood medications in existence. Myths about methadone are widespread among the general public and professionals alike. Understanding what methadone does not do may be as important as understanding what it does do.

MYTH: Methadone gets into the bones and weakens them.

FACT: Methadone does not “get into the bones” or in any way cause harm to the skeletal system. Although some methadone patients report aches in their arms and legs, the discomfort is probably a mild withdrawal symptom and may be eased by adjusting the dosage.

MYTH: It’s harder to kick methadone than it is to kick a heroin habit.

FACT: Stopping methadone use is different from kicking a heroin habit. Some people find it harder because the withdrawal lasts longer. Others say that although it lasts longer, it is milder than heroin withdrawal.

MYTH: Taking methadone damages the body.

FACT: People have been maintained on methadone for more than 30 years without evidence of any physical damage. Some people do suffer side effects from methadone—such as constipation, increased sweating, and dry mouth—but these usually go away over time or with dose adjustments.

MYTH: Methadone is worse for your body than heroin.

FACT: Methadone is not worse for your body than heroin. Both heroin and methadone are nontoxic, yet both can be dangerous if taken in excess—this is true of everything, from aspirin to food. Methadone is safer than street heroin because it is a legally prescribed medication and it is taken orally. Unregulated street drugs are impure and may be contaminated with dangerous chemicals and/or bacteria.

MYTH: Methadone harms your liver.

FACT: The liver metabolizes (breaks down and processes) methadone, but methadone does not “harm” the liver. Methadone is actually much easier for the liver to metabolize than many other types of medications. People with hepatitis or with severe liver disease can take methadone safely.

MYTH: The lower the dose of methadone, the better.

FACT: Low doses will reduce withdrawal symptoms but higher doses are needed to block the effect of heroin and cut

the craving for it. Most patients will need 60 to 120 milligrams of methadone a day to stop using heroin. A few patients, however, will feel well with 5 to 10 milligrams; others will need hundreds of milligrams a day in order to feel comfortable. Ideally, patients should decide on their dose with the help of their physician, and without outside interference or limits.

MYTH: Methadone causes drowsiness and sedation.

FACT: All people sometimes feel drowsy or tired. Patients on a stabilized dose of methadone will not feel any more drowsy or sedated than is normal.

MYTH: Methadone is harmful to your immune system and should not be taken by people with HIV.

FACT: Methadone does not damage the immune system. In fact, several studies suggest that HIV infected patients who take methadone live longer and are healthier than drug users who are not on methadone.

MYTH: Due to interactions with antiretroviral therapy, HIV/AIDS patients should not take methadone.

FACT: While methadone and certain HIV medications may affect each other’s metabolism, such interactions are easily managed by adjusting the doses.

MYTH: Western governments do not support methadone maintenance.

FACT: More patients receive methadone maintenance in the United States today (approximately 200,000) than at any time in the past 30 years. Methadone has been and remains the primary treatment for opioid addiction in Australia, Thailand, Hong Kong, Germany, the United Kingdom, the Netherlands, Austria, Switzerland, Italy, Spain, Croatia, Poland, Lithuania, Canada, and other countries.

Sharon Stancliff is the medical director at Harlem East Life Plan’s methadone treatment program in New York City. Peter Vanderkloot is a methadone patient living in New York City. Holly Catania is the project director at the Baron Edmond de Rothschild Chemical Dependency Institute at Beth Israel Medical Center in New York City.

PUBLIC HEALTH NEEDED IN PRISONS

by Holly Catania

Incarceration is not an uncommon event in the lives of injection drug users (IDUs). Dual epidemics of HIV/AIDS and injection drug use are devastating communities all over the world, especially Central and Eastern Europe and the former Soviet Union, creating a demand for greater access to the best-known drug treatment: methadone maintenance treatment (MMT). Providing MMT in prisons where IDUs are over-represented, dying of overdose, and at the highest risk for acquiring and spreading blood-borne diseases is commonsense public health policy.

Methadone treatment is widely accepted in prisons in Australia, Europe, and some places in Canada. The model program in the United States is in one of the world's largest jails. Yet access to methadone is severely limited worldwide. Providing medical care to prisoners that is comparable to what they would receive in the outside community is a common practice and a requirement under international treaties. Methadone and other pharmacotherapy treatments should not be an exception.

Opiate addiction is a chronic relapsing condition: over 80 percent of all people who stop taking opiates go back to using drugs. MMT has been available in a number of countries for many years and has been proven to be the most effective treatment in reducing the craving for opiates that leads to relapse.



Prison colony in Marijnsk, Russia. Photo © 2003 Alexander Glyadyelov

Yet MMT is not available in a single United States federal or state prison. In fact, MMT is provided at only one jail in the country: Rikers Island in New York City. With an average daily census of 14,000 inmates at the jail, the Rikers Island Key Extended Entry Program (KEEP) treats roughly 4,000 patients with MMT, provides about 8,000 methadone detoxes per year, and has operated as a model in-jail program since 1987.

Despite the proven success of KEEP, prison administrators and government officials in the United States have resisted implementing MMT for a number of reasons. One is

the philosophical objection of "I don't believe in substituting one addiction for another." Another concern is the possibility that providing MMT in a prison environment could allow for a diversion of medication or create logistical problems transporting inmates or medication. Funding is another often cited impediment.

While these concerns must be taken seriously, KEEP offers an established model that addresses many of the traditional official concerns about MMT and provides one example of a strategy that can do much to improve the health and safety of prisoners and the general public.

continued on page 13

COUNTRIES AND TERRITORIES THAT PROVIDE METHADONE IN PRISONS

Country	Country	Country
Australia	France (also buprenorphine maintenance in prison)	Poland
Austria (also buprenorphine and morphine maintenance in prison)	Germany (also needle exchange in prison)	Portugal
Belgium (detox only)	Italy	Puerto Rico
Canada	Ireland	Scotland
Denmark	Luxembourg	Slovenia
England	Netherlands	Spain
Estonia	N. Ireland (detox only)	Switzerland (also needle exchange in prison & heroin maintenance)
		United States (jail only)

Sources: Dolan, 2002; EMCDDA, 2001; Malinowska-Sempruch, 2002.

AT THE BEGINNING OF THE ROAD

Andrei Wolf, deputy of Russia's State Duma, was interviewed for Harm Reduction News by Asya Bidordinova, president of Charity Fund "For a Healthy Society," in Moscow, Russia.

How dangerous is HIV/AIDS for Russia?

The danger is great. It may be one of the greatest, underestimated challenges of our times. Let's compare HIV and drugs. Five years ago no one spoke about drug use issues. Two years ago, partly thanks to the mass media, drug use suddenly emerged as a national issue and people started thinking about possible solutions. To my mind, HIV/AIDS is at the same place today as drug use was five years ago. There is a definite understanding, but HIV is not considered a potential national catastrophe. I don't think we have real numbers on HIV/AIDS prevalence in Russia. If we did, many people would probably realize the gravity of the problem.

