Increasing opioid agonist treatment (OAT) coverage globally

Key takeaways from INHSU 2023 Policy Day,
Geneva, Switzerland

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Background and rationale

Each year at the International Conference on Health and Hepatitis in Substance Users, INHSU convenes a Policy Day focusing on core topics of interest to those working to improve the health and wellbeing of people who use drugs.

On the 16th October 2023 at the INHSU 2023 conference in Geneva, Switzerland, policy makers, practitioners, community members, and advocates gathered to discuss increasing opioid agonist therapy (OAT) coverage globally.

OAT reduces many of the harms associated with opioid dependence in the context of criminalisation. Improving OAT coverage globally will significantly affect morbidity and mortality outcomes for people who use drugs.

Although there is a gradual increase in harm reduction intervention coverage globally, coverage and scale of interventions, such as OAT, is limited.

The meeting provided a forum for discussing increasing country level and individual OAT access. By discussing delivery models, treatment modalities, developments in OAT options, and the necessary frameworks for structuring OAT implementation and scale up, the meeting aimed to:

1. Promote introduction of OAT in countries yet to provide
2. Promote scale up of OAT in countries not reaching targets for level of provision
3. Promote tailored OAT delivery models that are locally relevant and responsive to clients' needs

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Countries represented

- Australia
- Costa Rica
- Côte d'Ivoire
- Egypt
- France
- Germany
- India
- Italy
- Kenya
- Mozambique
- Netherlands
- Nigeria
- Romania
- South Africa
- Switzerland
- Tanzania
- UK
- Ukraine
- USA
- Vietnam

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Presentation Takeaways

The Policy Day opened with four presentations to provide context:

1. Global coverage and effectiveness of OAT
2. OAT commodity pricing
3. Community perspective of OAT access
4. Clinical perspective of OAT delivery

The following pages outline key takeaways from each presentation.

Global coverage and effectiveness of OAT

Louisa Degenhardt, UNSW

- OAT has evidence of wide-ranging impacts including reducing overdose risk and incidence of HIV and HCV
- Current OAT coverage is far from ideal. Globally, <20 people per 100 people who inject drugs have access to OAT
- Regionally, Australasia, South Asia, and Western Europe have high coverage, North America has moderate coverage, and the remainder of regions have low coverage
- There has been little shift in coverage between 2017 and 2022
- In addition to poor coverage, there is evidence of suboptimal dosing resulting in poorer retention, limited access to unsupervised dosing, and widespread use of urine drug screening (which has not been demonstrated to improve outcomes)
- In comparing methadone and buprenorphine, data has shown that at timepoints beyond one month, retention is better for methadone than for buprenorphine, there is some evidence that extra-medical opioid use is lower in those receiving buprenorphine, and there is no evidence of differences in adherence between methadone and buprenorphine
- It is possible that retention outcomes differ among people dependent on fentanyl, and that such differences are not consistent between methadone and buprenorphine
- Higher cost of buprenorphine is a barrier – to governments and to clients, depending upon funding models

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OAT commodity pricing
Umesh Chawla, CHAI

Key OAT market barriers include:

- There is a lack of robust international benchmark pricing and country level purchase data for methadone and buprenorphine
- There is limited visibility of country level demand which limits the scope of market shaping
- There is a lack of market transparency which can cause price variability and limit access to affordable products

Opportunities for strengthening OAT commodity pricing include:

- There is huge potential for market shaping and bringing down the costs of OAT products, this can be done by collectively sharing data and advocating for more information on OAT product availability, quality and pricing
- By better projecting country level need (quantities and time frames) countries can advocate for price optimisation
- There is precedent for price reduction in the field of HIV, HCV and TB where commodity pricing has reduced, and access significantly increased

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Community perspective of OAT access
Judy Chang, INPUD

- OAT is often described as "liquid handcuffs". The surveillance, registration, and multiple referrals associated with OAT programs, often requiring daily attendance, can be about control rather than compassionate care
- Accessing much-needed take-home doses is complicated and not widely available
- There are concerns about the mandatory nature of provider decisions and appointments, potentially limiting people's' ability to manage other responsibilities
- Expulsion from programs for missed appointments, may not consider people's other life responsibilities
- There is often an abstinence agenda, when OAT should be about respecting human agency and providing person-centred care. The measure of success in OAT should not solely be abstinence.
- There should be no mandatory drug testing
- There should be an integrated approach involving pharmacies, peer navigators, GPs, mobile vans
- Community involvement and perspectives when designing OAT programs is critical
- Countries and programs need to learn from past mistakes and adopt more progressive approaches
- There should be greater efforts to combat stigma and discrimination

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Clinical perspective of OAT delivery *Philip Bruggmann, ARUD*

