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CONTINUATION OF OPIOID AGONIST THERAPY AND NEEDLE AND SYRINGE PROGRAMMES DURING THE COVID-19 PANDEMIC IN UNODC HIGH-PRIORITY COUNTRIES FOR DRUG USE AND HIV

Situation Report during the first half of 2020

UNITED NATIONS OFFICE ON DRUGS AND CRIME
Vienna

Continuation of Opioid Agonist Therapy and Needle and Syringe Programmes during the COVID-19 Pandemic in UNODC High-Priority Countries for Drug Use and HIV

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ABBREVIATIONS

ART	antiretroviral therapy
CND	Commission on Narcotic Drugs
HBV	viral hepatitis B
HCV	viral hepatitis C
HRI	Harm Reduction International
IEC	information, education and communication
NSP	needle and syringe programme
OAT	opioid agonist therapy
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organization

DEFINITIONS OF KEY TERMS

Advocacy is the process of communication for change, with specific goals directed at individuals and groups that can bring about reforms in policy, law, structures, services and social or cultural environments.

Community-led interventions are interventions that are designed, delivered and monitored by organizations or networks of people who use drugs.

Harm reduction: For the purposes of this operational tool, harm reduction is defined as a comprehensive package of evidence-based interventions, based on public health and human rights, including needle and syringe programmes (NSPs), OAT and naloxone for overdose management.[1] (WHO 2022)

Low-threshold services aim to minimize the barriers a patient may face in relation to starting, continuing and re-engaging in opioid agonist therapy.

Opioid use disorders are characterized in the International Classification of Diseases Eleventh Revision (ICD-11) by the pattern and consequences of opioid use. This group of disorders includes the harmful use of opioids and opioid dependence.

Opioid dependence is defined in the ICD-11 as a "disorder of regulation of opioid use arising from repeated or continuous use of opioids. The characteristic feature is a strong internal drive to use opioids, which is manifested by impaired ability to control use, increasing priority given to use over other activities and persistence of use despite harm or negative consequences. These experiences are often accompanied by a subjective sensation of urge or craving to use opioids. Physiological features of dependence may also be present, including tolerance to the effects of opioids, withdrawal symptoms following cessation or reduction in use of opioids, or repeated use of opioids or pharmacologically similar substances to prevent or alleviate withdrawal symptoms. The features of dependence are usually evident over a period of at least 12 months but the diagnosis may be made if opioid use is continuous (daily or almost daily) for at least 3 months".

Opioid agonist therapy (OAT) refers to the prescription of opioid agonist medications with long-lasting effects at an appropriate dose to people with opioid dependence. It is provided under medical supervision and supported by access to evidence-based psychosocial interventions. OAT is most effective as a maintenance therapy (sometimes referred to as opioid agonist maintenance therapy or OAMT) and should be provided for as long as a person requires it. OAT is the term used for this intervention in this document.

Opioid agonist medications are medications that bind to and activate opioid receptors. The World Health Organization (WHO) has listed methadone (full agonist) and buprenorphine (partial agonist) as essential medicines since 2005. Other medications used for OAT include (slow-release) morphine, opium tincture and diamorphine (heroin) [5]. Methadone and buprenorphine are the most-studied agonist medications and are the focus of this tool.

People with opioid dependence in this tool refers to people who meet the ICD-11 criteria for opioid dependence.

People who use drugs refers to people who use psychotropic (or psychoactive) substances for non-medical purposes.

[1] Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations, (WHO, 2022) https://apps.who.int/iris/rest/bitstreams/1453332/retrieve

KEY MESSAGES

This report describes how adaptations in the delivery of opioid agonist therapy (OAT) and needle and syringe programmes during the COVID-19 pandemic in the 24 UNODC high-priority countries for drug use and HIV contributed to ensuring the continuity and sustainability of comprehensive HIV, HCV and other low-threshold services for people who use drugs, and the mechanisms adopted to maximize HIV service coverage.

The report focuses on the first half of 2020, when in many countries the governments declared a state of emergency due to the growing risk of COVID-19.

In response, some countries adopted a more flexible approach than they had previously taken, such as allowing take-home OAT to ensure that OAT patients would continue on and adhere to treatment. Some countries implemented take-home OAT for the first time.

The benefits to OAT patients of take-home doses quickly became obvious. Many countries surveyed for the report saw an increase in demand for OAT and OAT enrolment. The introduction or expansion of take-home OAT was not accompanied by any observed increase in the number of overdoses, nor the number of incidents of diversion to the black market.

Take-home doses of opioid agonist therapy (OAT) for people who use drugs who are in treatment for opioid dependence have been recommended for many years by WHO, UNODC and UNAIDS. The progress made in this regard during the pandemic should be maintained to improve the quality of life of people who use drugs who receive OAT.

Most countries surveyed for this brief are developing plans to maintain take-home OAT. The progress made in this regard should be maintained to improve treatment adherence and quality of life for people who use drugs who are in treatment for opioid dependence, including in non-emergency settings.

The following key messages emerged from the countries surveyed in this report:

- It is critical that needle and syringe programmes (NSPs) and opioid agonist therapy (OAT) are not disrupted during emergencies.
- NSPs and OAT form part of the package of essential harm reduction services recognized by the United Nations for the prevention of HIV and viral hepatitis C among people who inject drugs.
- Many countries developed emergency plans to maintain the continuity of NSPs and OAT programmes during the COVID-19 lockdowns. In a very short space of time, countries adapted the delivering programmes within the restrictions imposed by the situation, to prevent the interruption of services.
- Temporary emergency guidelines included new modalities or flexibility for dispensing prevention and treatment commodities, such as lifting restrictions on the number of needles and syringes that could be distributed and allowing secondary distribution by peers; and allowing take-home doses or doorstep deliveries for OAT.
- OAT take-home doses are recommended for stable patients to allow for regular socioeconomic life and thus facilitating better coverage of the programmes and better adherence to treatment.
- Benefits of new or extended OAT take-home doses for the patients were observed in many countries. The implementation and/or scale-up of OAT take-home doses and other measures such as home delivery were not accompanied by any observed increase in the number of methadone overdoses, nor in the number of incidents of diversion.

- Most countries surveyed in this report are developing plans to maintain the initiatives that have been successful during the pandemic. In some countries this will require reforming legislation.
- The community of people who use drugs played a key role during the pandemic in advocating for greater flexibility in the implementation of harm reduction services.
- In many countries surveyed in this report, the community was engaged in COVID-19 harm reduction task forces or coordination platforms, as well as in the development and implementation of new guidelines, ensuring that measures were adapted to the needs of people who use drugs.
- In some cases, partnerships between community organizations and national authorities were established for the first time in response to the emergency.

KEY STEPS TO ENSURE THE CONTINUATION AND SUSTAINABILITY OF HARM REDUCTION SERVICES DURING EMERGENCIES

- Recognize OAT and other harm reduction services as essential medical and psychosocial services
- Consider reviewing, within the framework of national legal systems, domestic legislation and regulatory and administrative mechanisms, where needed, to allow for take-home doses of OAT
- Develop national clinical guidelines for the provision of take-home OAT
- Engage and adequately resource community-led organizations to lead and support the delivery of take-home OAT and other harm reduction services
- Establish effective governance and coordination mechanisms for the development and implementation of take-home OAT, involving governmental institutions, health professionals, community-led organizations and community members, through both local and national networks
- Establish robust monitoring and evaluation systems to ensure follow-up of programmes and patients
- Develop take-home OAT services for women (including pregnant women who use opioids)
- Eliminate barriers to accessing OAT take-home services (particularly, by including OAT within law enforcement and police training and by increasing the involvement of peer-support workers)
- Ensure provision of OAT within prison settings and continuation upon release
- Have in place overdose prevention and overdose response programmes
- Ensure that staff are appropriately trained on take-home OAT service delivery
- Put in place systems to monitor, report and act on diversion to the black market if and when it occurs

1. INTRODUCTION

In 2020 there were an estimated 1.5 million new HIV infections globally. People who inject drugs accounted for an estimated 9 per cent of these infections, ranging from almost 43 per cent of new infections in Eastern Europe and Central Asia to 1 per cent in Eastern and Southern Africa [1]. People who inject drugs are at 35 times greater risk of acquiring HIV infection than those who do not inject drugs [2].

The main route of transmission of HIV, HBV and HCV among people who inject drugs is through the sharing of injecting equipment. The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommend a comprehensive package of interventions, known as the harm reduction package, to prevent HIV among people who inject drugs [3], and it has been endorsed by Member States of the Commission on Narcotic Drugs (CND), the UNAIDS Programme Coordinating Board and the United Nations Economics and Social Council. It includes:

- Needle and syringe programmes (NSPs)
- Opioid substitution therapy (OST)[1] and other evidence-based drug treatments
- HIV testing services
- Antiretroviral therapy (ART)
- Prevention, diagnosis and treatment of sexually transmitted infections (STIs)
- Distribution of male and female condoms
- Information, education and communication
- Prevention, vaccination, diagnosis and treatment of hepatitis
- Prevention, diagnosis and treatment of tuberculosis
- Community distribution of naloxone for the prevention of overdose deaths

To successfully address HIV where injecting drug use occurs, countries should prioritize implementing NSPs, OAT, ARV and HIV testing services and antiretroviral therapy (ART); however, the other elements of the package should also be implemented. International guidance on NSPs recommends a range of delivery methods, including delivery at the places where people live through outreach and through secondary distribution by peers. It also recommends that the number of needles and syringes distributed to each person be unrationed [4]. WHO, UNODC and UNAIDS recommend that OAT programmes allow for take-home doses for stable patients to facilitate better coverage and better adherence to treatment, and to allow them flexibility in their social and economic

[1] In this report, the term OAT (opioid agonist therapy) is used in place of OST (opioid substitution therapy).

life [5,6]. They also recommend that OAT be provided in combination with psychosocial support, although those who decline such support should not be denied OAT.

However, in some countries where NSPs and OAT are implemented, laws and policies can restrict access to these services. With NSPs, for example, strict exchange[2] may be imposed, secondary distribution[3] forbidden, or only a limited number of syringes distributed at each contact. In the case of OAT, directly observed administration of methadone or buprenorphine may be mandatory, requiring a patient to go to the clinic or to a pharmacist every day; and take-home doses may be forbidden, including for people who are clinically stable.

The impact of COVID-19 on people who use drugs

On 11 March 2020, WHO declared COVID-19 a global pandemic. The health emergency continues to pose serious risks for certain groups of people, including the elderly and people with stressed immune systems or underlying health conditions. People who use drugs can be particularly vulnerable to COVID-19 due to chronic conditions such as chronic obstructive pulmonary disease and HIV [7], in addition to stigma, social marginalization, criminalization and high rates of incarceration, and economic and social vulnerabilities, such as lack of access to housing, clean water or food, and poor access to health care.

Restrictions imposed to contain the COVID-19 pandemic have limited access to health services for people who use drugs across all regions, and in many cases have disrupted treatment and harm reduction services, including services for HIV, HBV, HCV and tuberculosis for people who use drugs [8].

As a consequence, health risks for people who use drugs have increased [10], taking different forms across countries, including marked increases in mortality by overdose in countries already heavily affected [9], greater exposure of people who use drugs to the risk of HIV, increased mental-health problems such as anxiety and depression, and increased difficulties faced by drug-dependent people living with HIV.