What can be done to improve the HIV/AIDS situation in Russia?

We must work on prevention and awareness for the general population because everyone must know the truth about HIV/AIDS. The mass media should create a broad and aggressive campaign to reach as many people as possible. People should be provided with information about HIV/AIDS, the ways it is transmitted, how to protect themselves, and how to live with HIV or among people who have HIV. Only correct, honest, complete information—without hysteria—will reduce the speed of the epidemic.

Of course we must also focus on prevention among the vulnerable groups: drug users, sex workers, and marginalized youth. Universal educational and advocacy campaigns should be targeted to these populations. The campaigns should not be too official, but instead involve Internet-based resources, youth mass media, and speakers who are meaningful to the people in these communities. A specialized approach for sex workers should include legal and medical counseling and provision of prevention materials.



Andrei Wolf. Photo by Alec Kachatryan

Methadone maintenance therapy (MMT) is known to have a positive effect on the quality of life of opiate-dependent people. What is the future of MMT in Russia?

Today this is the only method that truly allows us to deal effectively with this problem and reduce drug related harm. Substitution programs can protect drug users and their right to life and health, and at the same time protect society by reducing the spread of HIV/AIDS. There is no evidence to support the success of other methods. Repressive measures, such as police campaigns that mainly target drug users, don't solve the issue. Such measures have populist appeal but only aggravate the problem by pushing it further underground.

I believe that a joint effort among nongovernmental organizations, human rights advocates, medical professionals, foundations, and progressive-thinking representatives of the legislative and executive branches, can implement the required laws and create enough public tolerance to carry out MMT in Russia. Much depends on the professionals. Regional authorities and politicians listen carefully to expert recommendations while making decisions. Professional opinion also becomes the basis for public opinion by influencing the mass media. Opposition is substantial, however, both among politicians and medical professionals accustomed to Soviet-style dogma. Furthermore, the implementation of MMT is contrary to the interests of criminal groups and corrupt police forces that make a fortune off the drug problem.

What is the most effective argument in the Duma in favor of MMT and harm reduction?

Figures are the only effective argument. Figures confirming the success of these programs in the West will persuade the political elite in Russia. Since Russia is a leader-oriented country and much depends on "the opinion from above," a political decision will have to be made. If the Russian president were to mention this problem and possible solutions to it during one of his public speeches, then faceless and cowardly officials would immediately change their opinion. They have only one priority—to secure their place within the power structure. If they are able to stay in power by criticizing substitution treatment, they will criticize it. If they are able to keep their jobs tomorrow by advocating it, they will start promoting MMT.

Has Russia's criminal code been amended?

In early 2003, draft amendments, which took a year to prepare, were made to the articles of the criminal code that concern drugs. First, the amendments make a distinction between punishments for crimes related to the sale of drugs and crimes that are not. We are looking for a holistic approach to the problem, so while we are making the laws tougher for the sale or trafficking of drugs, we are simultaneously liberalizing the law for crimes unrelated to drug trafficking. This will make life more complicated for those Ministry of Internal Affairs officials who are racing for good results on paper and thinking they are a great success in fighting the drug mafia by arresting people for a matchbox of marijuana. Second, the amendments change the 1988 definition of "large" and "extra large" quantities of drugs. "Large" amounts of drugs are calculated as 10 times a single dose, and "extra large" as more than 50 times. These were the basics of the draft law, which the Duma supported in April 2003.

What are your thoughts on the International Conference on the Reduction of Drug Related Harm, held in Thailand in April 2003?

This was my first conference on the matter and I was pleasantly surprised with its wide scope and the number of participants. I realized that many other countries in the world share the same problem. Frankly, Russia has nothing to boast about. Nowhere else in the



Heroin Syringes, Tolgatti, Russia. Photo © 2003 John Ranard

If officials are able to stay in power by criticizing substitution treatment, they will criticize it. If they are able to keep their jobs tomorrow by advocating it, they will start promoting MMT.

world are people imprisoned for a matchbox of marijuana. So far Russia is unable to show off methadone programs, a clear distinction between users and sellers, or public tolerance to drug users. Most of our research and surveys have shown that a majority of the population is in favor of the death

penalty for those who sell, and often for those who use drugs. We are at the very beginning of the road, and the road won't be easy or short. But after seeing smaller, less developed, and less liberal countries find solutions to these issues, I believe that we should be able to as well.

PUBLIC HEALTH NEEDED IN PRISONS (CONTINUED FROM PAGE 11)

In New York City, several factors made it possible to establish MMT in the KEEP program. The rapid increase of the city's jail population, fueled by the war on drugs, led to overcrowding and unrest that alerted city officials that new measures to treat heroin-dependent prisoners were needed. The growing AIDS epidemic in New York City also created an incentive to improve services to IDUs to reduce the spread of HIV. The success of the pilot methadone detox program in the women's jail for pregnant prisoners prompted expansion to the men and to maintenance as well as detox. Most important, key city corrections administrators were willing to take a risk on a controversial program.

The establishment of KEEP's MMT program required the cooperation of several diverse agencies despite the differences in their organizational philosophies and missions. New procedures had to be developed by corrections; community-based methadone programs were enlisted and funded to provide post-release treatment; and hospital personnel had to agree to work inside a prison.

In the community, health care is the responsibility of the Ministry of Health, while in prisons it is most often under the Ministry of Justice. In France and Italy, laws governing the control of prisoners' healthcare were changed to allow the Ministries of Health to care for prisoners.

This resulted in the expansion of substitution treatment in prisons. In Canada, MMT was established in the federal prisons as a result of lawsuits.

Whichever strategy works best, it is essential that decisionmakers, politicians, and government officials become willing or are made to be willing to apply public health criteria to prisons to help break the cycle of death, disease, crime, and suffering associated with illicit injection drug use.

Holly Catania is the project director at the Baron Edmond de Rothschild Chemical Dependency Institute at Beth Israel Medical Center in New York City.

SUBSTITUTION THERAPY IN SOUTH EASTERN EUROPE

In an exciting demonstration of the forces that are now coalescing to address the problem of heroin use in South Eastern Europe, sister conferences were held in May: the First Adriatic Drug Addiction Conference, in Porec, Croatia, and the First Central and South Eastern European Symposium on Addictive Behaviors, in Piran, Slovenia. Substitution treatment was one of the most important topics for the 350 participants from 13 countries. The status of this treatment modality varies widely in the region as the five examples below and the facing article on Slovenia make clear.

Cooperation between experts in the region is vital to successfully upgrading treatment and rehabilitation in each country. To facilitate regional cooperation, these conferences will take place every other year and a coordination committee with representatives from all countries will be established. Many additional plans are in the works, including training experts in substitution therapy and turning the magazine *Odvisnosti* (Addiction), published in Slovenia, into a regional magazine by translating it into several languages.

