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Access to opioid agonist therapy in Russia: time for reform

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Russia, a country of 144 million people, has one of the fastest growing HIV epidemics in the world. Although HIV mortality and transmission have decreased globally, the incidence of HIV has increased in Russia, where more than 1·1 million people are infected with HIV and the number of new infections exceeds 103 000 cases per year¹. UNAIDS estimates that 80% of new infections in Eastern Europe and Central Asia occurred in Russia in 2015, fuelled by injection drug use². The efforts to halt the spread of HIV are hindered by the policies of the Russian government, which has scaled back harm reduction efforts and denied access to opioid agonist treatment to 1·8 million people who inject drugs in Russia, many of whom inject opioids.^{3,4}

In *The Lancet HIV*, Javier Cepeda and colleagues⁵ provide a compelling argument for the Russian government to re-evaluate their zero-tolerance drug policy toward the use of opioid agonist therapy (OAT) to better disrupt the HIV epidemic⁵. OAT with methadone and buprenorphine is a highly effective and cost-effective treatment for opioid use disorder and prevention of HIV.⁶ UNAIDS and WHO recommend OAT as a proven evidence-based intervention for reducing or eliminating illicit drug use⁷. OAT has been shown to be safe and tolerable, and leads to a reduction in crime and incarceration, increased social stability and employment, and better engagement in care among patients⁸.

The analysis provided by Javier Cepeda and colleagues is timely and persuasive. The authors develop a sophisticated mathematical model for injection and sexual transmission of HIV for two prominent cities in Russia: Omsk in the Siberian district and Ekaterinburg in the Ural district. Omsk and Ekaterinburg capture many trends that shape life in many cities across Russia. Both Omsk and Ekaterinburg had emerged as important industrial and technological hubs during the Soviet era, thriving in the realms of culture and science. Both cities saw their economic fortunes decline after the transition to a market economy and both cities provide a living testament to the devastation caused by the HIV and opioid co-epidemics in Russia. 1·8% of the total population of Ekaterinburg is thought to be infected with HIV, and HIV prevalence in Omsk is increasing.^{5,9}

Armed with detailed epidemiological and behavioural data, Cepeda and colleagues use modelling to show that scale-up of harm reduction programmes can have a substantial effect on HIV prevention. They found that scaling up of OAT and needle and syringe exchange programmes to 50% coverage, combined with increased recruitment to antiretroviral therapy, has the potential to prevent 58% (2·5–97·5 percentile interval 46–69) of new HIV

infections in Omsk and 38% (26–50) of new HIV infections in Ekaterinburg among people who inject drugs over the next 10 years. Following expansion of these three harm reduction programmes, the overdoses are projected to decrease by about a third in both cities over time. The future projections made by the authors show that the policies currently implemented by Russia are not sustainable and effect large social costs. The authors convincingly show that a correct combination of policies could substantially alter the outcomes in addressing the incidence of HIV and frequency of fatal overdose.

Although compartmental models, such as the one by Cepeda and colleagues, provide a useful insight into the scaling up of interventions to treat HIV, further studies are needed to guide HIV prevention efforts in Russia and globally. First, better surveillance data are required that would not only measure the rate of HIV transmission and prevalence of fatal overdose, but would allow us to understand population risk heterogeneity better across the different settings. These data should include population mixing patterns and changes in network structures that could be used to develop more targeted interventions and improve the validity of models. Improved estimates of the causal effects of harm reduction programmes in reduction of transmission are also needed. The effectiveness of harm reduction programmes is not guaranteed to translate to other settings, including Russia, without effective implementation and commitment of public resources.

The evidence from countries such as Ukraine, where OAT has been legal for more than a decade, suggests that the road to OAT scale-up is fraught with additional challenges. Studies¹⁰ of people who inject drugs in Ukraine suggest that individual-level barriers, including perceived ineffectiveness of treatment among patients, fear of law enforcement, and social stigma have contributed to individuals' unwillingness to start OAT, and these barriers are also likely to be present in Russia.

Scaling up of OAT also requires a focus on retention in care, which includes adequate dosing and adherence to medication to reduce concurrent drug use.¹¹ OATs are not a magic bullet against addiction, but they might prevent exacerbation of the problem by allowing the patients to better manage their addiction and to slow down the transmission of HIV infections and to prevent fatal overdose. A commitment to support and expand harm reduction programmes, including OAT, is a crucial step in the right direction. Without policy reform and commitment, Russia's current prospects for stopping the HIV epidemic appear bleak.

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