In March 2020, WHO issued a guidance document for maintaining essential health services during the COVID-19 pandemic, identifying NSPs and OAT as essential health services and recommending the maintenance of OAT, the management of severe withdrawal syndromes and the continuity of NSPs [10]. In addition, UNODC, in collaboration with WHO, UNAIDS, the United Nations Development Programme (UNDP), the International Network of People who Use Drugs (INPUD) and Harm Reduction International (HRI), developed and disseminated technical guidance on HIV service provision for people who use drugs in the context of COVID-19 prevention and control [11]. UNODC also assisted countries in developing contingency plans to ensure the continuity and sustainability of harm reduction services for people who use drugs.

[2] Strict exchange refers to NSP services that only distribute a clean needle in exchange for a used one that is returned by the person who injects drugs.

[3] Secondary distribution refers to needles and syringes distributed to people who use drugs by a peer who collects a quantity of items from the NSP service and then distributes them to other people who use drugs, according to their needs.

2. METHODOLOGY

Between April 2020 and March 2021, the UNODC HIV/AIDS section, in collaboration with WHO and UNAIDS, conducted five regional webinars for decision makers or managers at the national level. During these webinars, representatives of 34 countries[4] shared their experiences in ensuring the continuity and sustainability of harm reduction services for people who use drugs during the COVID-19 pandemic, with a focus on OAT.

UNODC has identified 24 high-priority countries for HIV and drug use:[5] Afghanistan, Bangladesh, Belarus, Brazil, Egypt, Indonesia, the Islamic Republic of Iran, Kenya, Kyrgyzstan, Mauritius, Morocco, Myanmar, Nepal, Nigeria, Pakistan, Philippines, the Republic of Moldova South Africa, Tajikistan, Thailand, Ukraine, the United Republic of Tanzania, Uzbekistan and Viet Nam. Following the webinars, a questionnaire was sent to all 24 countries, focusing on access to and sustainability of NSPs and OAT and overdose prevention during the COVID-19 pandemic during the first half of 2020. Responses were received from national authorities, non-governmental organizations and United Nations staff.

The information in this report was extracted from the questionnaire responses, from the country presentations made during the webinars, and through follow-up inquiries. The webinar participants were mostly government representatives (ministries of health, national AIDS programmes and drug control agencies), clinicians, academics and representatives of non-governmental organizations. The questionnaires were directed to governmental organizations, though in some cases non-governmental organizations responded. Interviews were also conducted with key stakeholders and community representatives of five high-priority countries – Afghanistan, the Islamic Republic of Iran, Morocco, Nepal and South Africa – to illustrate the implementation of flexible, innovative measures to ensure continuity of access to OAT.

Limitations of the methodology

Not all countries entered or exited the COVID-19 emergency at the same time during 2020, and some countries experienced several lockdowns during the first half of the year. While the qualitative data focused on the first lockdown that countries experienced, quantitative data collected through the questionnaire compared the situation in December 2019 with June 2020 for all countries.

[4] Afghanistan, Argentina, Bangladesh, Belarus, Colombia, Dominican Republic, Georgia, Egypt, India, Indonesia, Iran (Islamic Republic of), Kazakhstan, Kenya, Kyrgyzstan, Lebanon, Mauritius, Mexico, Morocco, Myanmar, Nepal, Nigeria, Pakistan, Paraguay, Philippines, the Republic of Moldova, South Africa, Tajikistan, Thailand, Tunisia, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan and Viet Nam.

[5] Criteria for high-priority countries include epidemiological data, country readiness (policy and legal framework), and resources and capacity. High-priority countries are also high-priority from the point of view of the impacts of COVID-19.

Some questionnaires were only partially answered, especially in the case of quantitative data when these were not yet available at the country level.

It should be borne in mind that other countries that are not part of the UNODC high-priority country list, and that are therefore not included in this report, such as India, also established strong and sustainable initiatives to ensure the continuity of harm reduction services during the COVID-19 pandemic, including through the introduction of take-home doses. This report therefore does not aim to be an exhaustive account of all measures implemented to globally sustain harm reduction services during the pandemic.

3. WHAT WE LEARNED FROM THE HIGH-PRIORITY COUNTRIES

This chapter summarizes the data from high-priority countries with regard to changes in service provision in response to the outbreak of the COVID-19 pandemic

3.1 Emergency response to the COVID-19 pandemic

During the first six months of 2020, as the COVID-19 pandemic was spreading, most high-priority countries (17 out of 24) experienced a lockdown or restrictions on movement lasting between 2 and 12 weeks (table 1). To respond to the needs of people who inject drugs, in 12 countries a specific harm reduction coordination mechanism or task force was rapidly put in place. In 10 of these 12, the community of people who use drugs was engaged. The emergency triggered the need for multisectoral coordination, which in many cases had not previously existed. Coordination and communication among stakeholders were mostly ensured through frequent Internet-based video conferences.

TABLE 1. OVERVIEW OF HARM REDUCTION RESPONSE TO THE COVID-19 PANDEMIC IN 24 UNODC HIGH-PRIORITY COUNTRIES FOR HIV AND DRUG USE, FIRST HALF OF 2020

Country	*Declared state of emergency*	*Duration of lockdown (weeks)*	*Specific harm reduction coordination*	*Community involved in coordination*	*NSP*	*NSP essential service during pandemic*	*OAT*	*OAT essential service during pandemic*	*Naloxone programme*
Afghanistan	Yes	12	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bangladesh	No	4	Yes	Yes	Yes	Yes	Yes	Yes	No
Belarus	No	None	No	–	Yes	No	Yes	No	No
Brazil	Yes	None	No	–	No	–	No	–	No
Egypt	Yes	12	No	–	Yes	–	No	–	No
Indonesia	No	None	No	–	Yes	No	Yes	Yes	No
Iran (Islamic Republic of)	No	12	No	–	Yes	No	Yes	Yes	No
Kenya	No	8	Yes	Yes	Yes	No	Yes	No	Yes
Kyrgyzstan	NA	NA	NA	NA	Yes	NA	yes	NA	yes
Mauritius	NA	NA	NA	–	Yes	NA	Yes	NA	NA

Country	*Declared state of emergency*	*Duration of lockdown (weeks)*	*Specific harm reduction coordination*	*Community involved in coordination*	*NSP*	*NSP essential service during pandemic*	*OAT*	*OAT essential service during pandemic*	*Naloxone programme*
Morocco	Yes	4	Yes	Yes	Yes	Yes	Yes	Yes	Not yet implemented
Myanmar	No	Movement restricted	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nepal	Yes	10	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nigeria	No	8	Yes	No	Pilot	No	No	–	No
Pakistan	Yes	13	No	–	Yes	Yes	No	–	No
Philippines	Yes	12	No	–	No	–	No	–	No
Republic of Moldova	Yes	8	Yes	Yes	Yes	No	Yes	Yes	No
South Africa	Yes	12	Yes	No	Yes*	No	Yes*	No	Yes (pilot)
Tajikistan	No	None	No	–	Yes	No	Yes	No	Yes
United Republic of Tanzania (Zanzibar)	NA	NA	NA	NA	Yes	NA	yes	NA	NA
Thailand	Yes	3	Yes	Yes	Yes	No	Yes	Yes	Yes
Ukraine	No	12+	Yes	Yes	Yes	NA	Yes	NA	No
Uzbekistan	Yes	4	No	–	Yes	Yes	No	–	No
Viet Nam	Yes	2	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: NA = data not available. – = not applicable. * = in some cities

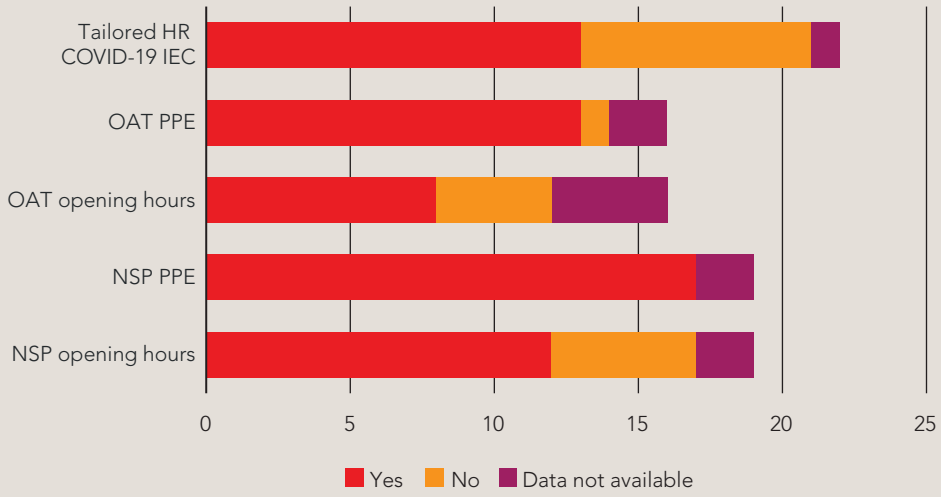
Ten of the 18 high-priority countries that had OAT programmes in place before the pandemic declared OAT an essential service, while only 8 out of 22 high-priority countries with an NSP in place before the pandemic identified it as an essential service.

In half of the countries (11 out of 22), a state of emergency was declared. This situation allowed for the introduction of measures such as take-home doses of methadone that in some countries were not permitted by law. However, the new measures were suspended as soon as the state of emergency was lifted in these countries.

3.2 Measures taken in harm reduction programmes to reduce risks of COVID-19 transmission

In most high-priority countries, measures were implemented to mitigate the risk of COVID-19 transmission in both NSP and OAT services, including masks, disinfectant, handwashing facilities and physical distancing, in addition to modified opening hours (figure I). Thirteen countries developed or distributed information, education, communication (IEC) materials on COVID-19 tailored specifically to the needs of people who use drugs, based on UNODC materials. In other countries, IEC for the general population were used (figure I).

Figure I. COVID-19-specific measures in harm reduction services, first half of 2020



3.3 Access to needle and syringe programmes

Information on NSP implementation modalities was available for 17 out of the 22 high-priority countries with this programme. Among these, seven countries have peer-led NSPs, 16 have programmes led by other non-governmental organizations and nine have NSPs led by national authorities (table 2). This remained unchanged after the onset of the COVID-19 pandemic.