Andrej Kastelic, Center for Treatment of Drug Addiction, Ljubljana, Slovenia

ALBANIA

Since the early 1990s Albania has recorded a steady increase in problems related to the production, trafficking, and use of illicit drugs. In 2001, an estimated 4,500 drug users needed treatment. Young people aged 20 to 24 make up 54 percent of all treatment demand. Alarming, 23 percent of users seeking treatment are under 19 years old. The share of users from this age group is rising rapidly, particularly among the Roma. Methadone has been registered in Albania for more than two years, but its cost has not been covered by the state or insurance agencies. Methadone is available in one pharmacy at a relatively high price. Only short-term methadone detoxification has been started with fairly restrictive eligibility requirements. During an 18 month period 68 patients were treated.

Zihni Sulaj, University Service of Clinical Toxicology, University Hospital Center, Tirane

BOSNIA AND HERZEGOVINA

A government-funded methadone detoxification program started in the Canton of Sarajevo in January 2002. Methadone maintenance therapy (MMT) started in July 2002, and within four months there were 40 patients. Methadone is used in other cantons in the country, but it is given on an ambulatory basis, so there is more risk for illegal distribution of methadone. The Public Institute for Alcoholism and Substance Abuse of Canton Sarajevo



Andrej Kastelic at the May 2003 conference in Porec, Croatia. Photo by Ante Ivančić

plans to implement MMT in other large cities; train mental health professionals to run the programs; and obtain government support for psycho-social rehabilitation programs.

Nermana Mehić-Basara, Center for Alcoholism and Substance Abuse of Canton Sarajevo

REPUBLIC OF CROATIA

Croatia's first drug treatment clinic opened in 1971, so by the time heroin use became an epidemic in the early 1990s Croatia already had a team of experts in place. Methadone was introduced in 1991. Out of Croatia's estimated 15,000 drug dependent people, 3,000 are on methadone treatment. Short-term detoxification is available in hospitals, but the outstanding program in

Croatia is the nation-wide outpatient MMT system coordinated between 15 centers for drug treatment and general practitioners (GPs). After a clinical evaluation, a specialist in the center decides on the client's treatment, regimen, and starting dose. Patients are then referred to their own doctor, who prescribes methadone. GPs see the patients every day in the office, and know their medical history, social circumstances, and family pathology.

A dense and well-developed network of GPs makes MMT available in "every village." More than 1,000 of Croatia's 2,400 GPs have MMT patients. The inclusion criteria are liberal and there are no waiting lists for entering treatment. Illegal opioid consumption is not a reason for discharge. Treatment is practically free. The GPs, however, do not receive pay for their methadone work and so they are becoming less favorable to MMT.

Substitution treatment in Croatia is well established and generally well accepted, but opposition is growing. Ironically, less opposition to methadone treatment was seen during the previous, conservative government. Although an absence of administrative regulations and strict rules was critical for the introduction of methadone, there is a growing need for guidelines.

Ante Ivančić, Center for Outpatient Treatment of Drug Addicts, Porec. For more on the history of MMT in Croatia, see Ivančić's article at www.opiateaddictionrx.info/content/whatsnew/222.html

continued on the next page

METHADONE THRIVING IN SLOVENIA

The mere possibility that HIV infection could increase rapidly has made harm reduction interventions among drug users a high priority.

by Tatja Kostnapfel Rihtar and Andrej Kastelic

Methadone maintenance treatment (MMT) is thriving in the Republic of Slovenia. It is supported by top policy-makers as well as by the public and clients. Since national guidelines for the management of drug users were adopted in 1994, 18 regional Centers for the Prevention and Treatment of Drug Addictions have been established. Their services are free and available to the estimated 5,000 to 15,000 injection drug users (IDUs) in Slovenia.

Out of the several hundred IDUs who have been voluntarily and confidentially tested for HIV in recent years, only 14 have been infected. The early use of substitution treatment and needle exchange programs may have contributed to the low prevalence of HIV. But the mere possibility that HIV infection could increase rapidly has made harm reduction interventions related to unsafe drug use and unsafe sexual behavior among drug users a high priority for the National AIDS Prevention and Care Program.

The 18 regional centers provide a full array of services, including individual, group, and family therapy; community health services; hepatitis and HIV testing; and rehabilitation and social reintegration. The centers have also added treatment of adoles-



Center for Treatment of Drug Addiction in Ljubljana, Slovenia. Photo by Andrej Kastelic

cents and drug dependent pregnant women and their children.

Drug dependence treatment is complex and requires a multidisciplinary team of specialists, from a general practitioner to laboratory technician. The decision to place someone in a methadone treatment program is made by the program manager after consultations with the team. Accessibility is a high priority, so even though the number of clients is increasing, there are practically no waiting lists. People who wish to enter the MMT program must have an opiate addiction and they must have attempted detoxification in the past.

The MMT programs had over 1,800 patients by January 2003. The results of evaluations in 1995, 1997, and 2000 show that more than 90 percent of the patients considered MMT “useful” or “very useful.”

Some centers provide outreach on HIV/AIDS information and safer drug use. Outreach workers provide clean injection equipment, and syringe vending machines have been installed in high-risk areas. Safer sexual practices are also promoted, including the use of condoms, which are widely distributed. The centers have published many informational pamphlets, as well as the scientific journal *Odvsnosti* (Addiction.)

Cooperation with all of the other addiction treatment programs in Slovenia has been key to the network's success. The centers work with local health, social, and education services as well as the police. They help develop treatment for drug users in prisons and military service. And they try to involve drug users in making policy.

Tatja Kostnapfel Rihtar is a consultant with the Sound of Reflection Foundation in Ljubljana, Slovenia. Andrej Kastelic is the director of the Center for Treatment of Drug Addiction in Ljubljana, Slovenia.

SUBSTITUTION THERAPY IN SOUTH EASTERN EUROPE (CONTINUED FROM THE PREVIOUS PAGE)

MACEDONIA

Macedonia's single MMT program sees an average of 301 clients per day. The Day Hospital for Prevention and Treatment of Drug Dependencies was placed in an old and unsuitable building on the outskirts of Skopje. Neither the staff nor its philosophy meets the clients' needs. The program is expensive, centralized, and lacks coordinated support from other social agencies. There is no clear treatment program based on protocol and Macedonian psychiatrists disapprove of MMT. Methadone is too frequently diverted to the black market and many clients use

methadone intravenously, which adds to medical complications and overdoses. An estimated 70 percent of the clients in treatment have been infected with hepatitis C.

