Opioid Substitution Therapy in Central Asia:

Towards Diverse and Effective Treatment Options for Drug Dependence

Alisher Latypov, David Otiashvili,
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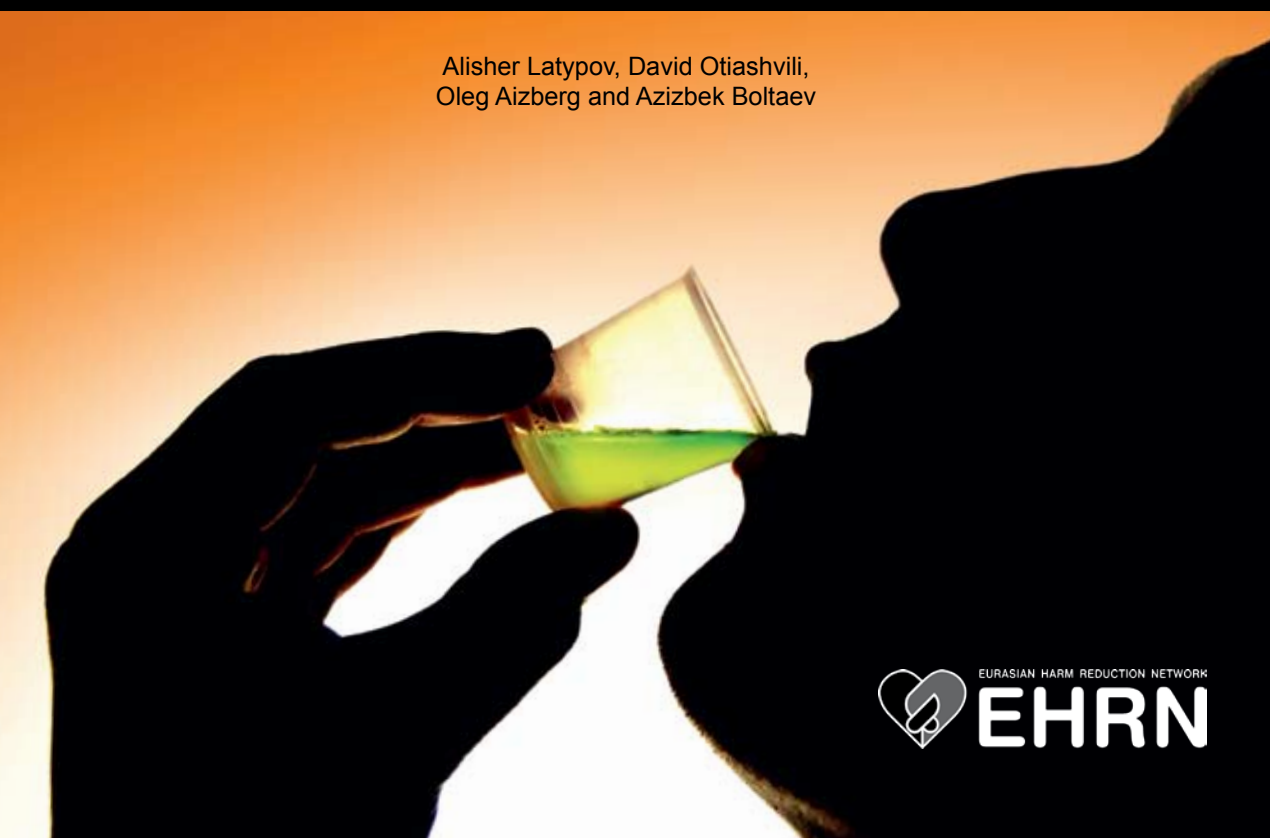

EURASIAN HARM REDUCTION NETWORK
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The Eurasian Harm Reduction Network (EHRN) is a non-governmental network with a mission to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and protecting human rights at the individual, community, and societal level. See www.harm-reduction.org for details.

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Contents

List of abbreviations

AIDS – Acquired Immunodeficiency Syndrome
ART – Antiretroviral therapy
CCM - Country Coordinating Mechanism
ECDC – European Center For Disease Control
ECOSOC UN Economic and Social Council
EHRN – Eurasian Harm Reduction Network
HIV – Human immunodeficiency virus
IDU – Injecting drug user
IHRA – International Harm Reduction Association
NGO – Non-governmental organization
OST - Opioid substitution therapy
TB - Tuberculosis
UN - United Nations
UNAIDS – United Nations Joint Program on AIDS
UNDP – United Nations Development Programme
UNODC – United Nations Office on Drugs and Crime
UNODC ROCA - United Nations Office on Drugs and Crime Regional Office for Central Asia
WHO – World Health Organization

Executive Summary

Situation

Globally an estimated 15.9 million people inject drugs, and 3 million of them have been infected with HIV. In addition to being vulnerable to HIV, people who inject drugs are also vulnerable to viral hepatitis and tuberculosis, sexually transmitted infections, other bacterial infections and death by overdose. Universally the coverage and quality of services available to drug users remain low. In the countries of Central Asia, injection drug use (mostly opiates) with unsterile injection equipment is the main route of transmission of HIV (ECDC, WHO, 2009). In addition many heterosexual HIV cases are associated with injecting drug use, particularly among the non-injecting female sexual partners of drug injectors.