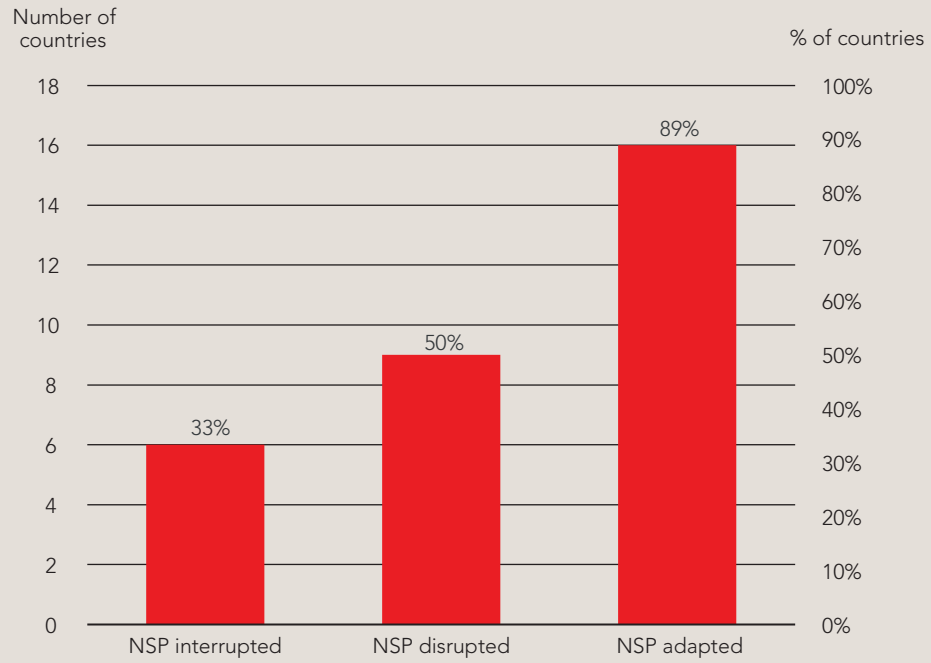
TABLE 2. IMPLEMENTATION OF NEEDLE AND SYRINGE PROGRAMMES

	Peer-led organization	*Other non-governmental organizations*	*Govt./municipal authority*
Afghanistan	Yes	Yes	
Bangladesh	Yes	Yes	
Indonesia		Yes	Yes
Iran (Islamic Republic of)	Yes	Yes	Yes
Kenya		Yes	
Mauritius		Yes	Yes
Morocco		Yes	Yes
Myanmar	Yes	Yes	Yes
Nepal		Yes	
Pakistan		Yes	
Republic of Moldova		Yes	Yes
South Africa	Yes	Yes	
Tajikistan		Yes	Yes
Thailand	Yes	Yes	
Ukraine		Yes	
Uzbekistan			Yes
Viet Nam	Yes	Yes	Yes

Note: Data were available for 17 out of 22 countries with NSPs.

Most high-priority countries ensured continued access to NSPs during the pandemic, independent of whether NSPs were declared an essential service, although services were disrupted or interrupted for a limited time or at limited locations. Almost all countries (89 per cent of those reporting) adapted services in some way at the national level to allow for their continuation (figure II). In some instances (e.g. South Africa), changes were made at the level of cities.

Figure II. Continuity of needle and syringe programme services in 18 countries, first half of 2020



Note: Data were available for 18 out of 22 countries with NSPs. Interrupted = services ceased completely at least until the end of the first half of 2020. Disrupted = services ceased partially or completely for a limited period.

Access to NSPs was adapted in many high-priority countries. Of the 17 countries reporting on NSPs, seven developed new NSP guidelines, with the engagement of the community in six of them. Dissemination of the new guidelines was supported by webinars for service providers and/or community organizations and, in a few instances, for local authorities. Guidelines provided for an increased number of syringes distributed by contact in Afghanistan, Nepal, Pakistan and Viet Nam (table 3), or for secondary distribution or for dispensing machines in the Republic of Moldova.

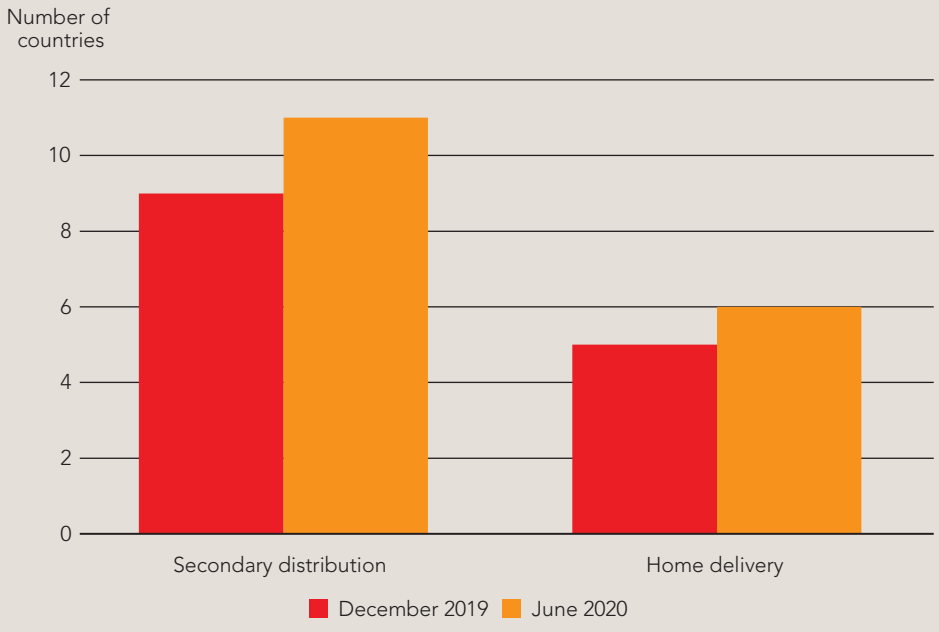
TABLE 3. POLICIES ON NEEDLE AND SYRINGE PROGRAMME DISTRIBUTION, DECEMBER 2019 AND JUNE 2020

Country	*Strict exchange Dec. 2019*	*Strict exchange June 2020*	*Max. NS per contact Dec. 2019*	*Max. NS per contact June 2020*
Afghanistan	Yes	No	12	28
Bangladesh	Yes	Yes		
Belarus			43	43
Iran (Islamic Republic of)	No	No		
Morocco	Yes	Yes	4	4
Myanmar	No	No		
Nepal	Yes	Yes	5	7
Pakistan	No	No	3	21
Tajikistan			40	40
Uzbekistan	No	No		
Viet Nam	No	No	25	Flexible

Note: Data were available for 9 out of 22 countries with NSPs.

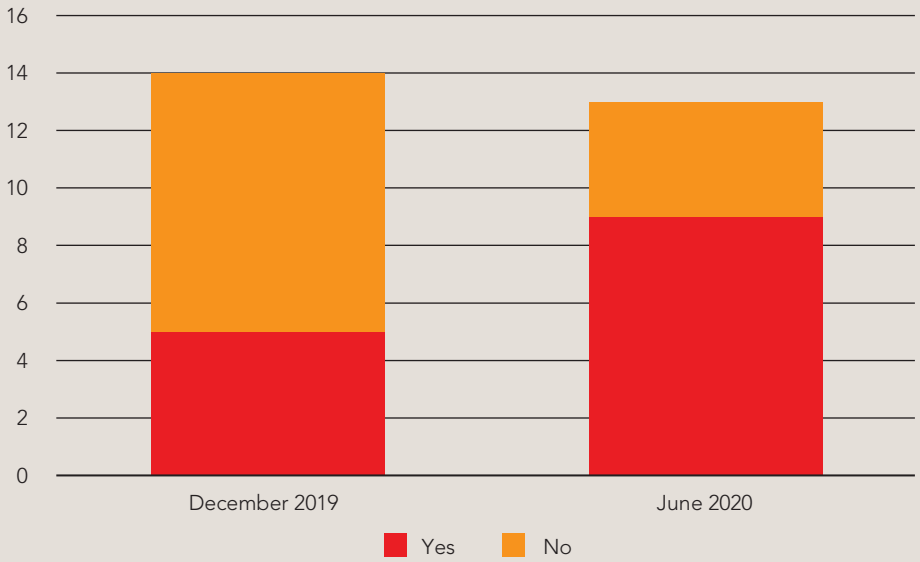
There was a small increase in the number of countries offering secondary distribution and home delivery of needles and syringes. Two additional countries (Afghanistan and Bangladesh) allowed secondary distribution, one of which (Afghanistan) also introduced home delivery (figure III). Some countries stopped all face-to-face counselling and individual or group support. At the same time, new methods of counselling – Internet-based or via telephone or even radio – were introduced. Out of 14 countries with NSPs reporting on counselling and support, 9 provided counselling and support virtually in 2020, compared with 5 that were doing so in 2019 (figure IV).

Figure III. Distribution of needles and syringes, December 2019 and June 2020



Note: Data were available for 15 out of 19 high-priority countries with NSPs.

Figure IV. Needle and syringe programmes offering virtual counselling and support, December 2019 and June 2020



Note: Of 19 high-priority countries with NSPs, data were available for 14 for December 2019 and 13 for June 2020.

In all high-priority countries for which data are available, all NSP services remained operating, except for Indonesia and the Republic of Moldova, where the number of NSP services decreased between December 2019 and June 2020 (table 4). In Pretoria, NSP services experienced severe disruptions since homeless people who use drugs were hosted in shelters in which NSPs were not available, and they were not allowed to leave the shelters to go to NSP services. By contrast, in Durban, South Africa, the previously halted NSP was reopened. During this period, the number of beneficiaries declined in most countries, by up to 71 per cent in Indonesia and 44 per cent in Morocco, while in a few countries it increased (table 4 and figure V).

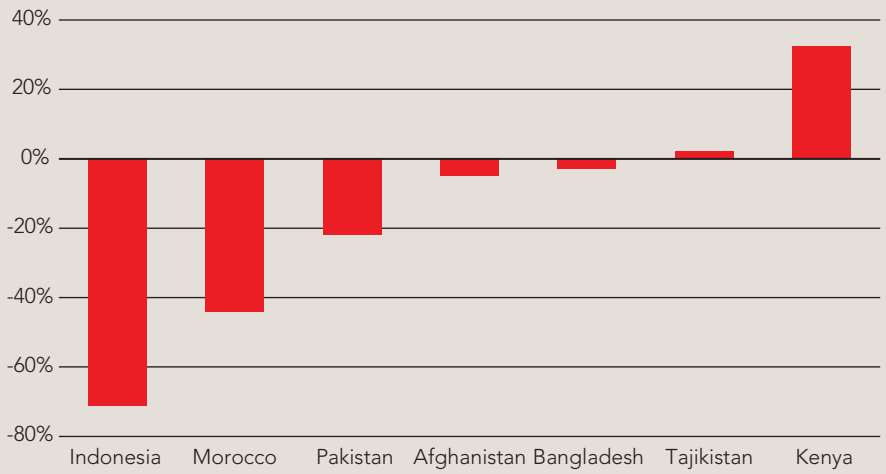
TABLE 4. TRENDS IN NUMBERS OF NEEDLE AND SYRINGE PROGRAMME SITES AND BENEFICIARIES, DECEMBER 2019–JUNE 2020

Country	*NSP sites Dec. 2019*	*NSP sites June 2020*	*NSP beneficiaries Dec. 2019*	*NSP beneficiaries June 2020*
Afghanistan	12	12	6 976	6 639
Bangladesh	21	21	10 004	9 708
Belarus	34	34	NA	NA
Indonesia	91	71	8 697	2 506
Iran (Islamic Republic of)	207	207	NA	70 000
Kenya	10	10	15 536	20 587
Morocco	10	10	941	528
Myanmar	46	46	64 597	NA
Nigeria	0	3	NA	NA

Pakistan	39	39	17 326	13 567
Republic of Moldova	37	32	16 164	NA
Tajikistan	60	60	36 108	36 921
Thailand	42	42	NA	NA
Uzbekistan	135	135	NA	NA
Viet Nam	53	53	NA	11 000

Note: NA = data not available.