Ivan G. Tulevski, Prevention and Treatment of Drug Dependencies, Kisela Voda, Psychiatric Hospital, Skopje

SERBIA AND MONTENEGRO

Out of Serbia and Montenegro's eight million inhabitants, UNICEF estimates there are 70,000 to 100,000 drug users. MMT is available in three cities, but there are only 90 clients. Since

MMT was introduced in 1987, it has not fared well with the disintegration of Yugoslavia and the poor political and economic situation. Inclusion criteria are exceptionally narrow: clients must be at least 25 years old; have several years of dependence and several failed attempts at therapy; and be infected with HIV. We are hopeful that the state and health service will adopt a more enlightened approach to the problem of dependency and open several methadone centers with broader inclusion criteria.

Nikola Vučković, Clinic for Dependence Diseases, Novi Sad

METHADONE, PREGNANCY, AND FEAR



Volgograd, Russia. Photo © 2003 John Ranard

by Lynn Paltrow

For over 35 years methadone maintenance treatment (MMT) has been proven to reduce illegal opiate use and the crime, death, and disease associated with it. Yet despite methadone's efficacy, less than 20 percent of opiate users in the United States have access to it. Pregnant women in particular have difficulty accessing MMT even though it is medically safe and recommended. Some pregnant women and new mothers have even been threatened with loss of child custody for obtaining the treatment.

National Advocates for Pregnant Women (NAPW) knows of many cases in which women were reported to child welfare authorities because they tested positive for methadone at the time of delivery. In some cases babies were removed from their mothers. Misinformed or prejudiced hospital staff view methadone as a sign of illegal drug use and an inability to parent rather than a responsible act to address a drug problem. NAPW has also received reports of pregnant and breastfeeding women who were told that they were not eligible for methadone treatment or who were given inappropriately low doses in the erroneous belief that lower doses protect the health of the fetus.

In February 2002, methadone treatment clinics in the United States received a letter from Barbara Harris, founder of CRACK (Children Require A Caring Kommunity), urging them to refer clients to her program. CRACK offers \$200 to current and former drug users to get sterilized or to use doctor controlled, long acting methods of birth control. "It is important for those using methadone or other drugs to refrain from getting pregnant," she wrote. Over 130 leading public health groups, health care providers, and activists

signed on to a letter decrying the suggestion that MMT is dangerous during pregnancy. Harris responded by saying: "We have also been told by many working at methadone clinics that methadone 'is not good for babies!'"

In fact, methadone can improve women's health and the outcomes of their pregnancies. According to a 1998 report by the Center for Substance Abuse Treatment, a panel of experts gathered by the United States government, concluded: "Methadone maintenance is strongly encouraged for all pregnant opioid-dependent women." The Institute of Medicine of the National Academy of Science, the National Institute on Drug Abuse of the National Institutes of Health, the Office of Research on Women's Health, the Office of National Drug Control Policy, and the United States Department of Health and Human Services all agree that methadone is indicated for the pregnant opiate user and that it provides major health benefits to the

expectant mother, her fetus, other children and family members, and the larger community.

Despite this consensus, many still believe that detoxifying a pregnant woman is better than allowing her to pursue methadone therapy. According to the experts this is bad advice. Detoxification not only makes relapse to heroin use likely (and with it the incidence of disease, malnutrition, and inadequate prenatal care) but it also can be harmful in its own right, potentially inducing an early abortion or leading to fetal distress. Moreover, MMT does not impair a child's developmental or cognitive functioning. Some babies born to mothers dependent on methadone (or other opiates) will have the opiate in their systems, but studies show that children can be weaned successfully and safely with no adverse or lasting effects.

Even after decades of experience with MMT, compassionate and effective drug treatment for women, who face unique stigmatization for their drug use, is almost impossible to find in the United States. Most treatment programs fail to recognize that many women turn to drugs as a way to block out traumatic experiences, such as childhood sexual abuse, rape, or domestic violence. Most treatment programs were set up for men. Those looking to establish drug treatment and substitution programs should do everything they can to make the programs welcoming and appropriate for women, including pregnant women and mothers.

Lynn Paltrow is the executive director of National Advocates for Pregnant Women in New York City. For more information, see www.advocatesforpregnantwomen.org.

SUBSTITUTION THERAPY'S LITTLE KNOWN BENEFIT



Overdose in Volgograd, Russia. Photo © 2003 John Ranard

Developing adequate, efficient, and humane models of OST is not only valuable for its immediate effect of reducing harm. It is also a type of vaccination against the mass overdose of an aging population of heroin users.

by Dan Bigg

Opiate substitution therapies (OSTs) are best known for reducing opiate dependence and the harm that comes from it. OSTs can also prevent overdose death. Ironically, for many considering OST, fear of overdose is a significant impediment. The truth is overdose is caused by separating people from heroin through detoxification or criminal justice approaches, not OST.

According to an article written by John Strang, et al. in the May 3, 2003 *British Medical Journal*: "Patients who 'successfully' completed inpatient detoxification were more likely than other patients to have died within a year." The article went on to note that "no patients who failed to complete detoxification died." Several studies over the last decade show OSTs have been successful in reducing death among participants by 75 percent. OST is one of the most proven interventions for reducing premature deaths among opiate dependent people. If your fear is overdose, your most proven effective response is OST.

Lethal overdose is largely a phenomenon of older people in their late 30s and early 40s whose physical condition has become weakened and more stressed over time. Countries that have large populations of young opiate users are experiencing an overdose honeymoon. But new heroin injectors who are protected from overdose now by their healthier bodies will age. Developing adequate, efficient, and humane models of OST is not only valuable for its immediate effect of

reducing harm. It is also a type of vaccination against the mass overdose of an aging population of heroin users.

The tolerance people develop to opiate effects is also a protection from overdose. A good OST program will help heroin users develop this protective tolerance. I have never heard of an opiate overdose death in a safer injection room (SIR) anywhere in the world. People receiving OST should have easy access to SIRs for overdose prevention and to protect their health in general. It is inevitable that some people will continue to inject and that reducing harm through safer injection continues to be important for people in treatment.

If prevention of overdose fails, naloxone, a full opiate agonist, can be used as a pure antidote for opiate intoxication. It reverses the effects of opiate overdose if given immediately to someone who is overdosing. But naloxone has not prevented increases in overdose deaths even in places with high quality emergency services because it has not been used quickly enough. Putting naloxone into the hands of people actually using opiates is increasingly proving to be an effective way to reverse opiate overdose. Chicago Recovery Alliance in the United States has trained almost 2,000 people in opiate overdose, rescue breathing, and naloxone prescription. After a decade's increase, local opiate-related overdose deaths dropped 20 percent from 2000 to 2001.

Dan Bigg is the director of Chicago Recovery Alliance in Chicago, U.S.A.

FINDING ALTERNATIVE SUBSTITUTES

Doctors decided to provide services to drug users with what they could get their hands on rather than complain, as many do, that they could not provide any substitution treatment at all.