The rapid scale up of prevention and treatment programs specifically targeting injecting drug users must be central to efforts to stop the spread of HIV and treat those affected by it. Opioid substitution therapy (OST) combined with psychosocial support is the most effective treatment option for opioid dependency and is an essential part of measures to prevent HIV transmission among injecting drug users (IDUs) and to support their adherence to antiretroviral therapy (WHO, 2009). OST is one of nine interventions in a comprehensive package of HIV-related services for injecting drug users endorsed by the United Nations. The UN Economic and Social Council (ECOSOC) and the Programme Coordinating Board of UNAIDS in 2009 indicate the existence of a common understanding within the United Nations about what a comprehensive package of HIV-related services for injecting drug users contains. It is outlined by the World Health Organization (WHO), UNODC and UNAIDS in their target-setting guide (WHO, UNODC, UNAIDS, 2009). Universal Access to HIV prevention, treatment and care was adopted as a commitment at the High-Level Meeting on HIV/AIDS in 2006 and is an objective of UNAIDS and WHO.

The governments of Kazakhstan, Kyrgyzstan and Tajikistan have commendably made the decision to introduce opioid substitution therapy programs, despite internal and external opposition. Kyrgyzstan has a strong reputation for leadership in harm reduction programming with some of the highest levels of access to services in Central Asia (Cook and Kanaef, 2008), and was one of the first countries in the Eastern European and Central Asian region to offer OST.

There are still many barriers to overcome to provide adequate access in Central Asia. In Uzbekistan a pilot OST program was closed in 2009 and the Uzbek government is currently opposed to restarting the program. Turkmenistan has never provided OST. None of the Central Asian countries where OST is available (Kazakhstan, Kyrgyzstan and Tajikistan) have managed to reach even 5 percent of the estimated IDU population (Mathers et al, 2008), while the WHO/UNODC/UNAIDS 2009 target setting guide considers anything below 20% as "low" coverage and anything above 40% as "high" coverage. In Kyrgyzstan only approximately 3% have access and in Kazakhstan and Tajikistan, less than 1% do. In Kyrgyzstan, where the coverage of patients is highest, only 948 people receive OST (while there are approximately 25,000 IDUs in the country). In Kazakhstan, only 50 people receive it. In Tajikistan, a pilot program was introduced in the second quarter of 2010, with plans proposed to cover up to 700 people by 2014 (Latypov, 2010). In Uzbekistan, only 142 people received treatment before the program was closed in June 2009 (Kerimi, 2009).

This study analyses the current legal, political and programmatic contradictions and barriers to wider access to OST, with the aim of providing governmental, civil society and international specialists with recommendations for overcoming barriers to further scale up of access to OST in the region. Research involved desk review of available literature, interviews with specialists from the region and a WHO/Europe-supported consultation with civil society, governmental and international specialists held in Bishkek, Kyrgyzstan, in February 2010. The report also uses materials provided by national experts from the Eurasian Harm Reduction Network (EHRN) and Futures Group International in the four countries between June and October 2009 as part of the USAID Health Policy Initiative, Task Order 1, Medication-Assisted Therapy Eastern Europe & Eurasia Project.

Conclusions and Recommendations

The situation regarding OST programs is different in each of the four countries and thus recommendations are provided separately for each country in the full report. However, across the four Central Asian countries covered, the following general conclusions and recommendations can be drawn in this report.

1. Further work is needed to form a solid legal basis for OST programming: In all of the countries decisions, regulatory documents and legal acts on substitution therapy seem to be made in response to short term needs, rather than being developed as part of long-term strategic planning and reform. Different pieces of legislation at different levels are often incompatible or directly contradict one another. In Kazakhstan, Kyrgyzstan and Tajikistan, substitution therapy was introduced by decrees at the level of government ministries and agencies. None of the countries have provisions in law that define the key principles of substitution therapy programs and guarantee that the state will provide them. With these provisions having yet to be introduced in law, the lack thereof at the present moment casts doubt on the commitment of the governments to carry through with the programs in the long term. As of late 2009, with the

exception of Kyrgyzstan, none of the countries have included methadone and buprenorphine in their lists of essential medicines, though methadone and buprenorphine have been included in the WHO Model List of Essential Medicines since 2005.

Recommendation: Regulations on OST services should be incorporated in law and methadone and buprenorphine should be included in national essential medicines lists.

2. Protection from human rights violations should be considered carefully when designing systems for tracking patients: The system of registering people with opioid dependence – and the human rights violations that occur related to the way information about them is used – is one of the main factors preventing many potential clients from taking part in substitution therapy programs. The legal framework of Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan on the one hand protects the privacy of medical information, but on the other hand there are still regulatory or quasi-legal means by which medical information is shared outside health system with (a) police and/or (b) bureaucratic structures (e.g. agencies issuing driving licenses, etc.). (For similar problems in Russia, Georgia and Ukraine, see Shields, 2009)

Recommendation: To ensure the privacy of medical information of people with drug dependence, relevant legislative and regulatory changes should be made. They should be enforced in practice using administrative penalties for breaching confidentiality and also by actively engaging ombudsmen and other human rights protection mechanisms. The system of registry of patients with drug dependence should be reformed using technical assistance from post-Soviet or other countries that have established systems for maintaining nation-wide databases with high levels of data protection.