- Diversification of OAT is important – not every opioid has the same effects in every patient. Personal preferences and input into dosage decisions should be respected
- The following factors can contribute to high coverage and retention in OAT:
  - Low threshold access. For example, same day treatment initiation and flexible opening hours
  - Integrated care. Such as psychiatric care, psychotherapy , internal medicine, infectious disease, gynecology. *However, these services should never be compulsory*
  - Peer involvement at different levels helps to tailor a service to the needs of patients
- Guiding principles for 'ideal' OAT provision:
  - Refusing therapy to a patient based on a positive urine test is unethical and can be compared to denying insulin to a diabetic patient with high blood sugar
  - OAT should be provided in a safe and trusting environment conducive to a therapeutic approach
  - Take home dosing should be available
  - There should not only be a choice of different medication but also different galenic forms suitable for patient's preferred method of consumption, including injection
  - OAT costs should be fully reimbursed or waived for patients to avoid economic barriers to treatment

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Roundtable Takeaways

Attendees were grouped into six multidisciplinary groups. Groups rotated through six roundtables discussing the following topics:

1. Starting and scaling Opioid Agonist Treatment (OAT) programs
2. Types of OAT medications and delivery methods
3. Training needs and workforce development for OAT programs
4. Financing OAT programs
5. Different delivery models for OAT
6. Empowering clients and fostering engagement in OAT programs

The following pages outline each topic's key themes and takeaways.

1. How do you get OAT started in a country? Once introduced, how do you scale up access?

- Leverage Global Fund funding opportunities – there is acknowledgement that countries will not be able to eliminate or control HIV/HCV without harm reduction, so use this to garner support for OAT programs. Several countries referenced success in linking OAT provision to health issues such as HIV as a way of 'kick starting' programs
- When establishing programs, or planning pilot programs, visit other programs in other countries to understand models that work, what evidence is needed to prompt scale up and methods for data collection, and how advocacy approaches have been used elsewhere
- Know your constitutions/religious texts (e.g. the Quran) and use these to your advantage – e.g. emphasising human rights and calls to support other's rights
- It is important to have community advisory boards guide implementation
- Ensure there are local political champion/s
- Ensure broad stakeholder engagement – ministries, funders, community, international bodies like WHO, UNAIDS, etc
- Local manufacturing of OAT is significant in making OAT programs cost effective

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Key takeaway

Harm reduction interventions such as OAT and needles and syringe programs (NSP) are effective at preventing HCV and HIV – leverage this to garner support and funding for OAT programs.

2. What OAT medications are available?

- There are a range of OATs used around the world, including:
  - Diacetylmorphine: Pharmaceutical grade heroin, also known as heroin-assisted treatment
  - Slow-release morphine: A long-acting form of morphine
  - Hydromorphone: Generally used for the short-term relief of severe pain, sometimes used to treat opioid use disorder
  - Methadone: A synthetic opioid that is used to treat opioid use disorder
  - Buprenorphine: A synthetic opioid that is used to treat opioid use disorder
- The most used forms of OAT are methadone and buprenorphine
- Methadone is taken orally, and is available in liquid, tablets, and powder (usually dissolved in water and taken as a drink)
- Buprenorphine comes in different forms, including a film or tablet that melts on the inside of the cheek or under the tongue, an implant that is placed under the skin and lasts for six months and an injection that is administered under the skin and lasts for one week or one month, depending on the formulation
- Methadone is generally the lowest cost option which could result in it being prescribed more than buprenorphine. However, in Switzerland where cost is not a factor, only 8% of people accessing OAT use buprenorphine due to the partial agonist effect

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Key takeaways

1. Choice of OAT and the form in which it is taken is important. Watch our short film about OAT choice 'My Choice', here
2. Globally, there is wide-spread urine drug screening. This is a barrier to OAT delivery and is not shown to have any positive impact on OAT outcomes

3. How do you meet training needs and build a workforce?

- Awareness raising and sensitisation for a broad cohort of people (e.g. police, corrections, data handlers, security guards) is needed as well as technical training. Prioritising training for Ministries of Health is important.
- Community should be engaged from the beginning, both as contributors to training design and as training recipients
- Effective training mechanisms include; country visits, establishing country champions, using case studies and personal testimony, and peer-to-peer training
- There are strong examples of training delivered by community (Ukraine)
- Important training topics:
  - Human rights, particularly in the context of law enforcement
  - Stigma and discrimination
- Challenges related to training and workforce development:
  - Measuring training impact
  - Managing staff turnover, both health care providers and community
  - Scalability and reach – ensuring all have access to appropriate training and support

Key takeaway

Training is crucial and is required for all stakeholders involved in establishing and maintaining OAT programs.

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4. How is OAT funded?