Making liquid opium from opium tar, Astrakhan, Russia. Photo © 2003 John Ranard

by Anna Moshkova

Substitution treatment with opiate-based drugs such as methadone is illegal in Russia. Nevertheless, the need for therapeutic support for drug users in Russia is assumed to be so great that one group of doctors started a pilot project with an alternative drug: Tramadol-retard. The doctors decided to provide services to drug users with what they could get their hands on rather than complain, as many do, that they could not provide any substitution treatment at all.

The project—which will remain anonymous because of the hysteria over substitution therapy in Russia—was one of the first attempts to provide therapeutic support for drug users in Russia. It took place in a large industrial city that has over 11,000 injection drug users (IDUs) and a low prevalence of HIV (110 cases.)

In November 2000, the group started the first phase of the project. They wanted to determine the need for substitution therapy and how well Tramadol-retard would work.

They chose this drug because its pharmacology is well known, it has prolonged action (6-8 hours,) and it is taken orally. Tramadol-retard also creates no euphoria, has a good capacity to reduce opiate withdrawal, and is not detected in urine when testing for opiates.

The average project participant was 31 years old with a long history of drug use, a low social position, and a high incidence of criminal activity. However, the participants who attended the program most regularly (21 or more times a month) were older, had used drugs for longer, and were more apt to be married and employed than the participants who attended less frequently. The project's conclusion was that it could be most effective for socially adapted middle-aged people with a long history of drug use. These people became the project's target group for the second stage of the pilot.

The next phase, begun in February 2002, aimed to decrease drug use over a long period of time among the participants. Tramadol-retard was taken twice daily. If random urine drug tests came up negative for over a week then participants were allowed to take their second daily dose home. In all, 37 IDUs participated in the program. Less than half dropped out of the program. After three weeks, testing revealed that 55 percent no longer used drugs; 36 percent had one or two positive drug tests; and 9 percent continued to use drugs periodically. The project concluded that there is a target group that can benefit from substitution therapy and that within this group the majority will stop using drugs altogether.

Harm reduction projects, especially those implemented by narcology clinics, can benefit from this trial, in spite of its small size. If enough such successful projects emerge around Russia, ultimately the walls of resistance to substitution therapy will break down.

Anna Moshkova is a program officer at IHRD.

IHRD'S ADVISORY GROUP

Desmond Cohen is the former director of the HIV and Development Program at the United Nations Development Program

Judit Fridli is the founder and chair of the Hungarian Civil Liberties Union

Krzysztof Krajewski is a professor of criminology at Jagiellonian University in Poland

Ethan Nadelmann is the executive director of the Drug Policy Alliance

Aryeh Neier is the president of the Open Society Institute

Robert Newman is the director of the Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center

And many thanks to departing advisors Semyon Gluzman and Gennady Roshchupkin for their valuable service to IHRD.

METHADONE, WHERE ARE YOU HEADING?!

by Jowita Fras

We are junkies: damn punks, HIV-generating waste, an abscess on the smooth, flawless ass of healthy society—that's how we are seen. And we start to wonder if there is some truth in it. But we are also damn professionals in our business. Shouldn't we, since we already have the doubtful honor of being called contemporary heretics, just one time, before being burnt, shout out that the earth is round? To be honest, we're best at shouting. But we shouldn't have to pay for it with disciplinary dismissal from a methadone program—a spectacular, pompous, and ineffective gesture.

Methadone maintenance therapy (MMT) makes the reduction of harm possible, both for the patients and for society with which a drug user is in ceaseless conflict. The philosophical premise of harm reduction is that if 100 percent success is impossible, you should choose the lesser evil. Instead of wasting energy and time (of which drug users definitely don't have much) on Sisyphean attempts to reach the remote goal of abstinence, we should concentrate on making our drug dependence less ruthless, on freeing ourselves from the everyday quest for drugs.

Polish methadone programs, which have been around for only 10 years, maintain a few hundred people. Most patients have forgotten what withdrawal means. Some have started families and are now enjoying motherhood, others are studying or working. And even if not all patients have settled down, harm reduction has helped change their lives for the better. The stability and normalcy that programs can bring to the lives of drug users is a moral triumph over anti-drug hysteria.

Some of the Polish programs, however, try to reduce methadone doses without a patient's consent, or pressure long-standing clients to think about giving up the substitute. Reducing a client's dose of medication for using illegal drugs while taking part in the program is an unethical punishment for breaking the rules. And dismissal from an MMT program



Jowita Fras, left, and members of MONAR in Planta Park, Krakow, Poland. Photo © 2003 MONAR

Every time patients are cut off from regular, legal, and free substitution, their freedom, health, and even life are threatened.

for using illegal drugs has nothing to do with harm reduction. The proper reaction should be more care, not less.

What can patients do when they receive repressive treatment? Instead of an atmosphere of friendliness and kindheartedness there is fear, distrust, and suspicion that makes patients careful of what they say. It is easy to earn disapproval but extremely difficult to earn praise and privileges. Blaming the program staff is a simplification—often they are carrying out instructions from higher authorities. And the patients are not faultless. But their transgressions are a natural side effect of MMT and they should not blind us to the basic goals of MMT: to promote self-dependence and stabilization. Instead, at every step patients are reminded of who they were or are and who is in charge. The staff retain their privilege of the final word or make impossible demands. They frequently turn down patients. Every time patients are cut off from regular, legal, and free substitution, their freedom, health, and even life are threatened.

The most serious concern is when rumors fly that a program's fate hangs in the balance and that the people who have been stabilized by methadone and have resumed active lives, yet still depend on a substitute, may be cut off. Termination of a program is every patient's worst nightmare. Although much of the misery would, as usual, come upon the patients, there would be other consequences: real armageddon in the streets.

Those who are "in charge" of methadone programs and recklessly playing this game should consider the words, the origin of which has slipped my mind: Oh gentlemen, gentlemen you are not playing fair, for you it's a trifle, for us a matter of life and death.

Jowita Fras has been in a methadone program in Krakow, Poland, for three years after many years as a heroin user. She is the mother of a two-year-old. This article is translated and excerpted from the original in *Monar na bajzlu*, published in Poland.

HUMAN RIGHTS ORGANIZATIONS were enlisted in the fight for harm reduction and against HIV/AIDS in Eastern Europe and the former Soviet Union at a meeting in Budapest in June that was organized by IHRD and Human Rights Watch. Representatives of human rights, HIV/AIDS, and harm reduction organizations from Georgia, Kyrgyzstan, Lithuania, Poland, Russia, Tajikistan, and Ukraine attended the conference.