3. Patient eligibility criteria should be brought into line with WHO recommendations. One of the criteria for patients' eligibility for substitution therapy in Kazakhstan, Kyrgyzstan and Tajikistan is a history of unsuccessful attempts at treatment through state abstinence-based treatment programs. Because the state drug treatment centers often do not use evidence-based approaches, a significant proportion of IDUs seek help at various NGOs, at religious rehabilitation programs, traditional medicine practitioners, and other service providers or support groups. Treatment attempts at these facilities often does not qualify as previous treatment attempts according to regulatory documents and therefore many IDUs who have avoided treatment at state services are ineligible for treatment. Moreover, denial of access to OST both undercuts its proven utility as an HIV prevention measure, and runs counter to the human right to the highest attainable standard of health.

Recommendation: Patient eligibility criteria should be brought into line with WHO recommendations, whereby agonist maintenance treatment is indicated for all patients who are opioid dependent and are able to give informed consent, and for whom there are no specific contraindications (WHO, 2009). The WHO/UNODC/UNAIDS target-setting guide is clear on this point: interventions and services should "be equitable and non-discriminatory." There should be no exclusion criteria except medical ones, e.g. OST should not be limited to only those IDUs who are HIV-infected or who have failed on other drug dependence treatment.

4. Location and working hours of programs should accommodate the needs of patients. In Uzbekistan, a hindrance to access to the program was the geographical distance between the places where IDUs lived and the drug treatment center where the only OST program in the country was located (Aizberg, 2008). The large number of patients being treated at this one site and their need to climb to the sixth floor in a building that had no lift also detracted from the program's quality. Program hours of operation sometimes make it difficult for patients to combine visiting the programs and work schedules. As noted at the 2008 Yalta Summit, "geographical isolation of drug treatment centers and ban on take-home doses" limited access by patients (International AIDS Society, 2008).

Recommendation: Hours of operation and geographic location of OST programs should be designed to accommodate the needs of patients enabling them to maintain jobs and reach treatment centers without unreasonable amounts of time and money being spent on transportation and without harassment of law enforcement personnel when receiving OST and any other drug treatment service. OST programs should strive to implement take-home medication protocols that allow patients to avoid costly, time-consuming, and medically unnecessary daily visits to OST dispensing sites. The WHO/UNODC/UNAIDS target setting guide is as well clear in stressing that interventions and services should be "physically accessible."

5. A broader array of service providers should be able to be licensed to provide OST services. Opioid substitution therapy is not offered by primary care physicians in any of the Central Asian countries though this is done successfully in many other countries, nor is it offered by government or NGO HIV prevention and treatment centers. The only country where OST programs are offered at family (primary) medical centers and within the penitentiary system is Kyrgyzstan. In Kazakhstan and Tajikistan (according to Ministry of Health guidelines) and Uzbekistan (until the program was discontinued on 25 June 2009), OST is the exclusive prerogative of specialized state drug treatment institutions, which limits access to treatment and the potential for different models to suit different patient needs, and hampers innovation in the

field. In a number of cases, notably in Russia, specialists from state drug treatment institutions are opposed to evidence based innovations and lead the opposition to introduction of OST (see, for example, Krasnov et al., 2006).

Recommendation: Provisions should be made for licensing of a broader variety of OST providers, including primary care clinics, AIDS service organizations, non-governmental organizations, and penitentiary health services.

6. Meaningful involvement of patients can improve program quality. With some exceptions, feedback from patients and their family members is rarely taken into account when planning and implementing measures to improve the quality of OST programs. Even when representatives of these communities are invited to working groups, they rarely have a chance to assert real influence on the decision making process.

Recommendation: Qualitative feedback from patients and their family members should be gathered systematically and used to improve service quality. Treatment literacy among patients, families and communities of drug users should be supported. Patient "community advisory boards" or "patient associations" should be supported.

7. Proper evaluation of and technical support to OST programs in piloting and further stages is essential. Unlike other programs to treat substance dependence, OST programs invariably attract special attention from politicians, communities and professional groups related in one way or another to the problems of drug use and HIV/AIDS, including law-enforcement agencies. Given the need to overcome political opposition to OST programming it is vital that data on the effectiveness of pilot programs is adequately documented and that these programs are provided with adequate technical support to deliver high quality services. However, the widespread use of compulsory treatment as a "drug treatment method" is often the norm. Self-reported treatment effectiveness of Central Asian narcological facilities, defined as abstention from drugs for at least 12 months following a treatment episode, is currently not higher than 12 percent, and no formal evaluation of drug treatment in prisons has ever been conducted (Kerimi, 2009). At the same time, data collected from drug users in Dushanbe in 2004 point to an average of 51 drug free days post drug treatment before relapse (Stachowiak, Stibich et al., 2006).