- High pricing is a significant barrier to OAT accessibility. OAT represents one of the more costly harm reduction interventions
- Political considerations make domestic production of OAT unlikely, and procurement remains centralised
- In many countries (especially low-and-middle-income countries), a combination of Global Fund and government funding supports OAT
- There is a notable absence of insurance models or public/private partnerships
- Recommendations for improving regulations and policies:
    - National and international controls on pricing should be implemented
    - Submit national estimates to The International Narcotics Control Board (INCB) for oversight
    - Internal and external policies, including factors like import duties, influence cost and pricing

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4. How is OAT funded? (continued)

- How to reach economies of scale to reduce costs:
  - Emphasise the importance of accurate need projections and robust data
  - Consider WHO pre-qualification to ensure quality standards
  - Facilitate knowledge sharing on pricing and procurement, exploring options like pooled procurement (e.g., WAMBO - the Global Fund's online procurement platform)
  - Develop negotiation capacities, leveraging the above strategies
- Ensuring cost-effective delivery:
  - Address community needs and client flexibility in service provision
  - Consider that Methadone administration models often include a higher level of medical involvement which comes at a cost
  - Acknowledge and mitigate additional costs related to control measures and potential wastage (seek examples of cost reduction while maintaining client-centred services). Recognise that any reliance on out-of-pocket expenses acts as a barrier and deterrent
  - Effective pricing strategies must be complemented by robust regulatory frameworks, policies, and guidelines. Emphasis should extend beyond medication costs to encompass overall delivery expenses

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Key takeaways

1. Enhance procurement capabilities at local, regional, and international levels
2. Demonstrate the cost effectiveness and savings of programs – cost effectiveness does not equate to compromised quality

5. What are the different delivery models and how do they work?

- Some countries have community-based models however many are centralised models (often in psychiatric or mental health settings which fuels stigma around OAT). Many are seeking to decentralise OAT delivery
- Harm reduction in prisons, including OAT provision, is lacking globally. There are 59 countries that provide OAT in prisons; this is an important delivery model to consider
- Integrating OAT provision with HIV/TB/HCV care can be an effective approach
- Policies governing take home doses, whereby clients are provided OAT medication to self-administer without any supervision or requirement to attend a clinic, should be considered
    - Take home dosing can lead to improved client experience and retention in OAT and can reduce the need for health care practitioner resources. However, some OAT clients appreciate the structure of daily supervised dosing and so personal choice is an important consideration
- Long-acting injectable buprenorphine (LAIB) is being delivered in some countries. LAIB can achieve sustained drug release for extended periods of time, which reduces dosing requirements and may lead to improved client experience and retention in OAT

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5. What are the different delivery models and how do they work? (continued)

- Barriers to effective OAT delivery models
  - Community involvement insufficient
  - Can require policy and law changes and collaboration with law enforcement
  - Many governments are worried about OAT medication diversion, this can threaten establishment of treatment services and compromise public acceptance of OAT
  - Stigma and discrimination in public health facilities is a major concern for people accessing OAT services
  - Centralised care may not be patient centred, generally a move to community-based OAT delivery is preferred
- Solutions
  - Option for take home dosing essential for increased quality care
  - Continuity with prison system important
  - Multi-disciplinary approach to service delivery is important
  - Public funding for service delivery is required for program sustainability

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Key takeaways

1. Diversification of service models is important. Particularly models that have a person-centred approach and are community driven
2. Attention should be given to establishing OAT programs in prisons

6. How do we deliver OAT in ways that empower clients and make people feel engaged and invested?

- Centre trust building – without trust you won't get people engaged in the program
- Involve community members / peer workers in OAT service delivery meetings/clinical meetings
- Need to ensure objectives of the OAT program and person engaging in treatment align – ensure a partnership approach and co-ownership of treatment decisions
- Listen to clients to understand what services/commodities are or are not needed – clients don't need unnecessary services based on assumptions

Key takeaway

Community involvement in policy making, service design, service delivery, and service evaluation is essential

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5 key takeaways and actions

1. **Research funding available in your region** – leverage Global Fund opportunities to garner support for OAT programs, emphasising the link to health issues like HIV and HCV. When seeking funding, demonstrate the cost effectiveness and savings of existing programs and focus on the benefits of integrated OAT programs

2. **Be inspired by other models** – visit existing programs in other countries to understand successful models, evidence requirements, data collection methods, and advocacy approaches

3. **Community involvement –** establish community advisory boards to guide program implementation, centre trust-building as a foundational element for client engagement, and involve community members/peer workers in all elements of OAT service delivery

4. **Investigate strategies to reduce costs –** high OAT pricing is a barrier to accessibility. Advocate for enhanced procurement capabilities, using robust data to reach economies of scale and reduce costs.

5. **Focus on training needs –** prioritise training for Ministries of Health, always engage the community in training design, and make sure it is comprehensive, covering human rights and stigma and discrimination

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