Figure V. Percentage change in number of needle and syringe programme beneficiaries in seven countries, December 2019 – June 2020



3.4 Access to opioid agonist therapy

Eighteen high-priority countries have OAT programmes, and in some of these, OAT services are implemented with the involvement of community-led organizations and/or peers in the delivery of supporting interventions. (table 5). There was a lockdown or restrictions on movement in at least 12 countries with OAT programmes, but all managed to ensure partial or complete continuity of OAT during the COVID-19 restrictions in the first half of 2020.

TABLE 5. IMPLEMENTATION OF OAT PROGRAMMES

Country	*Community-led organizations*	*Other non-governmental organizations*	*Govt./ Municipal authority*
Afghanistan	No	Yes	Yes
Bangladesh	Yes (after beginning of pandemic)	Yes	Yes
Belarus	No	Yes	Yes
Brazil	No	No	No
Egypt	No	No	No (approved in 2021)
Indonesia	No	No	Yes
Iran (Islamic Republic of)	Yes (opium tincture only)	Yes	Yes
Kenya	No	No	Yes
Kyrgyzstan	No	Yes	Yes
Mauritius	No	Yes	Yes
Morocco	No	No	Yes
Myanmar	No	No	Yes
Nepal	Yes	Yes	Yes
Nigeria	No	No	No
Pakistan	No	No	No (approved in 2021)
Philippines	No	No	No
Republic of Moldova	Peers involved in counselling services	No	Yes
South Africa	Peers involved in counselling services	Yes	No
Tajikistan	No	No	Yes
United Republic of Tanzania (Zanzibar)	No	No	Yes
Thailand	No	Yes	Yes
Ukraine	No	Yes	Yes
Uzbekistan	No	No	No
Viet Nam	No	No	Yes

Continuation of OAT

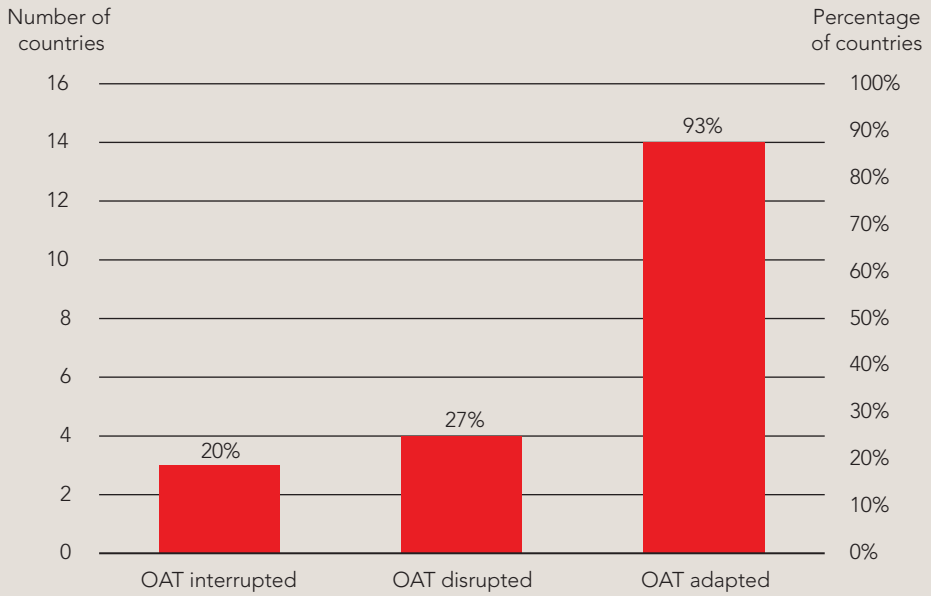
Almost all 18 high-priority countries with OAT programmes ensured their continuity by adapting services. New guidelines for OAT were developed in half the countries, with community involvement in most of these (Afghanistan, Bangladesh, Morocco, Myanmar and Nepal).

There were limited service interruptions in three countries and disruptions in four others (figure VI). Based on the data available from 11 countries, four experienced a reduction (of up to 30 per cent) in the number of patients enrolled at the end of the 2020 lockdown, compared with the number of patients in December 2019. In the other seven countries the

number of patients remained stable or increased, as the lack of heroin on the black market led to an increased demand for OAT in some countries.

In Afghanistan and the Republic of Moldova, the main reasons for disruption were issues related to the procurement of methadone or buprenorphine and the limited availability of stocks at the onset of the emergency.

Figure VI. Continuity of OAT services, first half of 2020



Note: Data were available for 15 out of 18 countries with OAT.

Initiation of new OAT treatments

In a few countries, new guidelines for OAT initiation were developed and implementers trained. In countries where both methadone and buprenorphine are available, preference was given to buprenorphine for the initiation of new treatments because of the lower risk of overdose.

However, treatment initiation was often limited or not possible due to COVID-19 control measures. In at least five of the countries reporting, there was a complete halt or dramatic reduction in new treatments, lasting from a few weeks to the entire duration of the lock-down. In Afghanistan, for example, the risk of stock-outs of methadone prevented the initiation of new OAT treatments. By contrast, in South Africa, where difficulties in finding heroin on the black market and strict restrictions on movement led to a large number of people experiencing withdrawal, high demand for OAT triggered the initiation of many OAT treatments among people hosted in temporary shelters.

Continuity and adherence to treatment

Restrictions on movement were a major barrier to treatment access, making it difficult or impossible for many people to attend the clinics to receive OAT and to get support and counselling. To ensure continuity and adherence to treatment, two main measures were established: implementation and expansion of take-home doses, and remote provision of support and counselling.

Take-home doses and outreach

Of the eight high-priority countries that prior to the COVID-19 pandemic had had a strict policy requiring on-site administration of OAT under supervision in the clinic, four changed their guidelines to allow take-home doses ranging from 7 to 21 days (in Nepal, supervision was delegated to a family member) (table 6). The seven countries whose guidelines already allowed take-home doses extended the number of days for these, varying from 7 to 30 days, although Thailand allowed for up to 180 days of take-home doses in some exceptional cases.

TABLE 6. OAT DELIVERY MODALITIES

Country	*OAT always DOT Dec. 2019*	*OAT always DOT June 2020*	*Take-home OAT Dec. 2019*	*Take-home OAT June 2020*	*Maximum days take-home OAT Dec. 2019*	*Maximum days take-home OAT June 2020*
Afghanistan	Yes	No	No	Yes	0	14
Bangladesh	Yes	No	No	Yes	0	7
Belarus	Yes	Yes	No	No	0	0
Indonesia	Yes	Yes	No	No	0	0
Iran (the Islamic Republic of)	No	No	Yes	Yes	6	21
Kenya	No	No	Yes	Yes	Not specified	Not specified
Mauritius	NA	NA	NA	NA	NA	NA
Morocco	No	No	Yes 1–2 weeks	Yes 1–4 weeks	14	28
Myanmar	No	No	Yes	Yes	3	14
Nepal	Yes	Yes (by family)	No	Yes	0	21
Republic of Moldova	Yes	No	Yes but limited	Yes	0	7
South Africa	No	No	Yes	Yes	NA	30
Tajikistan	Yes	Yes	No	No	0	0
Thailand	Depends on facility	Depends on facility	Depends on facility	Depends on facility	60	180
Ukraine [12]	No	No	Yes (50%)	Yes (90%)	10	10–15
Viet Nam	Yes	Yes	No	No	0	0

Note: NA = data not available.

In some countries, such as Kenya or Mauritius, vans went to the communities to deliver methadone. In most countries, OAT was home-delivered by health workers or through the family to patients who were in quarantine at home or admitted to hospital.

In Belarus, civil society, led by the Eurasian Harm Reduction Association, advocated for take-home methadone to be issued, leading to the development of a protocol allowing medical doctors to arrange take-home methadone in a state of emergency. However, the

Government did not officially declare a state of emergency, and the new guideline remains under review.

VIET NAM: ACCELERATING THE INTRODUCTION OF OAT TAKE-HOME DOSES DURING THE COVID-19 PANDEMIC

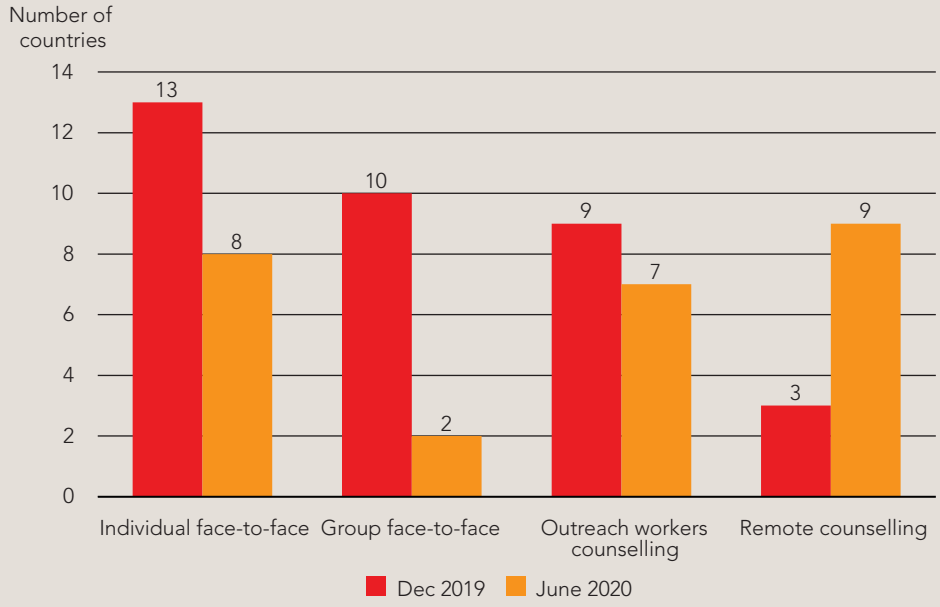
In Viet Nam, discussions on the introduction of take-home doses for OAT had started in 2019. The need for this scheme became more pressing with the onset of the COVID-19 pandemic, contributing to the Ministry of Health's approval to start implementation of take-home doses from the beginning of 2021. In April 2021, a pilot project was initiated in three provinces. In July, Viet Nam faced a severe new wave of the COVID-19 pandemic, resulting in the imposition of a strict lockdown in Ho Chi Minh City and other southern provinces. The positive initial outcomes of the pilot project led the Ministry of Health to allow all provinces to apply take-home doses for all OAT patients, in order to avoid a massive collapse in OAT service provision. As of 15 September 2021, local health authorities reported that 5,000 patients were benefiting from up to one-week take-home doses in Ho Chi Minh City alone.

Support and counselling for OAT patients

Providing counselling and support to people under OAT was the most challenging component of OAT programming during the lockdown. All group face-to-face meetings were cancelled, except in Tajikistan and Viet Nam. Individual face-to-face support and counselling was cancelled or extremely limited. Some support continued to be provided by outreach workers (figure VII).

