



**UNODC**

United Nations Office on Drugs and Crime



# NOT JUST FOR **EMERGENCIES**

How we can draw on the experience  
of COVID-19 to improve access to  
opioid agonist therapy

ADVOCACY BRIEF

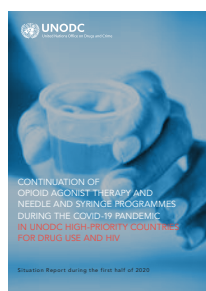


## Advocacy brief

The advocacy brief describes the results of adaptations in the coordination and delivery of opioid agonist therapy (OAT) taken by some countries during the COVID-19 pandemic to ensure the continuity of the essential services for people who use drugs. It makes recommendations on how countries can capitalize upon the successes achieved through the introduction and expansion of take-home OAT and other flexible approaches to OAT.

This brief is intended for policymakers, programme planners, service providers, including the community of people who use drugs, and health and law enforcement authorities. It argues that the successful measures taken during the pandemic should be implemented more widely, not just to prepare for the next health or humanitarian emergency, but also to deliver more flexible and person-centred harm reduction services in non-emergency settings.

The brief is based on the report prepared by UNODC in collaboration with WHO and UNAIDS that details the experiences and lessons learned from the COVID-19 pandemic with respect to the delivery of OAT, needle and syringe programmes and interventions for the prevention of overdose-related deaths. Most countries surveyed for this report are developing plans to maintain take-home OAT.



The report *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* is available at [www.unodc.org/documents/hiv-aids/2022/22-10823\\_eBook\\_4.pdf](http://www.unodc.org/documents/hiv-aids/2022/22-10823_eBook_4.pdf).

## Definitions of key terms

**Opioid agonist therapy (OAT)** refers to the prescription of opioid agonist medications 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 (also 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.

**Harm reduction:** For the purposes of this advocacy brief, 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.<sup>1</sup>

**Take-home doses of opioid agonist therapy:** For the purposes of this advocacy brief, take-home doses of opioid agonist therapy is defined as dispensing opioid treatment medications to stable patients for unsupervised use for a determined amount of time (subject to the treatment programme requirements).

<sup>1</sup>*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

Take-home doses of opioid agonist therapy (OAT) for people in treatment for opioid dependence have been recommended since well before the onset of the COVID-19 pandemic by WHO, UNODC and UNAIDS.

Faced with restrictions on movement following the outbreak of the COVID-19 pandemic, some countries adopted a more flexible approach to OAT service delivery, allowing take-home OAT to ensure that their patients would continue and adhere to treatment. In some countries, this brought about the implementation of 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.

The progress made in this regard should be maintained to improve treatment adherence and quality of life for people in treatment for opioid dependence, including in non-emergency settings.

## KEY STEPS TO ENSURE THE CONTINUATION AND SUSTAINABILITY OF TAKE-HOME OAT

- 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 community-based overdose prevention and overdose response programmes
- Ensure that staff is appropriately trained on take-home OAT service delivery
- Put in place systems to monitor, report and act on diversion if and when it occurs

*the successful measures taken during the pandemic should be implemented more widely*

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

The COVID-19 pandemic caught the world off guard. Health systems and communities, under-resourced for the emergency, were pushed to breaking point. The pandemic exacerbated the disparities and inequities already faced by people who use drugs, especially regarding access to prevention, diagnosis and treatment services for HIV, viral hepatitis or TB as well as overdose prevention and management and drug dependency services.

Across all regions of the world, lockdowns and other restrictions on movement were imposed to contain the pandemic. The biggest disruptions to harm reduction and health services for people who use drugs were in the first half of 2020, when many countries were in their first lockdowns and programmes were scrambling to adapt.

As states of emergency were declared, some countries addressed restrictions on movement with a more flexible approach to ensure continuity and adherence to OAT for people who use drugs by:

- Implementing or expanding take-home doses of OAT
- Delivering OAT to people under lockdown or in isolation
- Providing support, counselling and monitoring remotely, using telehealth and virtual platforms for information and support

This greater flexibility in delivering OAT has long been called for by UNAIDS, UNODC and WHO [1,2]. And the experience in countries that did so has shown success. In the first half of 2020, people who use drugs were able to maintain their health and well-being under extremely adverse circumstances in countries that adopted these measures.

Countries that took these steps saw positive results, despite the restrictions caused by lockdowns and limits on movement. During the first half of 2020:

- People in lockdown or isolation were able to continue OAT.
- Treatment adherence was good, with limited loss to follow-up.

- The demand for OAT and OAT enrolment increased.
- There were no increases in reported overdoses.
- There was no increased diversion of OAT medication to the black market.

To support these efforts, UNODC issued guidance on the continuation and sustainability of harm reduction services during the pandemic [3] and WHO issued guidance identifying OAT (along with needle and syringe programmes) as an essential health service that should be maintained [4].

COVID-19 provided unprecedented circumstances that set into motion adaptations that worked and that we can learn from.

As pandemic restrictions are lifted in many countries, we must build on the lessons learned from flexible programme implementation during the COVID-19 pandemic by putting in place regulatory and administrative mechanisms and removing legal barriers, while furthermore mobilizing the leadership and investment needed for a more efficient HIV and viral hepatitis response with and for people who use drugs and to support their safety and health, and that of their families and communities.