Recommendation: It is imperative that independent, scientifically based research on OST programs (see, for example, Moller et al., 2009) is carried out. It is important to ensure that pilot OST projects are not implemented without protocols to collect

baseline and followup information about the bio-psycho-socio- and behavioral characteristics of patients, as recommended by WHO. Programs should be given adequate technical support to evaluate, analyze, publish and promote the results of their work. Meanwhile, the introduction of OST programs should not be seen as a panacea: in all Central Asian republics, there is a pressing need to reform drug treatment services to broaden the spectrum and improve the quality of care, to make them more accessible, more humane and better targeted to the needs of individual clients. Particular attention should be paid to overcoming vertical division of services dealing with drug dependency treatment, mental health, and infectious diseases, and close integration should be promoted between them.

8. Russian language literature on modern drug dependency treatment should be made available. There remains a problematic lack of specialized literature on scientific evidence, programming, evaluation and other OST aspects available in Russian and the national languages of Central Asia. The majority of publications in Russian on Russian internet sites are negatively disposed to OST, and are not evidence based.

Recommendation: Governments, technical agencies and funders should ensure that current technical and medical information in Russian and national languages is available to clinicians operating programs they fund, license and provide technical assistance to. Entities like the Eurasian Harm Reduction Network's Harm Reduction Knowledge Hub, the Central Asian Information and Training Center on Harm Reduction and other national and international organization should specifically seek funds to translate literature on the subject and make existing literature more readily available on the internet.

9. Strategic work with the mass media can help to counter myths about OST and create a supportive environment. In Central Asia, as well as in countries throughout the Eurasian region there are widespread myths about OST programs such as the notion that they can increase drug use among the population, or that people who advocate for OST are doing so for some kind of financial gain. Both local and national level decision makers may be influenced by information available and by popular opinion.

Recommendation: It is essential that discussions about OST are grounded first and foremost on evidence-based medical, public health and human rights considerations. Strategic communication with the mass media by supporters of OST programs should be an important component of programs to promote OST programming in the long term.

10. Long-term and full-scale financing of OST programming should be promoted. In Kazakhstan, Kyrgyzstan and Tajikistan, agonist maintenance treatment programs are ultimately funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The governments of all three countries are not using their own money to support OST programs, despite allocating considerable sums toward counternarcotics activities.

Recommendations: In new proposals to the GFATM, funding for scaling up access to OST should be included. National supporters from within governmental institutions supporting OST, from civil society institutions and from international organizations should lobby their Country Coordinating Mechanisms (CCMs) and Principal Recipients (PRs) to include adequate funding for scale up and technical support for OST programs. GFATM structures, technical partners and civil society groups should encourage PRs to include adequate levels of funds for OST programming in their proposals. Simultaneously, to support long-term sustainability, advocates of OST programming should lobby national governments to begin to invest in the programs. The use of arguments based on the well-documented cost-effectiveness of these programs could be effective in these times of financial difficulty.

In conclusion, we would like to highlight one important tendency, which is a common thread running through each of the chapters on the individual countries in this report. Whatever the position of international organizations and donors may be, OST programs will be most successful, and will attract the highest number of drug dependent patients, in those countries where drug treatment specialists themselves are active supporters of OST and act as catalysts of drug policy reform. In those places where drug treatment specialists oppose OST, or adopt an ambivalent, wait-and-see approach, OST programs do not take off, are closed down, or remain at the pilot stage. The authors of this report, three of whom are drug treatment specialists themselves, appeal to all of their colleagues in Central Asia to focus their efforts on the speedy implementation of modern approaches to opioid dependence treatment, the most effective of which at the current time is OST, combined with psychosocial assistance (WHO, 2009).

Introduction

Today, opioid substitution therapy (OST) is one of the best studied and most effective methods of treating opioid dependency, when it is given in combination with psychosocial assistance (WHO, 2009; International AIDS Society, 2008). Research has shown that the level of illegal drug use significantly falls with the introduction of OST. Additionally, the level of criminal behavior among illegal drug users falls, the transmission of infectious diseases (HIV, Hepatitis C) is reduced, the physical and psychological health of patients improves, the risk of overdose is reduced, and death rates are lowered (WHO, 2009; WHO, UNODC, UNAIDS 2004; Lawrinson et al., 2008).

Substitution therapy is currently used in 65 countries, where around 950,000 drug dependent people are in OST programs (Cook and Kanaef, 2008; IHRA, 2009). Between the middle of the 1960s and the end of the 1990s, OST programs were introduced into the majority of European Union countries, which led to a significant drop in HIV transmission rates among IDUs and prevented the epidemic from spreading to the general population.

The level of access that drug dependent people have to OST programs varies greatly by country. In some states, the programs have a high threshold – for OST to be recommended, the patient has to meet certain criteria (previous attempts at treatment, particular lengths of time of drug use, other serious diseases). In its recommendations for treating opioid dependency, the WHO suggests just two criteria, if there are no other contraindications – the existence of drug dependency, and the informed consent of the patient. The WHO recommends a low-threshold approach to OST (WHO, 2009). This is because only a broad implementation of OST programs will help slow the spread of infectious diseases in those countries where the parenteral transmission of HIV and Hepatitis C plays a key role.