To mitigate the impact of the lockdown on the quality of support provided to OAT patients, countries developed or intensified remote counselling. Support was provided by telephone and through Internet-based technologies such as video calls or social media groups. In Nepal, each patient was contacted by telephone every day. In most countries patients were also provided with contact details of health workers they could call at any time. In Kenya, radios were used to maintain contact with patients. The extended use of Internet-based media and new technologies is an important innovation, but also has its limitations in countries with poor Internet, or where few people who use drugs have a phone or a smartphone.

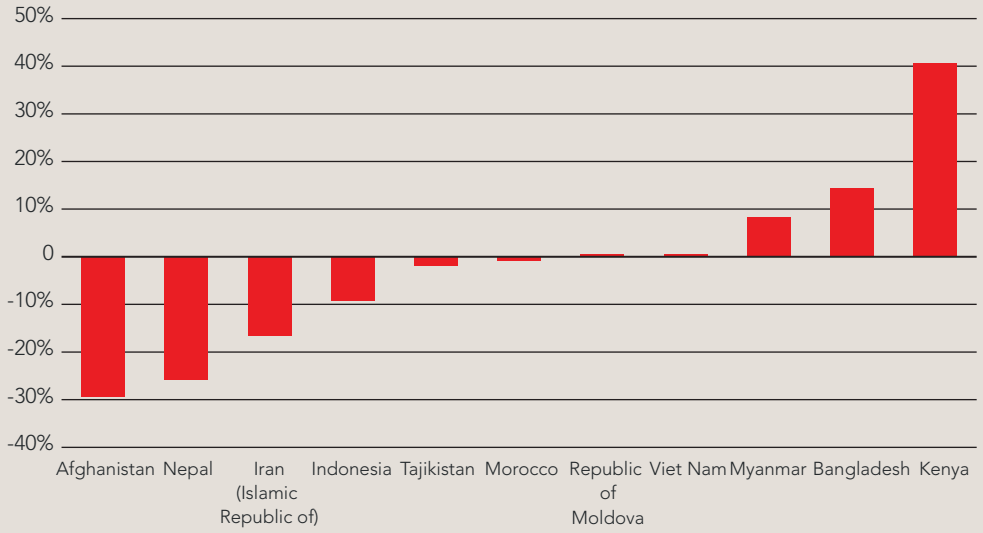
Figure VII. Support and counselling for OAT patients in 13 countries, December 2019 and June 2020



Note: Data were available for 13 out of 18 countries with OAT.

In about half of the countries reporting data, there was a substantial reduction in the number of patients enrolled in OAT in June 2020, compared with December 2019 (figure VIII).

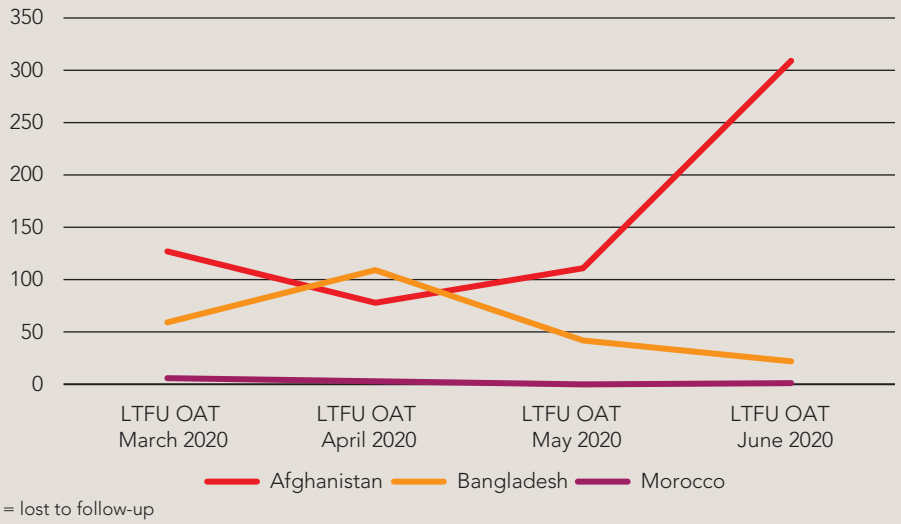
Figure VIII. Percentage change in number of OAT patients, December 2019–June 2020



Note: Data were available for 11 out of 18 countries with OAT.

Only three countries were able to report on the number of people lost to follow-up between March and June 2020 (figure IX). While in Morocco this number was limited, in Afghanistan, where the lockdown period lasted from 1 March until 30 June, the number of people lost to follow-up continued to increase throughout the period, reaching more than 300 in June. In Bangladesh there was an initial increase to 111 in April 2020, but following the end of lockdown on 25 April, which coincided with the establishment of peer-delivered OAT services, the number of people lost to follow-up declined. On the other hand, in Nepal, where very close monitoring measures were implemented, there were only two OAT patients lost to follow-up during the entire period of the lockdown.

Figure IX. OAT patients lost to follow-up in three countries, March 2020–June 2020



LTFU = lost to follow-up

Impact of take-home measures on overdose risks and diversion

None of the countries that implemented take-home doses during the COVID-19 pandemic, whether they have a solid monitoring system or not, reported any increase in the number of overdoses, or increase in the diversion of methadone, buprenorphine or opium tincture to the black market (table 7).

TABLE 7. TAKE-HOME OAT AND REPORTED CONSEQUENCES FOR DIVERSION AND OVERDOSE

	Take-home OAT during COVID-19	*Increase in diversion events*	*Increase in overdose deaths*
Afghanistan	Yes	No	No
Bangladesh	Yes	No	No
Indonesia	No	NA	No
Iran (United Republic of)	Yes	No	No
Kenya	Yes	No	Yes*
Mauritius	NA	NA	NA
Morocco	Yes	No	No
Myanmar	Yes	NA	NA
Nepal	Yes	No	No
Republic of Moldova	Yes	Yes	No
South Africa	No	No	No
Thailand	Yes	No	NA
Tajikistan	No	No	No
Ukraine	Yes	Yes	NA
Viet Nam	No	No	No

Note: NA = Data not available.

* Increase in overdose deaths was reported to be linked to an interruption in the supply of naloxone, and not to take-home OAT doses.

3.5 Access to naloxone for the prevention of overdose deaths

All nine high-priority countries that had a programme to make naloxone available at the service level or in the community to prevent overdose deaths maintained their programme during the COVID-19 pandemic. Access to naloxone varies; in most cases it is available through NSPs and trained peers from these programmes or outreach workers (table 8). In some countries naloxone is available at OAT service locations. In Morocco, guidelines for naloxone distribution have been developed and the programme will start in 2021–2022.

TABLE 8. ACCESS TO NALOXONE FOR OVERDOSE PREVENTION

Country	*Via community*	*Via NSP**	*At OAT***
Afghanistan	Yes	Yes	No
Kenya	Yes (CSO)	Yes	Yes
Morocco	Not yet implemented	Not yet implemented	Not yet implemented
Myanmar	Yes	Yes	No
Nepal	Yes	Yes	Yes
Republic of Moldova	No	No	Yes
South Africa	In Durban only		
Tajikistan	Yes	Yes	No
Thailand	Yes	Yes	Yes
Viet Nam	Yes	No	No

Note: * = Naloxone distributed by outreach workers and peers (NSP).
** = Naloxone provided at OAT service sites (but not take-home)

In Durban, South Africa, naloxone kits were distributed during the pandemic. In Thailand, civil society organizations continued to provide naloxone during lockdown to people with a history of overdose in sites where people who inject drugs gather to use drugs, but they faced restrictions on travel. In Kenya, the naloxone programme experienced disruptions due to procurement issues, resulting in a temporary increase in the number of overdoses.

Seven of the high-priority countries reported having a system to monitor overdoses (Bangladesh, the Islamic Republic of Iran, Myanmar, Nepal, Tajikistan, Ukraine and Viet Nam), but no country provided solid data on the number of overdoses in 2019 or 2020 in their responses to the questionnaire. Nevertheless, in none of these countries was there any report of a higher number of overdoses linked to OAT during the lockdown.

4. KEY FINDINGS: PEOPLE-CENTRED AND SUSTAINABLE COVID-19 RESPONSES WITH AND FOR PEOPLE WHO USE DRUGS

This chapter analyses the data collected and draws lessons from each country experience. It looks at the steps taken in response to the pandemic, highlights lessons learned and makes recommendations on how to sustain successes.

The outbreak of the COVID-19 pandemic led to sudden lockdowns, curfews and other limitations on movement which drastically restricted access to harm reduction services. In most high-priority countries, opening hours of services were modified and reduced, and the number of attendants also decreased. While not all countries experienced a complete lockdown, or in some cases only for a limited time, all countries faced challenges maintaining the continuity of the services. Common problems included addressing the withdrawal symptoms of opioid-dependent people, difficulties arranging transport to attend the OAT clinics and COVID-19 safety for both patients and staff.

4.1. Developments in harm reduction services in response to the pandemic

In several high-priority countries, harm reduction services for people who use drugs, especially OAT and to a lesser extent NSPs, were recognized as essential services that must be maintained during the COVID-19 pandemic. This unique situation triggered a number of initiatives and innovations to ensure the continuity of services for people who use drugs. The developments occurred in five main areas:

- Establishment of new partnerships between health authorities, law enforcement agencies, civil society and community-led organizations, including the community of people who use drugs
- Flexibility in the implementation of NSPs (and continuity of naloxone provision)
- Flexibility in the implementation of OAT services
- Development of virtual support for OAT patients through telephone, video calls and Internet-based apps
- Development of new guidelines for NSP and OAT services

New partnerships

The COVID-19 pandemic has improved the partnership between harm reduction services – including OAT services, community-led organizations, general or public health services – and law enforcement agencies. In Mauritius, Morocco and Nepal, for example, health authorities coordinated immediately with the police to ensure that community health workers, clients of harm reduction services and non-governmental organizations received permits to travel during lockdown periods. (See also the example from Durban, South Africa, in chapter 5.)

More than half the high-priority countries surveyed established new task forces to develop an adequate response, in almost all cases (10 out of 12 countries) with the inclusion of the community of people who use drugs. In many instances it was the first time such partnership and coordination mechanisms had been established, and for many countries it was the first time they had engaged meaningfully with the community of people who use drugs. Internet-based media were largely used to ensure communication and strengthen coordination between stakeholders, and new guidelines were often disseminated through webinars.

The emergency response also allowed for providing more important roles to non-governmental organizations, including peer-led organizations, which in some countries were engaged to help develop or review guidelines for more flexible services, as well as taking up (or continuing) key roles in service delivery. For example, in Nepal, Recovery Nepal, a peer-led organization, was authorized to deliver OAT while the state of emergency was in place. In Bangladesh, community networks were engaged as volunteers to dispense OAT and follow up with patients. They also arranged meals for street-based people who inject drugs, in conjunction with harm reduction interventions, including NSPs. In Afghanistan, Bridge, a community-led organization, was already part of the national harm reduction task force and continued in this role. In Cape Town, the South African Network of People who Use Drugs (SANPUD), together with academia and civil society organizations, advocated for the provision of harm reduction and OAT for people who inject drugs and provided protective equipment to people who use drugs, hygiene kits to women who use drugs, and training to city health and social services on targeted counselling. This resulted in the initiation of OAT for a limited number of patients at two shelters.

