Opioid substitution therapy in resource-poor settings

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Approximately 10% of new HIV infections worldwide are attributable to injecting drug use, often of an opiate such as heroin.[1] Opioid substitution therapy supplies illicit drug users with a replacement drug, a prescribed medicine such as methadone or buprenorphine, which is usually administered orally in a supervised clinical setting. The effectiveness of this therapy is recognized in developed countries, where the provision of opioid substitutes to opiate-dependent people is a fundamental component of the response to the dual public health problems of injecting drug use and HIV transmission.[2] However, better prevention of HIV transmission among and from injecting drug users is still needed, especially in resource-poor settings.[3]

Opioid substitution therapy programmes are effective in substantially reducing illicit opiate use, HIV risk behaviours, death from overdose and criminal activity, and financial and other stresses on drug users and their families.[4–6] These programmes also improve adherence to antiretroviral therapy and the physical and mental health of injecting drug users.[4–6] Many injecting drug users who would otherwise have no contact with any health services are attracted by these programmes, which then act as gateways to other services including primary health care, HIV testing, antiretroviral therapy and services for tuberculosis, hepatitis C and sexually transmitted infections.[7] Additionally, a critical ingredient of the HIV-prevention response is mobilization of affected communities, which is only possible for injecting drug users when they are not fully occupied with obtaining an ongoing supply of illicit drugs.

Despite the evidence of effectiveness, it is estimated that only 8% of injecting drug users globally currently receive opioid substitution therapy – even less in developing countries.[1] There is substantial global inequity in access – for example, 90% of injecting drug users in the United Kingdom of Great Britain and Northern Ireland and 69% in Australia are receiving such therapy; compared with 3% in China and India, and none in the Russian Federation, where opioid substitution therapy is not available.[1] Opioid substitution therapy is endorsed by the Joint United Nations Programme on HIV/AIDS, the United Nations Office on Drugs and Crime and the World Health Organization[2] – methadone and buprenorphine are on its Essential Medicines list.[8] Yet doubts about the wisdom of providing opioid substitution therapy to injecting drug users are widespread in developing countries, where abstinence is often seen as the only legitimate treatment goal, and human rights are frequently violated in attempts to achieve this.[9] Barriers to effective implementation of opioid substitution therapy programmes in these settings include: a lack of political will to act; the need to change relevant laws; entrenched social and structural discrimination against injecting drug users; the cost of providing the therapy (despite the ample evidence of cost-effectiveness);[10] and the relative lack of local evidence for effectiveness in resource-poor settings.

Even among those involved in HIV prevention and care there is often limited understanding of addiction and of the role of opioid substitution therapy as treatment. Opiate dependence is a chronic relapsing condition with sometimes catastrophic effects for individuals, families and communities. This is only amplified in resource-poor settings. Opioid substitution therapy is not a cure for drug dependence – it is a therapy for management of a chronic condition. Some clients may need therapy for years and some for their entire life. One of the most consistent findings in both high-income and resource-poor settings is that the more time injecting drug users spend on opioid substitution therapy, the better the outcomes and the less they are likely to engage in high risk behaviours.[11]

India is a good example of a developing country that is gradually integrating the provision of opioid substitution therapy into public health policies and programmes. Following two successful pilots in 1999–2002[12] and 2006–07,[11] the National AIDS Control Organization has included opioid substitution therapy in its third five-year plan, proposing to scale-up the programme to reach 40 000 injecting drug users by 2011.[13] However, coverage remains inadequate at this time and challenges to the scale-up include: current unavailability of methadone (but not of buprenorphine, a more costly alternative); ineffective health services in some areas, necessitating government accreditation and monitoring of many existing opioid substitution therapy programmes run by nongovernmental organizations; and residual scepticism about its value in India.

Governments of countries in which injecting drug use and HIV transmission are recognized public health problems now face several questions. What is the most effective model for implementing opioid substitution therapy? How can opioid substitution therapy become a fundamental component of integrated HIV prevention and how can the quality of the programmes be ensured and evaluated? ■

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