In Central Asia, OST programs currently function in three countries. In Kyrgyzstan, a program has been running since 2002, and in Kazakhstan a pilot program began in 2008. In Tajikistan, an OST program was started in 2010. In Uzbekistan, a pilot OST project was closed in 2009, and currently there is no OST available in the country. The introduction of OST programs to the Central Asian region met with a range of problems. Narcological services were formed back in the 1970s, and are therefore heavily oriented around treatment programs based on abstinence (mainly detoxification). None of the Central Asian countries where OST is available have managed

to reach even 5 percent of the estimated IDU population, while the WHO/UNODC/UNAIDS 2009 target setting guide considers a coverage level between 20 and 40 percent as "medium." Since the Summit on Broadening Access to OST in the Countries of Eastern Europe and Central Asia in Yalta in 2008, there have been both positive and negative changes in Central Asia. However, overall, the level of access to OST remains unacceptably low.

The goal of this survey is to analyze the situation surrounding OST in four Central Asian countries. Special attention is paid by the authors to current legal and political barriers and contradictions, with the aim of improving the situation and promoting the future introduction and broadening of OST programs in the Central Asian region. For this reason, the study briefly mentions only a few positive aspects related to OST in these countries. The study contains recommendations to overcoming the barriers mentioned, and improving the quality of OST programs. Due to several reasons beyond the authors' control, an analysis of the situation in Turkmenistan has not been included in the survey.

This document is intended for NGO representatives and employees of state organizations working on issues related to OST programs. The survey will also be useful for specialists working in drug treatment, harm reduction programs and HIV/AIDS/Hepatitis C prevention and treatment.

Data collection methods and procedures

This overview was written based on the review of current publications on OST, various reports available locally, and consultations and interviews conducted with specialists in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan.

The report also uses materials provided by national experts from the Eurasian Harm Reduction Network (EHRN) and Futures Group International in the four countries between June and October 2009 as part of the Eastern Europe and Eurasia Medication Assisted Therapy Project. Materials were collected using a pilot version of an Inventory tool to compare country legislation, policies, regulations, guidelines/protocols with international best practices in substitution therapy programs. Before the start of data collection, all of the national experts underwent two days of training on how to use the inventory. In addition to the national documents collected for the purposes of inventory, EHRN experts from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan recommended additional materials to the authors.

Information thus received was then studied and analyzed in detail both at a regional level and in the individual Central Asian countries. Based on this analysis, short situation summaries were drawn up on each of the four countries in which the key problems were identified and recommendations for further action to support OST programs were made. An important role in the analysis of problems and the drawing up of recommendations was played by representatives of government services, NGOs and international organizations, who took part in the consultation meeting on OST advocacy in Central Asia, which took place on 9-10 February 2010 in Bishkek.

The political, legal and programmatic environment around OST in four Central Asian countries

Kazakhstan

Description of the situation

Kazakhstan, with a population of over 15 million, is the regional leader in terms of the number of IDUs. According to various estimates, there are between 100,000 and 160,000 IDUs in the country (UNODC ROCA, 2007a; IHRD, 2008). The main drugs injected are opium derivatives. Kazakhstan has registered more than 12,000 cases of HIV and, according to UNODC data, has the highest number of cases per 100,000 population of all Central Asian countries (UNAIDS, 2008; UNODC ROCA, 2008). IDUs account for 73 percent of all registered cases of HIV (UNODC ROCA, 2008).

The spread of HIV among different population groups is not uniform and is particularly high among IDUs. Estimates suggest that around 9.2 percent of Kazakh drug users are HIV positive. (Mathers et al., 2008).

According to a UNODC regional report, around 10,000 people underwent treatment in drug treatment clinics and centers of Kazakhstan in 2006 (UNODC ROCA, 2007a). In the vast majority of cases, treatment for dependence was aimed for full abstinence from drug use. As part of the treatment process, particular emphasis is placed on detoxification with use of a wide range of strong psychotropic substances that can alter patients' consciousness and which, in the opinion of the doctors, enables them to deal with the difficult symptoms of withdrawal. The post-treatment psychosocial assistance and rehabilitation available is often inadequate. Compulsory treatment of drug (and alcohol) dependency by court order, and under the full control of law enforcement bodies, is common practice. There is no treatment for drug dependency in the penal system.

There are two pilot OST projects in Kazakhstan, one based at the Pavlodar Regional Center to Prevent and Treat Dependency, and the other at the Karaganda Regional Drugs Treatment

Center. The projects have been active for over a year, and are funded by a grant from the Global Fund to Fight AIDS, TB and Malaria. Around 50 patients are receiving treatment. The main criteria for inclusion in the program is a confirmed diagnosis of opioid dependency, an age of 18 or over, a history of injecting drugs of three years or more, and two unsuccessful attempts at treatment. This last criterion is not necessary for HIV-positive patients.

Increasing program coverage and evaluation

The introduction of OST became possible thanks to the support of government officials on the Country Coordinating Mechanism (CCM) and the positive role of the State Scientific Center for Drug-Related Medical and Social Problems, which agreed to scientifically monitor the pilot project.