IHRD'S LEGAL ADVOCACY INITIATIVE'S first three projects attended a capacity building training in Kiev in May. The training, organized by IHRD and the Public Law Initiative, was attended by the All-Ukrainian Harm Reduction Association; "AntiAIDS" Harm Reduction NGO, Russia;



Methadone distribution counter in Ljubljana, Slovenia. Photo by Andrej Kastelic

experienced harm reduction advocate with the Open Health Institute, Moscow, and Roman Dudnik, president of the Russian Network of People Living with HIV/AIDS and a staff member of AIDS Foundation East-West, Moscow, attended meetings with leaders in the fields of HIV, harm reduction, human rights, and law.

TRAINING IN DATA COLLECTION, monitoring, and evaluation is coming soon to the more than 80 harm reduction projects that have asked for it. IHRD's working group on the subject met in March in New York to identify the training needs of projects in the region and to start developing curricula for a practical training.

THE SEX WORK technical advisor working group met in Prague in June following the seminar "Sex, Drug Use, Mobility, and HIV/AIDS in Central and Eastern Europe," organized by the European Project AIDS and Mobility. The conference brought together service providers from across CEE to talk about the convergence of drugs and sex work.

ADVOCACY IS EASY as long as you follow the training manual written by David Burrows with input from dozens of activists, scholars, and service providers from CEE/fSU

and elsewhere. The manual will be published on IHRD's website in September. A set of three initial advocacy trainings began in Krakow in May, led by Gerry Hale. IHRD funded the project in cooperation with the International Harm Reduction Association, the World Health Organization, and HIT, a UK-based harm reduction training institute.

"UNINTENDED CONSEQUENCES: Drug Policy Fuels HIV Epidemic in Russia and Ukraine" was IHRD's contribution to a U.N. Commission on Narcotic Drugs meeting in Vienna in April. IHRD and the U.K. NGO "Forward Thinking on Drugs" organized a session highlighting the links between drug policy and the HIV epidemic. IHRD's follow up plans include working with drug policy decisionmakers to ensure that harm reduction principles are better established within national drug strategies. IHRD's report is available at http://www.soros.org/harm-reduction/pub_files/unintended_consequences.pdf.

THE 14TH INTERNATIONAL CONFERENCE on the Reduction of Drug Related Harm in Chiang Mai, Thailand, in April was attended by scores of professionals from CEE/fSU, including 21 who received scholarships from IHRD.

NEWS BRIEFS

and Public Union (NGO) RAN, Tajikistan. The projects initiate legal advocacy, provide public education, and offer legal assistance to harm reduction program staff and clients.

HIV/AIDS AND USER ACTIVISTS had a chance to consider enhanced ways of working together. At the conference "Increasing Advocacy Possibilities for the Rights of People Living with HIV/AIDS in the Newly Independent States" in Minsk, Belarus, in May, participants identified their priorities for the advocacy process and worked out action plans. Donors present at the meeting were poised to help put these action plans to work within five months of the conference through a grants competition.

GAY MEN'S HEALTH CRISIS hosted two more activists in May and June for an intensive six-week course in New York as part of IHRD's continuing HIV Advocacy Fellowship Program. Vitaly Zhumagaliev, an

THE GLOBAL FUND TO FIGHT AIDS, TB, and Malaria has reappointed Kasia Malinowska-Sempruch to serve on its Technical Review Panel for an additional year.

NEW YORK CITY'S Lower East Side Harm Reduction Center has named IHRD's Matt Curtis to its board. Sue Simon has completed her term as board chair after serving for five years.

SUBSTITUTION TREATMENT

GEORGIA NOW ALLOWS SUBSTITUTION TREATMENT, and the Ministry of Health has agreed to support, with IHRD, two pilot methadone projects in Tbilisi and Batumi. The long and complex process of advocating for harm reduction in Georgia started with round table debates in 1999 followed by high level policy study tours. Eventually needle exchange projects were opened in 2001 and advocacy was sustained by a coalition of local medical and legal professionals.

UKRAINE LEGALIZES METHADONE after hard work by its advocates. Pilot methadone projects will begin in the second half of 2003. Ukraine's Ministry of Health, the World Health Organization, UNDP-Ukraine, and

the International Renaissance Foundation-Kiev organized a conference in June to discuss access to antiretroviral drugs for IDUs and substitution treatment for opioid dependence.



In this photo taken at the Kazan conference, Anna Moshkova of IHRD and Mario Sanchez of the Clinique Montevideo, Paris, are being interviewed by local media. Photo by Leonid Vlasenko.

INSPIRED BY AN IHRD STUDY TOUR to methadone clinics in Paris, Nice, and Geneva in October 2002, co-sponsored by Beth Israel Medical Center and hosted by the Clinique Montevideo, Vladimir Mendelevich, M.D., organized a substitution therapy conference in his home city of Kazan, Russia, in March. Substitution therapy experts presented reports to health professionals at the IHRD-supported meeting. Although Russian law forbids the use of opiate agonists, the participants supported the idea of substitution therapy pilot projects

to determine its usefulness in Russia. Mendelevich hopes to continue to deliver scientific information on substitution therapy to his colleagues throughout Russia.

SLOVAKIAN HARM REDUCTIONISTS, encouraged by information they got at an IHRD/East East Program meeting in March, were able to negotiate with the pharmaceutical company Schering Plough to decrease its price of Subutex by almost 25 percent. The workshops held in Bratislava discussed the costs and access of substitution treatment in Czech Republic, Hungary, Poland, and Slovakia.

WEBSITES

WWW.AIDS-DRUGS.UZ has information on drug use, HIV/AIDS, and sexually transmitted infections in Uzbekistan. The all-Russian site is a joint project of the Uzbek government and the U.N. Office on Drugs and Crime.

WWW.CATIE.CA provides HIV/AIDS treatment information to people living with HIV/AIDS, caregivers, and service organizations. The site, in English and French, has information that could be useful to harm reduction and HIV/AIDS professionals in CEE/fSU.

POLICE AND DRUG USERS: FRIENDS FOR...LIFE

Communication between drug users and the police has always been less than good. As long as drug using is illegal, this is somewhat understandable. But even people on opposite sides of the law can understand and treat each other better. In an effort to increase police officers' knowledge about HIV prevention and harm reduction, IHRD has worked with the Open Society Justice Initiative in Budapest to create a training module that focuses on an accurate understanding of drug use and drug related harms. Incorporating human rights standards into policing is a top goal of the training.

The training module leads students through an introduction to harm reduction and human rights concepts, the legal and policy frameworks for drugs policing, and guidelines for police interventions. The multimedia format CD-ROM that includes text animation and video

scenarios will introduce a new curriculum to police training institutes in CEE/fSU, train police instructors in its use, and ultimately improve police relations, safety, and effectiveness in police interactions with drug users.

Police training academies in Bulgaria, Czech Republic, Latvia, Lithuania, Moldova, Poland, Romania, and Slovakia have agreed to include the training module in their 2003 training curricula. The first training of police trainers will be in the fall of 2003.