THE ISLAMIC REPUBLIC OF IRAN: MOBILIZING NETWORKS FOR A COLLECTIVE RESPONSE TO HARM REDUCTION NEEDS DURING THE PANDEMIC [13]

To respond to the COVID-19 crisis among people who use drugs in the Islamic Republic of Iran and ensure an effective and equitable response, a non-governmental organization, Rebirth Charity Society, established a COVID-19 prevention and control working group that brought together non-governmental organization representatives (including 23 peer-support workers), clinicians, psychologists, social workers, academics, representatives from the State Welfare Organization and intergovernmental organizations. More than half of the 50 members had a history of drug use. The group communicated mostly via online messaging apps.

Group leaders ensured that all contributions to discussions and decision-making, particularly from peer-support workers, were valued, highlighting community achievements and inviting peer-support workers to give their views on community needs. Group members were encouraged to collect and share reports, video and photographs of daily activities across the country, which were used to understand supply shortages and determine priority actions.

The working group organized the distribution by peer-support workers of protective equipment, water and meals and snacks to people attending community-based drop-in centres, homeless shelters and mobile outreach services; developed and disseminated IEC materials, including a booklet and a podcast, provided protective equipment to peer-support workers, and advocated successfully for an improved government policy on the treatment of people who use drugs and homeless people in the context of the pandemic.

Flexibility in needle and syringe programmes and continuity of overdose death prevention

The high-priority countries surveyed managed to maintain some access to needles and syringes during the lockdown, with the introduction of several measures such as lifting strict exchange policies, introducing secondary distribution through peers and, in almost all countries, increasing the number of syringes distributed at each contact. However, in most countries the total number of beneficiaries declined, given the numerous challenges in accessing the services or for outreach workers to reach people who use drugs.

Respondents to the questionnaire identified several positive outcomes of the measures they implemented in the NSPs as a result of COVID-19 restrictions. These included:

- Increased flexibility
- Strengthened outreach work and implementation of new approaches to maintain support to the beneficiaries via phone, social media, Telegram or WhatsApp groups
- Specific attention paid to homeless people
- Increased awareness in the country of the need for NSPs, and increased support for NSPs from stakeholders
- Ongoing training for implementers (staff and outreach workers) through webinars
- Regular online meetings with outreach workers

NSPs also faced several challenges during the periods of lockdown or restrictions in movement which affected the quality of the programmes:

- Administrative difficulties in obtaining authorizations for outreach workers
- Increased fear of the police, and difficulties in reaching people who inject drugs
- Reduced frequency of contacts
- Challenges and weakness in linkages with other health services such as HIV testing
- Reduction in the collection of used syringes
- Inability of new clients to reach services
- Severe service disruption in some places

A limited number of the high-priority countries have a community-based naloxone programme. While there were no innovations reported in these programmes, all of them managed to maintain some continuity in naloxone distribution throughout the first months of the pandemic, despite difficulties in procurement and supply in some countries.

Flexibility in OAT services

Countries that implemented greater flexibility in dispensing OAT, whether through the introduction of take-home doses or by extending the period for take-home doses, identified many benefits for the patients or for the programme.

For patients:

- Increased self-confidence
- Protected and promoted their human rights by treating them with trust and dignity
- Reduced transport costs and time
- Improved quality of life because of greater time available for work and family
- Lower exposure to active drug use
- Reduced risk of transmission of airborne diseases at the clinics

For the programme:

- Increased visibility and political support for OAT programmes and for treatment and care for people who inject drugs
- Reduced crowding in the clinics
- Disruption of OAT programmes prevented during the state of emergency
- Proved the effectiveness of take-home OAT doses

The greater flexibility introduced into the OAT programmes did not lead to an increase in the reported number of overdoses or reported number of incidents of diversion.

In some countries with a restrictive legal framework regulating OAT, such as legal requirements for the daily distribution of OAT, flexibility in the dispensation of OAT was only permitted because of the state of emergency. (In Belarus, for example, OAT flexibility was never introduced because an official state of emergency was not declared.) In these countries, such as Afghanistan and Nepal, innovations or new guidelines for take-home OAT dosages were stopped as soon as the state of emergency was lifted, regardless of the positive impact of the innovations and the absence of negative effects such as more overdoses linked to OAT medications or greater diversion of these medications to the black market. Steps are currently being taken in Nepal to review the legislation to allow the implementation of take-home OAT on a regular basis.

Development of virtual support and counselling

One of the major challenges was the continuation of support and counselling for the clients of harm reduction services. The COVID-19 pandemic was an opportunity to create new channels of communication built on online technologies, or by phone or radio where access to Internet-based media was limited. It was an opportunity to explore new, less constraining ways to maintain contact and address potential health problems or other needs encountered by the clients of NSP or OAT services. In some instances, phone calls were also used to monitor OAT patients closely, such as in Nepal.

While online technologies made it possible to continue providing regular support to OAT patients in situations where travel and face-to-face contacts had to be avoided, the absence of face-to-face individual or group support and counselling sessions, coupled with the social isolation due to lockdown, had a negative impact on some patients.

New guidelines for needle and syringe programmes and OAT services

In the countries that introduced innovative measures during the pandemic, specific guidelines were developed for NSPs or for OAT. The state of emergency made possible the introduction of flexibility measures that were not provided for by law, such as take-home doses of OAT.

In almost all cases, the community of people who use drugs was involved in the development of the new guidelines. In 7 countries out of the 17 providing data, new guidelines were developed for NSPs, with the engagement of the community in 6 of them (Afghanistan, Bangladesh, Myanmar, Nepal, Pakistan and Viet Nam). Of the 14 countries that adapted their OAT services, 8 developed new guidelines, with the engagement of the community in 6 of them (Afghanistan, Bangladesh, Morocco, Myanmar, Nepal and Viet Nam). Countries disseminated the new guidance documents through webinars for service implementers, community representatives and local authorities.

KENYA: ADDRESSING INTERSECTING VULNERABILITIES – COVID-19 AND GENDER-BASED VIOLENCE

In Mombasa Country, the Muslim Education and Welfare Association (MEWA), a non-governmental organization that provides harm reduction services to people who use drugs, conducted a survey between March and May 2020 of almost 600 women and adolescent girls who use drugs. This revealed that during the pandemic they had experienced increased levels of gender-based violence, including intimate partner violence, physical violence and psychological violence.

MEWA therefore began an initiative integrating harm reduction, COVID-19 response and gender-based violence response. In addition to the harm reduction services, HIV care and legal support that MEWA already offered, the initiative implemented community COVID-19 case identification, contact tracing and referrals, provided information on quarantining, and monitored clients quarantining at home. It offered one-on-one and couples counselling and parenting skills-building, and also implemented a social protection programme that supported 200 women and 50 adolescent girls in immediate danger of gender-based violence. The initiative distributed food and hygiene kits, and offered education for alternative income streams through skills-building and financial management courses. MEWA is conducting sensitization about gender-based violence issues in the wider community, as well as working to scale up the social protection programme and advocating for resources for children and for women who use drugs.

4.2. Sustainability of new initiatives

In view of the effectiveness of the measures introduced during the initial stages of the COVID-19 pandemic, and their alignment with international guidelines, most countries surveyed for this report are considering retaining some of the new policy guidelines in a sustainable way to ensure better long-term access to NSPs, OAT and to prevent overdose deaths.

Take-home doses of OAT

Some countries that made take-home doses their general strategy during the pandemic plan to maintain and expand this. Myanmar plans to scale up its take-home programme. In Thailand, some facilities are considering maintaining methadone home delivery and take-home doses. The Republic of Moldova, where take-home OAT was introduced, plans to maintain the policy but with a differentiated approach according to individual factors. Bangladesh plans to review its therapeutic guidelines to include take-home doses and community distribution of naloxone. In Ukraine, take-home doses will be maintained.

Morocco plans to introduce OAT (both methadone and buprenorphine) in other galenical forms that are easier to dispense, to facilitate its take-home programme.

In South Africa, there was a lack of funding to continue providing OAT to clients in temporary shelters in Pretoria, but pre-existing OAT services continued. In countries such as Afghanistan and Nepal, which introduced take-home doses during the emergency for the first time, the initiative was stopped at the end of the lockdown due to the legal framework imposing daily doses. These countries plan to document the experience acquired in 2020 and use it to advocate for introducing modifications to the law and to guidelines.

Virtual treatment and support

All countries plan to build on lessons learned during the emergency and maintain virtual support and follow-up of patients. Countries are considering developing guidelines to support online counselling and psychosocial support.

To ensure the sustainability of remote OAT and support, some countries, such as the Islamic Republic of Iran and Morocco, have initiated a review of laws or guidelines to allow for OAT through telemedicine during emergencies.

The Republic of Moldova is developing an OAT app providing video-guided treatment for new patients and to support to patients in treatment. The app will be ready in 2022.

Coordination and communication

The COVID-19 pandemic highlighted the interest in and need for strengthening collaboration between actors, including other health programmes such as ART and TB programmes at the local level, to improve the effectiveness and quality of OAT programmes.

4.3. The COVID-19 pandemic: lessons that will change the post-pandemic future

The COVID-19 pandemic, and the restrictions implemented to control it, led to the development of new guidance for implementing harm reduction services for people who inject drugs. This exceptional situation was an opportunity to develop new promising practices and learn important lessons to strengthen harm reduction programmes. These lessons include:

- The benefits of greater flexibility and innovation in providing harm reduction services, especially NSPs and OAT
- The importance of declaring harm reduction services to be essential medical and psychosocial services
- The importance of community-led organizations' engagement, leadership and support in the delivery of harm reduction services
- The need to ensure that access to harm reduction services (including delivery of services by community health workers or peer-support workers) is not banned or subject to harassment by law enforcement
- The opportunities provided by new communication technologies for remote support for services, communication between stakeholders and monitoring
- The need to develop effective virtual group support activities
- The importance of establishing a robust and inclusive coordination mechanism (involving governmental institutions, health professionals and community actors – including community-led organizations – and of developing collaboration through national and local networks)
- The value of good communication in increasing and sustaining support from stakeholders
- The importance of developing relations and partnerships with law enforcement agencies
- The need for robust monitoring and evaluation systems to ensure follow-up of programmes and patients

The pandemic experience also has more specific implications for how countries providing harm reduction services can improve their preparation for the next emergency response. Steps include:

- Conducting a more detailed assessment of the response during the current COVID-19 pandemic

- Revising legislation to build on the lessons learned from the COVID-19 pandemic
- Developing/reviewing national guidelines for maintaining harm reduction services during emergencies
- Increasing the involvement of the community of people who use drugs in response planning to increase acceptability, access and retention in services
- Developing flexible communication and coordination mechanisms among stakeholders
- Ensuring that contingency stocks of needles and syringes and of methadone/buprenorphine for OAT are available
- Coordinating plans with stakeholders to provide the homeless with safe shelter and access to services
- Developing virtual or on-site procedures for providing support and monitoring activities

5. COUNTRY DEEP DIVES: CHALLENGES AND INNOVATIONS

Afghanistan[6]

Afghanistan had an estimated 25,736 active people who inject drugs in 2019. Drop-in centres for harm reduction services are available in 12 of the 16 provinces, and OAT is provided in five provinces through six methadone centres – two in Kabul and one each in Balkh, Herat, Kunduz and Nangahar. In two provinces there are community-led mobile teams for people who inject drugs.