There are practically no normative legal documents that touch on OST. The main documents related to the pilot program are two decrees from the Ministry of Health, which explain the technical organization of the treatment and give recommendations for support, rather than offering any kind of normative backup. Despite WHO recommendations, methadone is not included in the country's list of essential medicines and is imported exclusively on the basis of special permission given by the relevant governmental organs, for use in the pilot projects.

Several government structures have either direct or indirect control over the OST programs. The State Scientific Center for Medical and Social Drugs Problems is providing scientific backup for the project and carrying out monitoring. Control over the use of narcotic and psychotropic substances is carried out by the Committee for Fighting Drug Use and Trade of the Interior Ministry according to set procedures. Monitoring of the program, its effectiveness and the turnover of methadone, is also carried out by:

- The Pharmaceutical Committee of the Ministry of Health of Kazakhstan, which controls the distribution of medical and other substances in the sphere of public health, as well as licensing issues for narcotic and psychotropic substances;
- The National AIDS Center, which is the principal recipient of Global Fund funding, and is responsible for implementing the program;
- Regional Health Administrations in Pavlodar and Karaganda, which organize treatment and distribute methadone for the pilot projects.

The main guidelines for medical personnel on the use of methadone in OST programs are contained in recommendations published by the State Scientific Center for Drug-Related Medical and Social Problems. These are entitled "Taking methadone in drug treatment and programs for harm reduction from illegal drug use" and "Rules for implementing substitution therapy" and are ratified by a Ministry of Health decree. Based on these recommendations, the drug treatment specialist who is treating the patient can work out an individual plan of treatment.

OST is not available in the prison system or in general hospitals. There is a plan to gradually increase the project so that it covers seven regions (with 200 patients by 2010). All of the OST centers will be based in regional drug treatment facilities. Currently, patients are allowed to

take methadone only in a specially designated area. Removing methadone from this area is not allowed and patients must take methadone under supervision of medical personnel.

Involvement of the government, international organizations and local NGOs

The parliament, government and president of the country are not actively involved in issues surrounding OST, and their positions have not been defined or outlined anywhere. The government has frequently stated that a pilot project will be implemented. There are several cases where legal documents have been approved, such as the order for the import of methadone, which is ratified by the government. However, the overall position of the government on OST is not clearly defined.

Currently, all the regulations surrounding OST are set by the Ministry of Health. The Ministry of Health will likely determine the future of the program. The ministry sets an order for the import of medications, decides which medications will go into which lists of controlled substances, and through the Committee on Pharmaceutical Control, the ministry has the power to issue and withdraw licenses. The ministry decides which regions are recommended for OST programs, sets the regulations, and carries out monitoring. Currently, the ministry's opinion on OST is positive. The need to increase the number of patients on OST and introducing it to 7 regions is under discussion as is the possibility of financing the program from the state budget, and also of producing methadone on Kazakh territory if and when the program reaches 10,000 patients. It should be noted that, as a rule, the Ministry's position reflects the opinion of the Minister of Health, and if the Minister changes, the Ministry's position could also change.

The position of the Interior Ministry with regards to OST is not fully clear, however from a speech given by the Chairman of the Committee to Fight the Drugs Trade in October 2008 (when the OST program started), the ministry has a negative opinion of OST. They oppose the idea of introducing a "legal" drug into the country. According to some officials in the ministry, by supporting OST programs, the government could be sending a dangerous message to the population that using drugs is acceptable.

The Global Fund's requirement that approaches to HIV must be evidence based promoted OST in the country. Despite the fact that OST was included in the country application, and was approved by the Country Coordinating Mechanism (CCM), in which the majority of members are government representatives, the implementation of the project was delayed.

The Global Fund issued a warning that funds could be withdrawn and this led to the start up of the OST program. The Global Fund has a lot of influence on the National AIDS Center and the Ministry of Health as a formal contract is signed between the Global Fund and the National AIDS Center. Since the Global Fund covers a large proportion of the costs of healthcare and harm reduction programs, the Ministry of Heath tries hard to respond to the demands of the Global Fund.

Currently, there is very little promotion of OST by NGOs or organizations of affected populations and their relatives. There are a few organizations which support the introduction of OST, but they have no significant influence on the decision making process. Even though the NGO sector is invited to participate in the work of committees or working groups, their

participation often has a purely formal function and they are unable to exert real influence. For NGOs to have more real influence, careful planning, technical assistance, and continued efforts to build intersectoral dialogue are necessary.

Barriers to the development of OST, and advocacy priorities

Contradictions in the legislative framework and other documents on issues concerning OST

Currently, OST is carried out by state institutions only. Although the law does not contain a direct prohibition (or a direct authorization) for non-state actors to offer OST, the procedures and requirements would make that difficult to carry out. It should be noted that the OST program is currently only a pilot project, and all the procedures are carried out directly by the relevant state bodies, in this case the Ministry of Health. The provision of the OST does not require any special separate licensing under Kazakh law, and falls within the category of "out-patient drug treatment". However, organizations are required to have a license for controlled medications which is difficult to acquire.

There are no provisions to enable or prohibit IDUs from taking part in developing policy and legislation but lawmakers are cautious about the idea of involving IDUs in the legislative process. Nevertheless, a precedent has already been set for involving affected populations in the development of policy at governmental level. There are representatives of people living with HIV/AIDS, and also those who have tuberculosis In the Country Coordinating Mechanism. However, government bodies see this as an exception, brought about by the demands of the donors and international agencies (UNAIDS, 2007).