IHRD is also continuing its series of study tours, bringing police from around the region to Krakow, Poland, for intensive meetings with local police and harm reductionists. In the first half of the year groups from Albania and Armenia went to Krakow. Groups from Belarus, Central Asia, Georgia, and Lithuania are expected to go in the second half.



ZAHARI NIKOLOV

1970-2003

On June 5, 2003, our colleague and friend Zahari Nikolov died tragically. It is a great sorrow for us. We lost an excellent colleague and very close personal friend. We will remember Zahari for all those moments of joy and happiness and also the challenges that we went through together. We will remember Zahari's professionalism and his openness to give help and support. Zahari supported the Bulgarian harm reduction program as well as many other programs in Central Asia and Eastern Europe. We are very sad and we feel very forsaken. We want to express our deep sympathy for all who loved him.

Initiative for Health Foundation, Bulgaria

On the table in our office an envelope says, "For Zahari." No last name. Because there is only one Zahari. In the envelope are a few photos of him. In one picture Zahari does not look like the person we remember. We showed this photo to some friends and asked them to guess his profession. The answers were strikingly similar—he is a poet. He was a Poet. He loved his work and his people, and we loved and respected him. But poets do not live long—they burn out, giving the fire of their souls to others. As a great Russian poet said: "Death chooses the best..." With deep condolences to Zahari's family and friends.

*Sergey Oleynik and Nadezhda Fedoseeva for the harm reduction team
in Penza, Russia*

Zahari was a true friend, always ready to help and support in a difficult situation, a kind person one could always rely on in a team, in any circumstance. I have the feeling that if it were possible to talk with Zahari, to spend some more time with him, it would be possible to unite Zahari's and our efforts against the disease and ultimately overcome it together...

Emilis Subata, Vilnius Substance Abuse Treatment Center, Lithuania

Zahari was always surrounded by co-workers and "clients." Whether professional colleagues or the most down-trodden, vilified, abandoned Roma drug users, all seemed to respect and love this extraordinary man. They respected and loved his humor, his compassion, his commitment to the medical needs of those he served, his dancing talent, his ability to convey lessons from his wealth of experience. We are all blessed by the privilege and pleasure of having known this rare and yet, as we know, all-too-human individual. We will honor his memory best by carrying on the work to which he was so devoted.

Bob Newman, Edmond de Rothschild Chemical Dependency Institute, USA

We lost him very suddenly. The emptiness he left us will never fill.

Aleksandr Slatvitskiy, Klaipeda Substance Abuse Treatment Center, Lithuania

I first met Zahari at a training for new harm reduction applicants in Bratislava. As the training team sat and ate breakfast, Zahari got up from the table and asked a young man who was sitting by himself to join us. I was struck by the thoughtfulness and kindness of this simple gesture, and it became an unforgettable first impression of a man who would become a favorite colleague and a friend.

Jennifer Traska Gibson, IHRD, USA

I knew Zahari only a little. I am still trying to come to grips with the reality of his death. He was a warm, caring man with a radiant smile and great professional passion for his work. Unlike so many other men in the region he was fighting alongside women, ensuring their equal access to harm reduction and other services. He gave his heart to others piece by piece...until nothing was left there for him. A tragedy.

Anna Alexandrova, Canadian AIDS Society, Canada

Memories of Zahari. A complicated and surprising man; full of passion for his work; a healer; had an easy laugh. Proud father of two girls; understood the importance of bringing home the prettiest outfits for Barbie. Wanted to make the world a better place; achieved it. Had dark eyes that sometimes twinkled and sometimes were sad. A natural leader in both thought and deed. Powerful advocate; beautiful dancer. Friend.

Sue Simon, IHRD, USA

First Zahari was a man who cared
Cared to nurture life among those most at risk of losing it
Thinking freely to create health in Bulgaria
Was not always easy in face of other goals among colleagues
Loving his children and the lives he and Margret brought to the world
His children helped him see and gave him strength
While the world, today, made a struggle to his ideals and Caring
Zahari beamed at toys for his children and the face of a person newly aware
Of how to care for themselves while caught up in habits
Scores of people had the pleasure of knowing and laughing with Zahari
As he traveled the world to help and spark Life in so many places
He was born to father revolution at home and away where life was at risk
Of losing its firm hold and this is not an easy way to Care...
Zahari will be missed by his kindred spirits everywhere...

In sorrow, Dan Bigg, Chicago Recovery Alliance, USA

Zahari's death is a terrible loss for me. I made my first site visit with OSI/IHRD with Zahari, and I learned many things from him. He was wonderful, fun to be with, and very kind and supportive. He quit the Russian technical advisor team last year, but still every time I think about the team one of the first faces that comes to my mind is his.

Alec Khachatryan, UNAIDS, Russia

I don't have enough words to share my feelings.

Elena Jankova, Initiative for Health Foundation, Bulgaria

The harm reduction movement in Romania lost a great friend. We learned a lot from Zahari as he generously helped us from the beginning and shared his experiences. He came to Romania once as a trainer for new projects. Zahari's advice is still reflected in many of the projects' successes and in many avoided mistakes. Probably many will remember Zahari for his professionalism, I will! But I will also remember him as he was last time we met, a happy loving father choosing a beautiful toy for his daughters.

Monica Ciupagea, IHRD, Hungary

I met Zahari four years ago in Sofia. IHRD was not sure how to help expand Bulgaria's harm reduction programs. It took only a few minutes during my first meeting with Zahari to realize that he was our answer. Zahari was a leader,



a colleague, an inspiration. He was also a friend. During my stay in Bulgaria my mother's health took a turn for the worse. Zahari helped me make the decision to leave Bulgaria, in the middle of meetings, the day of his daughter's birthday party, to make sure I got home in time to say good-bye to my mother.

Kasia Malinowska-Sempruch, IHRD, USA

Zahari, it is hard to get over this loss. Our only comfort is that some day we will see you again...

Marek Zygodlo and Grzegorz Wodowski, MONAR, Poland

When I first met Zahari, he and I were both just starting outreach NEP projects, the first in our countries. We understood each other. I will always remember how we discussed what if our projects fail? It didn't happen, but to have somebody to share the fear and happiness with is a wonderful thing. We became members of the Central and Eastern European Harm Reduction Network steering committee at the same time. Anytime I look back there he is. We didn't meet very often. But every meeting was inspiring, full of laughs, speaking about all kinds of issues. I remember how proudly he always showed pictures of his loved family, when he bought a small computer for his older daughter. Speaking about them with passion and strong love. How he happily introduced new colleagues from Bulgaria to the harm reduction community. Zahari is a part of me, of my history, and it's hard for me to believe that he is not with us anymore. I will always remember him. I miss him very much.