The Afghan Ministry of Public Health reported the first confirmed case of COVID-19 on 24 February 2020. The Afghanistan National Program for Control of AIDS, STI and Hepatitis (ANPASH) immediately called for an urgent meeting of the harm reduction technical working group. The group adopted several initiatives: (a) the development of three standard operating procedures for the provision of harm reduction, methadone maintenance therapy and antiretroviral medications (ARVs); (b) the development and dissemination of COVID-19 IEC materials; (c) the provision of extra commodities to people who inject drugs; (d) the provision of take-home doses of methadone (up to 14 days) and three-month dispensation of ARVs; (e) guidelines for COVID-19 control in health facilities, including COVID-19 screening of patients; and (f) stocking up supplies (methadone, ARV medications). A lockdown was enforced in March 2020 and maintained until September 2020.

According to the new standard operating procedure, for already registered patients, daily doses of methadone were replaced by take-home doses for one to two weeks, depending on adherence level. Patients were given clear guidance and follow-up was ensured by an assigned team member (OAT facility coordinator, medical doctor, counsellor or nurse) through phone contacts three times per week. Doorstep delivery was organized by peers for people in quarantine.

The main reason for the interruption in registration of new patients was a methadone shortage at the beginning of the lockdown. In addition, initiation of OAT is usually conducted at the inpatient department, which was difficult or impossible during the pandemic.

[6] Sources: Presentation at UNODC/WHO webinar by the Afghanistan National Program for Control of AIDS, STI and Hepatitis (ANPASH), May 2020; interviews with Dr Mohammad Rafiq and Dr Basir Hamidi (National AIDS Control Program), a representative of the community of people who inject drugs and an OAT programme patient, March 2021.

Several challenges were faced during the lockdown: reduced access of outreach workers to people who inject drugs, reduced activities of HIV testing services, lack of protective equipment for staff and a risk of methadone stock-out by the end of June 2020. With the support of neighbouring countries and of UNDP, supplies of methadone were organized and stock-outs avoided.

TABLE 9. TAKE-HOME PLAN: AFGHANISTAN

Before COVID-19	*During COVID-19 lockdown (Mar. 2020–Sep. 2020)*	
Daily dose (16.5 mg per day)	Take-home dose for up to two weeks	
Results	*July 2019–Dec. 2019*	*Jan. 2020–June 2020*
Number of new patients	304	7
Number of patients lost to follow-up during the period	789 (cumulative)	888 (cumulative)
Number of overdose deaths	No solid data	No solid data
Total number of patients under OAT (last month of the period)	1 200	863

There were no reports of overdose deaths related to methadone and no reports of diversion of methadone during that period.

Some people were lost to follow-up during the lockdown, but by the end of December 2020 the number of patients under OAT was 1,416, compared with 1,200 at the beginning of the year.

The conditions for homeless people under OAT were particularly difficult. Coming every day to the centre to receive the dose of methadone, they were no longer allowed to spend time in the centre for a rest, a shower or coffee, and had to leave immediately after administration of the treatment.

Overall, national authorities, service providers and patients agree that the implementation of take-home doses during lockdown was effective. OAT was not interrupted and there were no reports of diversion or overdose. Follow-up and support of those enrolled in the methadone programme by phone or visits by outreach workers and by the methadone clinic staff was very good. Good communication with the centres and access to the centres was maintained.

Sustainability plan[7]

Home-based methadone distribution was included in the Global Fund proposal for an additional 3.2 per cent in COVID-19 funding, but was rejected. After lockdown, the earlier guidelines were reinstated, leading to an end of take-home doses in September 2020. The current law does not allow for take-home doses and prescribes the dispensation of methadone only under strict supervision.

Stakeholders, including patients, recommend an assessment of the take-home methadone initiative be undertaken to document the results and advocate with the Ministries of Public Health, Interior and the Drug Regulation Committee for the introduction of take-home doses of methadone for at least one week at a time in the national guidelines for methadone

[7] This sustainability plan reflects the situation prior to the change of Government in Afghanistan in September 2021.

maintenance treatment (MMT). Other recommendations include reopening access for homeless OAT patients to rooms for taking a rest.

ANPASH plans to conduct a rapid assessment on the effectiveness of take-home methadone, and based on the findings will advocate for continuity of take-home methadone in Afghanistan.

The Islamic Republic of Iran[8]

In the Islamic Republic of Iran, around 1,244,000 people who use drugs receive OAT. The majority (72 per cent) receive methadone treatment, with 16 per cent receiving buprenorphine and 10 per cent opium tincture treatment, provided through 7,431 clinics.

The first case of COVID-19 was reported in the Islamic Republic of Iran in mid-February 2020. The closing of schools and restaurants was initiated from 23 February. There was a complete lockdown only for two days.

In mid-February, the Iranian National Center for Addiction Studies (INCAS) identified three priorities for its programme: (a) the protection of staff and patients from COVID-19 infections; (b) addressing potential mental-health problems due to the pandemic; and (c) ensuring continuity of drug dependence treatment.

To reduce patients' need to travel to treatment centres, treatment plans were revised to include more flexibility in take-home doses, accompanied by a strict protocol for patient education and monitoring. Individual or group support was provided through Internet-based media or phone calls. For patients in quarantine or admitted to hospital, treatment was brought by a family member.

Before the pandemic, guidelines allowed for one-week take-home doses for stable patients who had been under OAT for five months and had negative urine tests. National authorities released a new comprehensive national guideline developed by INCAS on the provision of OAT during COVID-19 [14]. Take-home plans depended on individual factors and allowed for up to two weeks' take-home doses. For the initiation of OAT, preference was given to buprenorphine over methadone.

TABLE 10. SIMPLIFIED TAKE-HOME PLAN DURING THE COVID-19 PANDEMIC

		Supervised doses
Phase 1	Before stabilization	Three times per week
Phase 2	Stabilized for one month	Two times per week
Phase 3	Stabilized for two months	Weekly
Phase 4	Stabilized for three months	Every other week

There was no report of overdoses and no increase in diversion.

[8] Sources: Presentation at UNODC/WHO Webinar by the Iranian National Centre for Addiction Studies (INCAS), May 2020; interviews with Dr Alireza Noroozi of INCAS, and with an opium tincture patient and a buprenorphine patient, April 2021.

The perspective of OAT patients

A patient treated with opium tincture, who before COVID-19 was receiving take-home doses for 10 days, reported that during the pandemic he received a higher dosage of the medications, and for 20 days. Another patient, who started buprenorphine treatment 18 months ago, reported that before COVID-19 he was receiving doses for one week (or up to one month if he could afford it). For him, the main barrier to take-home doses of buprenorphine for longer periods was economic. During the first two weeks of the pandemic, his buprenorphine treatment was interrupted, and he obtained buprenorphine from the black market. In general, these patients found the quality of the services during COVID-19 pandemic restrictions lower than before COVID-19. Because of the reduced number of staff at the centres, waiting times were very long, and they also stressed the reduced availability or lack of support.

Before COVID-19, patients would participate in face-to-face group therapies three times a week. These activities were cancelled and replaced by WhatsApp groups. But most patients did not engage in the group discussions, and patients felt isolated. According to one patient under opium tincture treatment, the absence of group therapy was a major problem and responsible for relapses to street drugs for many patients.

Sustainability plan

The new guidelines will be evaluated. The two patients and INCAS expressed mixed feelings about the outcomes of the initiatives established during COVID-19 pandemic. While on the one hand the increase in dosage and extended periods for take-home doses were positive points, on the other, the lack of support through group therapy – especially during a time when there was hardly any socializing, including with family – had a negative impact on adherence to treatment, and this would need to be addressed to fully realize the benefits of more flexible OAT dispensing.

Access to OAT in the Islamic Republic of Iran is limited by the high costs for patients. This includes the cost of the medications, transport costs, fees for counselling sessions and the time needed to go to the centres, which affects work opportunities. The patient recommended that more centres be opened closer to the homes of patients, and that opening hours be adapted to allow patients time to go to work.

Morocco[9]

Morocco has 40,640 people who use drugs enrolled in drug dependence treatment, including 2,044 people (first trimester of 2021) under methadone treatment in one of the seven drug dependence treatment centres (*centres d'addictologie)* providing OAT in the community, and 100 people under methadone in one of the five prisons offering OAT.

The country's first case of COVID-19 was reported on 2 March 2020. A state of medical emergency was declared on 19 March, and lockdown started the following day.

To reduce physical contact between patients and staff, facility opening hours were reduced and take-home doses of methadone were expanded. Before lockdown, the majority of OAT patients received take-home doses for 7 days, and in exceptional cases for 14 days. During lockdown, take-home doses varied from 8 to 28 days. For people who were unable to come to centres located in other areas of the city because they had not received authorization to

[9] Sources: Presentation at UNODC/WHO webinar, May 2020; interviews with Dr Omar Bouram, Service de la Santé Mentale, DELM, with a nurse and health worker from the Centre d'Addictologie, Tetouan, and with two users of the OAT service (one man and one woman), June 2021.

travel or were in quarantine, OAT was home-delivered by community health workers from harm reduction non-governmental organizations. Homeless people were administered methadone under daily intake in the drug dependence treatment centres. Medical consultations and psychological support were provided through phone calls, Internet-based video conferences and email. A specific hotline for people who use drugs was established during lockdown. In addition, psychosocial services were available, including support for family mediation, financial assistance, meals and accommodation for homeless people.

All interventions were implemented through a newly established multisectoral partnership that included government health authorities, non-governmental organizations, law enforcement, scientific societies such as the Society of Addictology, national experts and academics. Coordination between medical teams and harm reduction teams in the drug dependence treatment centres was dramatically enhanced. Coordination between the national programme and local teams was ensured through an Internet-based application. Guidelines were developed and thematic webinars organized to strengthen the capacity of health staff to deliver the services in the pandemic context.

Continuity of OAT for people who were under treatment before the pandemic, including for foreigners who were stranded in the country, was ensured thanks to the new measures, including extended take-home doses and support. The number of people lost to follow-up was minimal, but initiation of new treatments was put on hold during lockdown. During this period there was no report of diversion of methadone. (The country has no overdose reporting system.) According to representatives from the community, there was an increase in the number of overdoses during COVID-19, linked not to the use of methadone but to the circulation of new substances and substances of different quality to the usual.

The perspective of OAT patients

According to beneficiaries of the OAT programme, the changes introduced in the programme due to COVID-19 successfully ensured the continuity of OAT. The extension of take-home doses to 21 or 28 days was greatly appreciated, as it reduced costs for transport to the centres and the risk of police controls, which were intensive during lockdown. The main challenge was the high economic precarity of people who use drugs in general, which was exacerbated by the pandemic.

For homeless people and particularly women, the situation was especially difficult. Access to support was very limited or not existent. A homeless woman in Tetouan who had just started OAT a month before lockdown reported that as a woman, she had no access to temporary accommodation. Given the restrictions on movement at that time, there was no one on the streets to provide food, money or support. All homeless people were receiving their daily dose from the centres.