There are certain limitations on the freedom of movement and freedom to choose where to reside. On the one hand, the government recognizes that people should have freedom of movement, but on the other hand there are a range of measures that limit this right. In particular, all people who are on the drug treatment register are required to undergo periodic check-ups at drug treatment facilities near their place of residence until they are fully removed from the register. Appearance at the check-up can be forced if necessary, using law enforcement agents. The Soviet-era "registration" system has not been fully phased out in Kazakhstan, which means that people need to be registered at their place of abode, and changing region requires a range of procedures, including changing identification documents, removal from the army register, removal of registration at current address, and removal from the register at the drug treatment facility (if the individual is registered there).

Taking into account that patients can take the substitution medication only at the designated place, in person, moving house for OST patients is virtually impossible, as it would mean they have to leave the program. For the same reason, if patients are sent to prison, they also have to leave the program.

Participation of the government

The impression is given that OST exists in the country purely in order to satisfy the demands of the foreign donors, and the government does not feel obliged to implement or broaden the programs. OST is the most effective way of treating opioid dependency (and of preventing HIV in countries where the epidemic is spreading largely due to injecting drug use), and as such it should be financed from the state budget. For this to happen, the following is necessary:

- Inform decision makers of the need for diverse and effective treatment options for drug dependency (and HIV prevention) and the need to include OST in the list of drug treatment programs financed by the state;
- Draw the attention of relevant officials and structures to the recommendations of various UN organizations (WHO, UNODC, UNAIDS) and to the concrete benefits the country will receive after OST programs are broadened (high effectiveness, low cost). Drug treatment specialists, the National Center of Medical and Social Issues in Drug Treatment and the Ministry of Health could become the main partners in this process, if thoughtful and targeted work is carried out by WHO, UNODC and UNAIDS to coordinate their efforts to ensure the scale up of OST programs.

Quality and appeal of services offered

At certain stages, the quality and effectiveness of the programs can have a decisive impact on discussions about broadening OST. Making difficult demands of program participants can put clients off and create barriers to involving them in treatment. A system of monitoring quality and effectiveness of OST programs should be in place, and the programs should periodically be evaluated by independent external experts who are not involved in implementing the programs themselves. The main target groups for advocacy are the structures that are directly involved in planning and implementing OST programs, especially the State Scientific Center for Drug-Related Medical and Social Problems. The process of providing this group with information on best practices, positive experience in developed countries, and recommendations and guidelines of international organizations on ensuring high quality and effectiveness of OST programs should be coordinated.

The politicization of the drugs problem, including OST

OST often becomes the subject of political discussions. Opponents, including those from the law enforcement agencies, often use "moral arguments" against OST. For example, they claim that the state sanctioned use of drugs sends the wrong message to the population that taking drugs is acceptable. All debates on OST should be depoliticized and OST should be viewed unequivocally as a method of medical intervention with defined medical indications and contraindications, effectiveness, advantages and limitations.

Information levels among the target group and the general public

Part of the population may believe that the only legitimate goal for drug treatment should be complete abstinence from narcotics, and would thus consider OST unacceptable for ideological reasons. Many drug users also have a negative attitude towards OST. There are various myths about the "harmful" nature of methadone, the dangerous levels of dependency that it provokes, and so on. These myths are often voiced by drug users themselves, and give disinformation to potential clients of the program and the general public. Providing a large proportion of the population with truthful and factual information about OST should be the main method to counter those who seek to discredit the programs and spread false information. Potential clients of the program should be actively informed. There should be a permanent information campaign that is well planned and thought out. The following is necessary for successful advocacy:

- Spread balanced (not aggressive) and truthful information about OST through the press, television, radio and internet media. Use translations of relevant UN documents, speeches, interviews and publications of leading local and international experts, and also the positive results of pilot programs and examples of positive changes in the lives of their patients..
- Attract supporters among progressive local experts (drug treatment and infectious diseases specialists, epidemiologists, lawyers), and help promote their active inclusion in OST advocacy. This group is capable of playing a key role in advocacy, as experts are seen as authoritative and are trusted.
- Facilitate the formation of groups of activists made up of IDUs, OST patients and people living with HIV/AIDS, and carry out educational work with them to create a correct understanding of OST.
- Facilitate the active inclusion of these groups into advocacy work at local and regional levels. Facilitate the inclusion of vulnerable groups into regional cooperation with partner organizations and networks.

Kyrgyzstan

Description of the situation, key problems, barriers and contradictions.

Kyrgyzstan is currently the regional leader in terms of OST provision. The treatment has been used in the country since 2002 and is currently in use in 17 centers in nine regions of the country. This program growth was achieved due to the solid support of a number of people in the government, especially those working in the Ministry of Health. NGOs played a major role, and were supported by international donors such as the Open Society Institute, the World Bank and others. As in other countries of the region, a key factor was the support of the Global Fund to fight AIDS, TB and Malaria.