Katarina Jiresova, Odyseus, Slovak Republic

Dr. Zahari Nikolov, a psychiatrist who dedicated his professional life to furthering the best practices of harm reduction in Central and Eastern Europe and the former Soviet Union, helped start the first methadone program in Bulgaria. The program's participants created this sculpture to express how Zahari and methadone changed their lives. Zahari also formed the first NGO in Bulgaria dedicated to reducing drug-related harm, the Initiative for Health Foundation. Zahari was an IHRD technical advisor for many years and sat on the steering committee of the Central and Eastern Europe Harm Reduction Network. At the time of his death, Zahari was the director of the Sofia Municipality Center for Addictions.



CONTACTS

IHRD COORDINATORS

Albania

Valdete Sala and
Ledja Curri
Open Society Fund—Albania
soros-al@osfa.soros.al

Armenia

Anahit Papikyan
Open Society Institute—Armenia,
panaida@osi.am

Azerbaijan

Layla Imanova
*Open Society
Institute—Azerbaijan*
limanova@osi-az.org

Belarus

Nastia Kamlik
Positive Movement
kamnast@tut.by
Valentina Stalyho
United Nations Development Program
valentina.stalyho@undp.org

Bulgaria

Elena Zlatanova
Open Society Foundation—Sofia
ezlatanova@osf.bg

Croatia

Danica Eterovic
Open Society Institute—Croatia
deterovic@soros.hr

Czech Republic

Vlasta Hirtova
Open Society Fund—Prague
vlasta.hirtova@osf.cz

Estonia

Mall Hellam
Open Estonia Foundation
mall@oef.org.ee

Georgia

Lasha Zaalishvili
Open Society Georgia Foundation
lasha@osgf.ge

Hungary

Katalin Szoke
Soros Foundation—Hungary,
szoke@soros.hu

Kazakhstan

Valeria Gourevich
Soros Foundation—Kazakhstan
vgourev@ Soros.kz

Kyrgyzstan

Elvira Muratalieva
Soros Foundation—Kyrgyzstan
elvira@soros.kg

Lithuania

Virginija Ambraseviciene
Open Society Fund—Lithuania
virginij@osf.lt

Macedonia

Vera Dimitrievska
Open Society Institute—Macedonia
vdimit@soros.org.mk

Moldova

Viorel Soltan
Soros Foundation—Moldova
vsoltan@soros.md

Poland

Aleksandra Duda
United Nations Development Program
aleksandra.duda@undp.org

Romania

Alina Bocai
UNAIDS Romania
alina.bocai@undp.ro

Russia

Alexei Bobrik and
Vitaly Zhumagaliev
Open Society Institute—Russia
zhuma@osi.ru

Slovak Republic

Tanja Rajniakova Hicarova
Open Society Fund—Bratislava
tana@osf.sk

Tajikistan

Zarina Abdullaeva
Open Society Institute—Tajikistan
azarina@tajik.net

Turkmenistan

Rustam Alymov
*United Nations Development Program
Foundation—Kyiv*
rustam.alymov@untuk.org

Ukraine

Denis Poltavets
*International Renaissance
Foundation—Kyiv*
poltavets@irf.kiev.ua

Uzbekistan

Iskandar Ismailov
Open Society Institute—Uzbekistan
iskandar@osi.freenet.uz

IHRD TECHNICAL ADVISORS

COUNTRY TAs

Albania

Grzegorz Wodowski
MONAR Krakow, Poland

Bulgaria

Elena Yankova, *Initiative
for Health Foundation, Bulgaria*

Central Asia

Natalya Babina, *Pavlodar Regional
AIDS Center, Kazakhstan*

Batesh Bapenova, *Aqmola Regional
AIDS Center, Kazakhstan*

Olga Blinova
Anti-AIDS Center NGO, Russia

Natalia Kirillova
NGO “RAN,” Tajikistan

Sergey Oleynik
Anti-AIDS Foundation, Russia

Yevgeny Ten
NGO “Socium,” Kyrgyzstan

Tatiana Vanenkova, *Nikolaev
Charity Fund “Unitus,” Ukraine*

Marek Zygodlo, *Krakow Association
for Drug Use, Poland*

Croatia

Grzegorz Wodowski
MONAR Krakow, Poland

Macedonia

Elena Yankova, *Initiative
for Health Foundation, Bulgaria*

Russia

Asya Bidordinova
AIDS Foundation East West, Russia

Olga Blinova
Anti AIDS Center NGO, Russia

Alec Khachatryan,
UNAIDS Moscow, Russia

Vladimir Musatov
Médecines du Monde, Russia

Sergey Oleynik
Anti-AIDS Foundation, Russia

Evgeny Petunin
Stop AIDS Foundation, Russia

Russia (cont'd)

Anya Sarang
Independent consultant

Iraida Sivacheva, *Pskovian
Anti-Aids Initiative, Russia*

Alexander Tsekhanovich
Médecins du Monde, Russia

Tatiana Vanenkova, *Nikolaev
Charity Fund “Unitus,” Ukraine*

Igor Vassilenko, *Public
Foundation, “Help,” Kazakhstan*

Ukraine

Sergey Kostin
The Way Home, Ukraine

Andrey Protopopov
*Charitable Anti AIDS Fund,
Ukraine*

ISSUE TAs

Data Collection

Aleksandr Slatvickij
*Klaipeda Addiction
Treatment Center, Lithuania*

Grzegorz Wodowski
MONAR Krakow, Poland

HIV Treatment

Marek Beniowski
*Center for AIDS Diagnostics
and Therapy for Katowice
District, Poland*

Jay Dobkin
*Columbia Presbyterian Hospital,
USA*

Methadone

Tynchtykbek Asanov, *Republican
Narcology Center, Kyrgyzstan*

Andrej Kastelic
*Center for Treatment of Drug
Addiction, Slovenia*

Emilis Subata
*Vilnius Substance Abuse Treatment
Center, Lithuania*

Sex Work

Robin Montgomery
AIDS Foundation East West, Russia

UPCOMING EVENTS

November 5-8	November 17-18	December 4-6	December 8-11	April 5-7, 2004
<p>Drug Policy Alliance Bi-Annual Conference</p> <p><i>East Rutherford, New Jersey, USA</i> www.drugpolicy.org</p>	<p>Buprenorphine: Voices of Experience</p> <p><i>New York City, USA</i> www.opiateaddictionRx.info</p>	<p>EUROPAD Italian Conference—Methadone and Other Substitutive Therapies</p> <p><i>Pietrasanta, Italy</i> www.europad.org</p>	<p>6th International Conference on Home and Community Based Care for People Living with HIV/AIDS</p> <p><i>Dakar, Senegal</i> www.dakarvih2003.sn</p>	<p>European Opioid Conference</p> <p><i>Visegard, Hungary</i> www.demon.co.uk/ interfocus/eocweb</p>