Sustainability plans

After lockdown, initiatives such as home delivery or hotlines were stopped. Similarly, the maximum number of doses for take-home methadone was reset as before to 14 days. Plans are being developed to maintain some of the initiatives, including:

- A mental-health plan to provide psychosocial support to people with mental-health problems, including people under OAT, in the event of any type of disaster
- Development of legal tools and technological support to allow for distanced care and support for people who use drugs, including telemedicine and electronic prescriptions

- Phone contacts with patients for counselling and tracing those who miss appointments
- Coordination between community actors and health professionals through joint meetings and consultations on cases to improve care and support to individuals in need
- Establishment of committees or task forces to strengthen management of the OAT programme at both local and national levels
- Monitoring through an electronic-based system
- Accelerated introduction of less constraining substitution medicines (other galenic forms of methadone, buprenorphine)

Myanmar[10]

Myanmar has an estimated 93,000 active people who inject drugs (IBBS, 2017–2018). There were 71 methadone clinics in 2019, located in five of the country's 17 states or regions. The total number of methadone patients was 19,991 at the end of December 2019.

COVID-19 preparedness plans started on 5 January 2020, and the first confirmed COVID-19 case was reported on 23 March. A stay-at-home policy was implemented, with limitation of movements except for essential services. Gatherings were limited to five people.

The following possible risks linked to the COVID-19 emergency in Myanmar were identified: the disruption of methadone treatment; the deferment of the opening of 18 new methadone clinics planned for 2020; delayed initiation of OAT; and reduced training, counselling and peer network activities, in addition to COVID-19 infection control.

To avoid crowding in methadone clinics, take-home methadone doses were introduced from the first week of March. New patients were given three-day take-home doses, and patients under OAT for more than three months and with random negative urine tests were given doses for up to 14 days. Take-home doses for 21 days were given to patients hosted in COVID-19 quarantine sites or who lived in travel-restricted areas. For safety, take-home doses of methadone were delivered in labelled containers with childproof caps.

Health staff at OAT clinics were mentored and supervised regularly via teleconference. Coordination between local authorities and health-service providers was strengthened. COVID-19 IEC materials and prevention equipment were distributed to patients visiting the centres. In the OAT clinics, handwashing facilities were renovated and control measures implemented to reduce the risk of COVID-19 transmission.

[10] Source: Presentation at UNODC/WHO webinar by the Drug Dependency Treatment and Research Unit, Ministry of Health and Sports, Myanmar, May 2020.

TABLE 11. TAKE-HOME PLAN: MYANMAR

Before COVID-19	*During COVID-19*	
Daily dose in MMT clinics for 80% of patients	Take-home doses for 80% of patients	
Take-home doses for about 20% of patients	Take-home doses for 3 to 14 days	
	Induction of new patients: 3-day take-home doses	
Results	*July 2019–Dec. 2019*	*Jan. 2020–June 2020*
Number of new patients	5 200	4 123
Number of patients lost to follow-up	2 716	2 617
Number of overdose deaths	1	3
Total number of patients under OAT (last month of the period)	19 991	21 644

A rapid assessment of implementation and outcomes of methadone take-home doses in Myanmar during COVID-19 has been conducted and is being finalized.

The take-home dose initiative was effective and did not lead to increased diversion: on the contrary, information indicates that there was less diversion than before. Two cases of accidental ingestion of methadone were reported. Naloxone stocks were regularly checked and refilled to avoid stock-outs.

The evaluation identified for the future the need to promote and expand tele-mentoring for health staff to all methadone clinics and to provide psychological support to service providers. It also recommends the provision of take-home naloxone.

Nepal[11]

Nepal has an estimated 35,000 people who inject drugs. In 1991 it became the first country in South Asia to start harm reduction, with NSPs. OAT with methadone and buprenorphine is provided at eight governmental and four non-governmental sites located in 10 districts. The 2017 national guideline for OAT does not make provision for take-home doses.

The first case of COVID-19 was notified on 23 January 2020. On 20 March a lockdown was put in place, lasting until June 2020. In view of the difficulties faced by OAT patients and implementers, a meeting of the harm reduction technical working group was called by the Ministry of Home Affairs, which decided to modify the guideline and implement take-home OAT to reduce the number of patients at OAT clinics.

A new temporary guidance for harm reduction programmes was developed by the National Centre for AIDS and STD Control (NCASC). The new protocol included take-home doses and several measures to prevent diversion and overdose. Patients were required to ask a family member to accompany the patient to the clinic when collecting the medications for the week and to supervise at home the daily intake of the dose. All patients had to sign a consent form. Their phone number, as well as those of family members, was recorded. For new patients, OAT was dispensed on a daily basis. For patients and family members unable to travel to the clinics, starting the second week of the lockdown, doses were brought by staff of the social support unit (SSU) to the patient's home. All patients were followed up

[11] Sources: Presentation at UNODC/WHO Webinar, by Ministry of Home Affairs, Narcotic Drug Control Section, Nepal, April 2020; interviews with Mr Arjun Bhandari, under-secretary of Ministry of Home Affairs, Narcotic Drug Section, and with Mr Rishi Ojha, community representative.

daily by phone and provided with counselling by the SSU, and a tracking sheet was maintained. A member of the technical working group monitored the OAT centres weekly.

TABLE 12. TAKE-HOME PLAN: NEPAL

Before COVID-19	*During COVID-19 lockdown*
Daily dose on site	Take-home doses for one week

Results

The measure was implemented for seven weeks, until 12 May 2020, when the lockdown was partially lifted. Weekly reports were shared with all stakeholders of the technical working group.

During that period there was no report of overdoses, nor of diversion, and no irregularities were observed. Very few patients were lost to follow-up.

TABLE 13. RESULTS: NEPAL

2020	*Number of patients: buprenorphine*	*Number of patients: methadone*	*Total*	*Comment*
24 March–31 March	173	693	866	7 days take-home
1 April–7 April	167	693	860	
8 April–15 April	168	699	867	
16 April–23 April	173	691	864	6 new patients and 5 re-enrolled
24 April–27 April	178	695	873	2 lost to follow-up
28 April–4 May	166	675	841	15 patients on daily doses
5 May–11 May	168	674	842	23 patients on daily doses
12 May	End of take-home doses			

Patients were satisfied with the initiative and treatment was not interrupted.

Sustainability

The take-home dose policy could not be maintained after the first lockdown because the current law requires doses to be administered daily. It will be necessary to advocate with parliament to modify the law.

In May 2021, in view of the second wave of the pandemic, NCASC published updated interim guidance for continuing HIV programme service delivery during the pandemic, which makes provision for take-home doses of methadone or buprenorphine and provides clear guidance on how to implement and monitor the programme [15].

Future plans include the revision and amendment of the old guidelines, extension of the number of OAT sites and regular monitoring of the centres. Recovery Nepal and other

stakeholders are advocating for the take-home dose policy implemented during COVID-19 to be assessed and data used to support the maintenance of take-home doses. At local level, surveys should be conducted to assess the family situation of each person who injects drugs. A community-led support project and IEC materials will be developed. Plans also include the establishment of coordination mechanisms for OAT and harm reduction services at all levels.

South Africa[12]

South Africa has an estimated 75,000 people who inject drugs, 14–21 per cent of whom are living with HIV (ranging from 11 per cent in Cape Town to 58 per cent in Pretoria). As of 2019, OAT was available in Cape Town, Johannesburg and Pretoria through the private sector, with coverage estimated at between 25 per cent and 50 per cent. OAT services started in Mbombela (Mpumalanga Province) in the first part of 2020.

The first confirmed case of COVID-19 in South Africa was notified on 5 March 2020, and on 23 March a state of emergency and national lockdown was announced, significantly affecting street-dwelling and marginalized people. Several regulations were adopted, including the creation of temporary shelters for people living on the street.

Pretoria

In Pretoria there was already political support for harm reduction, including NSPs and OAT, with the engagement of the city, civil society, family doctors and academia. With the lockdown, about 2,300 homeless people were moved to Caledonian Stadium. Many people rapidly started going into opioid withdrawal. Community drug services adapted their services, integrating COVID-19 screening, primary health care and assistance to people facing withdrawal symptoms. People who were already stable on OAT were placed on weekly take-home doses, and their treatment continued without interruption. Protocols were adapted to rapidly initiate OAT for people sheltered in the stadium.

In a period of six weeks, 1,200 people started methadone. City officials expressed concern about provisioning OAT outside the stadium, concerned that "walk-ins" off the street would access the OAT services, and they eventually required clinical teams to move within the stadium. An NSP was explicitly forbidden in the stadium, as city officials regarded the concurrent provision of OAT and NSPs to be mixed messaging.

This rapid initiation of many OAT patients increased the need for methadone supplies, which was generally met. Provision of more comprehensive harm reduction (such as integrating treatment for HIV, TB, viral hepatitis and other chronic diseases) was impossible, given the emergency nature and conditions of the response.

Durban

Historically, authorities in Durban have shown significant resistance towards harm reduction. In 2018, eThekwini's NSP services were stopped by the municipality.

With the onset of the COVID-19 pandemic, thousands of people were put together in shelters, and hundreds started to go into withdrawal. Civil society, community and academic providers partnered with the municipality to provide services in selected shelters,

[12] Sources: Presentation at UNODC/WHO webinar by Andrew Scheibe on behalf of the harm reduction partners, May 2020; interviews with three community members (one woman and two men) from the South African Network of People who Use Drugs (SANPUD).

including symptomatic management of opioid withdrawal and initiating 240 people onto short-term methadone or tramadol. For people unable to go to the centres because of TB, medications were given by the nurse to peers to deliver to the patient's home. Naloxone was introduced in harm reduction sites for overdose management and distributed in training law enforcement. The positive public health and security impacts of the programmes and the partnership with law enforcement changed the attitude of the police towards people who use drugs at all levels [16]. As a result, local authorities publicly expressed their support for harm reduction, and the previously halted NSP was reinstated in the middle of the pandemic. In addition, OAT services began in Durban in January 2021.

Results

The COVID-19 pandemic created an opportunity for large-scale OAT programmes implemented in various municipalities in South Africa and supported by the authorities.

There was no report of overdoses, and research conducted during the pandemic did not show any increase in overdoses. No major problem of diversion was reported.

Challenges included that at the end of the lockdown, when shelters were closed, it was difficult to track people who had been there. Some did not like the restrictions imposed in the shelters, and several people dropped out of the programme.

Sustainability

The initiatives implemented during the COVID-19 pandemic led to several positive impacts, including buy-in by authorities for harm reduction and political will for OAT, reduced stigma against people who use drugs, and the development of a support programme specifically for women by the South African Network of People who Use Drugs (SANPUD).

In a non-pandemic situation, the majority of OAT is delivered free of charge by donor-funded civil society organizations and academic institutions. There is currently no national or provincial funding for OAT maintenance. At the end of the lockdown, Pretoria did not have funds to support the OAT programme for people in temporary shelters, although the rest of its programme continued, albeit with reductions in funding.

SANPUD and the harm reduction network are pursuing advocacy for authorities to fund OAT programmes beyond the state of emergency, and to have OAT placed on the Essential Medicines List for primary care in the public sector, so that it can be funded from domestic sources, rather than from donor funding as is currently the case in all cities except Pretoria.

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