From the beginning of the pandemic, the community of people who use drugs took a vital role in collaborative decision-making with governments, health, and law enforcement authorities – as well as in delivering services to their peers.

COVID-19 revealed once again how vital harm reduction services are for people who use drugs. These services provide not only life-saving commodities and care, but also equally essential human and social connections.

## People-centred and sustainable COVID-19 responses with and for people who use drugs

The recommendations below will help in the next emergency – whether it is a health emergency or a humanitarian crisis – but they are equally valid for improving the HIV and viral hepatitis response in non-emergency situations.

### Flexibility is essential!

Greater flexibility in dispensing OAT demonstrated the effectiveness of take-home doses. The pandemic was also an opportunity to explore new channels of communication and support. Here are the implications for harm reduction going forward:

- Take-home doses of OAT for stable patients should be expanded – they support adherence to OAT and provide other benefits to patients (see box below) without leading to an increase in diversion or overdose.
- Peer support in the delivery of OAT can be effective and can increase trust among patients.
- Online technologies and phone contact make it possible to provide regular support to OAT patients when travel and face-to-face contact are difficult or must be avoided. However, these methods have their limitations in countries with poor Internet access, or where few people who use drugs have a phone or a smartphone.

### BENEFITS OF TAKE-HOME DOSES OF OAT

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- ★ Improved quality of life for patients as a result of greater time available for work and family
- ★ Reduced crowding and risk of transmission of airborne diseases (such as TB and COVID-19) at clinics
- ★ Reduced transport costs and time for patients
- ★ Promotion of the human rights of patients by reducing stigma and treating them with trust and dignity

### Coordination is key!

COVID-19 triggered the need for multisectoral coordination. Good results were documented in countries that established partnerships – in some cases for the first time – between harm reduction services, community-led organizations, communities of people who use drugs, health services and law enforcement agencies. This is what we learned works:

- A robust and inclusive coordination mechanism for harm reduction and other health services, involving governmental institutions, health professionals and community actors – including community-led organizations – and collaboration through national and local networks
- Partnerships with law enforcement at national and local levels, wherever feasible, to support flexible delivery of harm reduction services
- Virtual platforms to ensure communication and strengthen coordination between stakeholders
- Webinars to disseminate new guidelines widely and efficiently

*Greater flexibility in dispensing OAT demonstrated the effectiveness of take-home doses*

## Community at the centre of the response!

Trusting communities of people who use drugs has consistently proved to be a winning strategy. From the beginning of the pandemic, community-led organizations proved creative and resilient, finding solutions to protect people who use drugs. The emergency response was an opportunity for peer-led organizations to take further leadership in service delivery. These lessons from COVID-19 have implications for harm reduction in non-emergency situations too, and should be a priority for local and national governments:

- Support community-led organizations to engage in leadership and delivery of harm reduction services
- Include representatives of the community of people who use drugs in the design and implementation of relevant policies
- Allocate adequate resources to support peer-led interventions
- Ensure the access to gender-responsive harm reduction services (including delivery of services by community health workers or peer-support workers)

### THE COMMUNITY TAKES THE LEAD IN HARM REDUCTION DURING THE COVID-19 PANDEMIC

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- ★ Recovery Nepal, a peer-led organization, was authorized to deliver OAT while the state of emergency was in place.
- ★ In Bangladesh, community network volunteers dispensed OAT and followed up with OAT patients.
- ★ In Cape Town, the South Africa Network of People who Use Drugs (SANPUD) and other stakeholders advocated successfully for the provision of harm reduction and OAT at two shelters, provided protective equipment and hygiene kits to people who use drugs, and trained city health and social services staff on harm reduction counselling.

## Identify and address existing legal barriers that restrict OAT provision!

In some countries, flexibility in OAT dispensing was only permitted during the state of emergency. In order to continue this in non-emergency situations, it is important to identify and address existing legal barriers that restrict OAT provision.

### THE RISK OF “BUSINESS AS USUAL” ONCE THE EMERGENCY IS OVER

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- ★ In Afghanistan and Nepal, take-home OAT dosages were stopped as soon as the state of emergency was lifted.
- ★ In Belarus, advocacy by civil society, UNODC and WHO led to the development of “OAT instruction” and “The Clinical Protocol for Opioid Dependence Treatment”. OAT instruction was approved in late 2021 and is currently implemented, including take-home OAT. The clinical protocol has not yet been approved.

The following actions are needed to ensure that OAT is delivered flexibly in both emergency and non-emergency contexts:

- 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, in line with the recommendations of UNAIDS, UNODC and WHO
- Use multisectoral partnerships such as the ones formed during the pandemic to advocate for the changes needed to allow for the flexible implementation of OAT
- Advocate for services that are tailored to the needs of specific populations, such as women who use drugs (also including services addressing gender-based violence), young people and homeless people who use drugs (including shelter- as well as street-based services)

1 WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention (WHO, 2004).  
2 Guidelines for psychosocially assisted pharmacotherapy for the management of opioid dependence (WHO, 2009).  
3 COVID-19: HIV prevention, treatment, care and support for people who use drugs and people in prisons (UNODC, 2020).  
4 Maintaining essential health services: operational guidance for the COVID-19 context, interim guidance, 1 June 2020. (WHO, 2020).



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