

Policy and Practice of Opioid Agonist Treatment (OAT) in 23 Countries

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Study Background

- Opioids → most severe drug-related harm, including fatal overdoses, contributing to two-thirds of all drug-related deaths globally (WDR'24)
- Critical need for effective and accessible treatment and management of OUD
- OAT (methadone and buprenorphine) reduce harm:
 - ↓ illicit opioid use
 - ↓ risk of overdose
 - ↑ social functioning and quality
- Access to OAT and maintaining adherence face numerous barriers
 - Regulatory
 - Financial
 - Social



Study Aim

- Significant variations in OAT practices and policy exist in different countries
- We sought to understand these differences in the regulatory landscape, availability, and practices related to OAT



Study Design and Methods

- We distributed a survey to **NECPAM and ISAM NeXT** from January to June 2024
- Designed according to “Opioid agonist treatment guiding principles for legislation and regulations” developed by the **Pompidou group and Council of Europe**
- Membership to both networks require **demonstration of expertise** in the field of addiction medicine



Study Design and Methods

- Eligibility criteria → active practice in addiction medicine and/or at least five years of experience in OAT services, research, or policy
- **Convenience sample** from a pool of addiction medicine experts
- Respondents from 23 out of a total of 35 countries completed the survey
- Twenty-six respondents from 23 countries representing **all World Health Organization regions**



Methods

The survey included both closed and open-ended questions covering the following key areas:

- 1) **Country's Opioid Use/Dependence Data**
 - Prevalence of opioid use, opioid use disorder, injection opioid use
 - Prevalence of related health conditions such as Human immunodeficiency virus (HIV), hepatitis C (HCV), and hepatitis B (HBV)
- 2) **National Policy on Drugs**
 - National drug policies
 - Harm reduction strategies



Methods

3) Availability and Access to OAT

- Availability and formulations of OAT
- Practice of telemedicine and take-home dosing for OAT

4) Funding and Remuneration of Healthcare Services

5) Training, Research, and Innovation

- Training healthcare professionals to prescribe and provide OAT

6) Recognition of OAT medication on National Essential Medicines lists



Data Analysis and Validation

- Data reliability was ensured by **cross-referencing** published literature and national-level policy documents
- Each respondent had the chance to correct their country-level data four times
- Due to the heterogeneity of the data, quantitative calculations were not always possible but where possible, were analyzed and compared using descriptive statistics
- Qualitative data were compiled and summarized as a descriptive narrative by TC



Results - Respondents

- Most respondents were medical doctors (16/26) specializing in addiction medicine
- 6/26 were researchers
- All had 10+ experience in addiction medicine
- Responses and countries grouped into regions
 - Asia (Japan, China, Malaysia, Nepal, India, Iran, Lebanon)
 - Europe (Albania, Czech Republic, Netherlands, Italy, Spain, Portugal, Ireland)
 - Africa (South Africa, Nigeria, Kenya, Somaliland)
 - South America (Brazil, Uruguay)
 - North America (Canada)
 - Australasia (Australia and New Zealand)

} NA-AS



National data on opioid use disorder, injection, and overdose

Results

- Issues with **lack of data** fell into the following themes:
- Lack of national data on opioid use and especially OUD in Asian, African and South American countries
- Heterogeneity in reporting of illicit and/or licit opioids
- Heterogeneity of reporting → number of individuals/percentage population /percentage of illicit opioid users who report a loss of control over their use

THANK YOU



SACENDU

SOUTH AFRICAN COMMUNITY EPIDEMIOLOGY NETWORK ON DRUG USE

Treatment Demand Data • Service Quality Measures (SQM)
• Community-Based Harm Reduction Services



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National data on opioid use disorder, injection, and overdose

Results

- Opioid injection prevalence data were limited
- Data for HCV and HBV prevalence were similarly scarce, with only a few countries reporting relevant statistics
- Opioid-related overdose data from national surveys available mainly in North America and Europe

THANK YOU



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Results

Availability and Access to OAT

- **All respondents reported that** methadone, buprenorphine, or buprenorphine/naloxone are registered as OAT
- Iran also registers opium tincture
- Canada includes Slow-Release Oral Morphine, diamorphine, and hydromorphone
- Methadone is the most commonly prescribed OAT in 14/23 countries
- 5/23 use buprenorphine/buprenorphine-naloxone more commonly
- Buprenorphine film is available in 6/23
- Long-acting depot buprenorphine in 7/23



Availability and Access to OAT

Results

- Urine drug testing mandatory in 8/23
- Trained and supported nurse practitioners can prescribe OAT in 4/23
 - Canada, New Zealand, Australia, and the Netherlands
- Written informed consent is required in 18/23 countries
- OAT is not available in prison in 7/23



Telemedicine-based OAT Regulations

Results

- **Respondents indicated that:**
- Official telemedicine guidelines or policies in 9/23
- Only 5/9 allow telemedicine-based OAT dispensing **all in NA-AS**
 - all the OAT medications can be prescribed via telemedicine routes except for New Zealand where only methadone can be prescribed
- The Netherlands does not have telemedicine guidelines but still allows for telemedicine-based OAT dispensing



Take-home dosage of OAT

Results

- 18/23 reported to allow take-home dispensing of methadone
- 16 permit take-home buprenorphine
- 14 Buprenorphine-naloxone
- Duration of methadone take home varies considerably:
 - Methadone – 1 day in Nepal, 30 days in Spain and Uruguay, 4 weeks in SA mainly in private



Results- OAT coverage and funding

- National data for coverage of OAT per 100 people who inject opioids were only available in 12 countries
- National data were absent for African and South American countries
- We input data from Colledge-Frisby et al. (2023)
- Average 50,71% coverage of OAT per 100 people who inject opioids
- Higher averages in NA-AS and European countries (67,67% and 65% respectively)
- Lower averages in Asia (40%) and Africa (2%)
- No data were available for South America
- 16/23 indicated that OAT is fully funded by public health or NGO
 - Exceptions: China, Japan, Lebanon, **South Africa**, Nigeria, and Somaliland



Results- Training needs

- The majority of respondents (14/23) indicated that physicians **must** receive special training to prescribe OAT
- 8/23 that trained pharmacists can also dispense OAT
- 5/23 integrated OAT training into the undergraduate medical curriculum
- 6/23 OAT training occurs at the postgraduate level 
- 8/23 reported no OAT training available for physicians
- 9/23 indicated that undergraduate training is available for pharmacists who dispense OAT



National Essential Medicines Lists

Results

- Among the countries with a National Essential Medicines List, eight (8/15) respondents indicated that some OAT medications are included
- 5/15 indicated none
- SA has methadone on EML but for in-patient acute opioid withdrawal only



Discussion

- Harm reduction **policy does not always translate** to a scaling-up of harm reduction services indicated by low coverage in India and Africa
- Urgent need to **expand OAT access** in low- and middle-income Asian, South American and African countries
- Facing regulatory and funding challenges
- **Long-acting depot buprenorphine** success in Australia
- **Trained and supported nurse practitioners** prescribing OAT is a progressive step forward in lowering barriers and improving access to OAT → especially to rural and underserved populations
 - Notably, these countries had some of the highest percentages of OAT **coverage** for PWID



Discussion

Our “wishlist” for improving addiction care and developing standardized international best practices:

- National availability of methadone, buprenorphine (long-acting depot), naloxone, naltrexone
- Trained nurse practitioners’ prescribing ability
- WHO-aligned enrolment criteria
- Telemedicine for remote prescriptions
- Standardized take-home dosing policies
- Government/NGO funded OAT
- Undergraduate OUD training for doctors and pharmacists



Conclusion

- Global disparities in OAT regulations persist, with limited coverage in low and middle income countries
- Improving training, telemedicine access, and essential medicines inclusion can enhance global OAT accessibility and quality





South African National Data: Opioid use Injecting use Overdoses

SA data is drawn from

SACENDU treatment data

- Registered public substance treatment facilities
- Community based harm reduction services
- Minimal private treatment data (in and outpatient)
- ? Unregistered rehabs

Household surveys targeting key populations



South African Policy

National Drug Masterplan 2019- 2024

- Policy reflects concerns regarding drugs harms
- Sets out OAT, harm reduction and management of comorbidity
- Implementation still focusses on detox and referral to psychosocial treatments

Essential Medicines list

- OAT available for detoxification only
- In practice, not every hospital has access



Availability and Access in South Africa

EML- inpatient detox only

Private and public clinics:

- Variable
 - Evidence based and integrated
 - Ad hoc
- Medications
 - Methadone
 - Buprenorphine/ naloxone
 - Buprenorphine
- Concerns
 - Variable prescribing practices
 - Not funded by medical aids
 - Medication stock outs

Sultan Bahu

- Western Cape Pilot project
- Good retention in care and short-term recovery rates

COSUP

- City of Tshwane pilot project
- Good retention in care comparable to other LMICs

NACOSA

- Funds several NGO programs involved in harm reduction
- Positive outcomes



Tele Healthcare and OAT in South Africa

Telehealth guidelines overseen by HPCSA

No dedicated telehealth OAT services

Public service barriers:

- Data and cellular access
- Privacy

Private:

- Funder rules may differ



OAT Training in South Africa

SAAMS

- In person
- Prescribers
- Online guidelines

TBHIV Care

- Online
- Broad group of practitioners
- Case based



Closing Thoughts

OUD in SA poses a significant public health concern

Epidemiological data exists and can be further strengthened

There is a disconnect in drug policy and practical on the ground care

OAT is limited in the EDL with variable OAT practices in public, private and NGO settings

Efforts have been made to offer evidence based OAT training

Despite advocacy, government buy in, budget and rollout of OAT is still needed

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