There are close to 25,000 IDUs in Kyrgyzstan (Mathers et al., 2008). According to the 2006 sentinel surveillance study, 7.4 percent of IDUs were HIV positive, 48.4 percent had hepatitis C, and 11.6 percent had syphilis (The Government of the Kyrgyz Republic, 2007). As of 1 December 2009, the number of officially registered cases of HIV was 2671, of which 1684 were IDUs (The Kyrgyz Government Countrywide Multisectoral Coordinating Committee for Socially Significant Infectious Diseases , 2009).

Currently, patients with opiate dependency in Kyrgyzstan are offered the following forms of treatment:

1. In-patient and out-patient detoxification in drug treatment facilities;
2. In-patient medical and psychological rehabilitation and 12-step programs in the National Drug Treatment Center and the Osh Regional Drug Treatment Center;
3. OST in drug treatment facilities, family medicine centers, and medical institutions within the penitentiary system.

The legal basis for OST

OST in Kyrgyzstan is regulated through decrees from the Ministry of Health and the Drug Control Agency (the latter was disbanded in 2009, and its functions transferred to the Ministry of Health and the Ministry of Internal Affairs). In medical institutions within the penitentiary system, OST is also regulated by the joint decrees of the Ministry of Justice and the Ministry of Health. These documents establish a legal foundation for the delivery of OST in Kyrgyzstan and allow ministries to draw up further resolutions and internal regulations.

Kyrgyzstan is implementing the "State program to fight the HIV/AIDS epidemic and its socio-economic consequences, 2006-2010". The goal of this program is to increase the effectiveness of efforts to counter the transmission of HIV by carrying out activities among vulnerable population groups. The program also allows for support of OST programs, including in the penal system. Another program active in Kyrgyzstan, and ratified by the president, is the "Kyrgyz national program for countering drug use and drug trade for the period up to 2010". This also refers to OST as one of the methods of treatment and harm reduction, though it suggests that these programs be financed by external donors.

Regulation of OST

The selection of patients for OST programs is regulated by Decree No 41 of the Ministry of Health from 2001, and No 56 from 2007. Decree No 41 defines criteria for entry to OST programs in the following way: "opiate dependency with regular injecting drug use for a period of over two years, and several unsuccessful attempts at treatment in the country's drug treatment facilities."

Additionally, there are further criteria which allow for patients to be included in the program even if they do not meet the usual criteria:

1. Complications of opioid use (various life-threatening conditions, hepatites B and C, trophic ulcers, sepsis, suppurations, poor physical condition, HIV/AIDS);
2. Other diseases (cancer, mental disorders, diabetes and others);
3. Pregnancy;
4. Individual cases by decision of the Consulting Commission.

The decree does not specify in which type of treatment institution the patient should have gone through unsuccessful treatment attempts, and which documentation is necessary to prove that the attempts took place. In Decree No 56 from 2007, which deals with the broadening of OST programs, the same criteria are used as in the 2001 decree, however there is no requirement for the patient to have undergone several unsuccessful attempts at treatment. It is worth noting that in both decrees, there is a possibility for individual cases to be considered by the Consulting Commission, which gives doctors a certain degree of freedom to choose patients for the OST programs and allows for OST programs to reach more people with drug dependency.

OST is currently carried out only in special drug treatment facilities, or by narcology specialists at family medicine centers. Institutions that provide OST must have permission from the Ministry of Health, and both decrees state that OST can be carried out only in state-run institutions. Patients are selected for OST programs by a special consulting commission, which is created at the medical institution by decree of the chief doctor. An individual plan of treatment is drawn up for each patient. The consulting commission carries out an evaluation of the treatment every three months and adjusts the treatment plan accordingly. During the period of program participation, patients are required to go through periodic testing for other drugs including psychotropic drugs, with the aim of collecting objective data on the effectiveness of treatment. If a patient undergoing OST is hospitalized in a different medical institution, the administration of the institution providing OST is required to arrange the provision of methadone to the patient with the hospital where the patient is located..

The indications for receiving OST as laid out by the Ministry of Health decrees limit the number of people who are able to receive the treatment in Kyrgyzstan. For inclusion in the program, a history of treatment attempts, the presence of somatic illness and a specified duration of an illness are required. These limitations do not meet the WHO 2009 guidelines which state that the diagnosis of drug dependency alone, along with the informed consent of the patient, should be enough to include a person in an OST program.

Substitution therapy in the penitentiary system is regulated by a joint decree of the Ministry of Health and the Ministry of Justice. This decree states that OST should be provided if the patient meets no less than three of the following criteria:

1. Injecting opioid use
2. Age over 18
3. Serious somatic illness (except TB – if a patient has TB, he or she is sent to a specialized TB hospital and is excluded from the project)
4. Several unsuccessful in-patient drug treatment attempts
5. Patient took part in OST program prior to his or her imprisonment
6. Patient has HIV or hepatitis C
7. Period of incarceration no less than three years from the date of starting OST

It should be noted that this decree discriminates against those who have TB and those with short prison sentences – neither group may be included in the OST program.

OST in practice

OST programs have been implemented in Kyrgyzstan since 2002. Pilot OST methadone programs were set up at the National Drug Treatment Center in Bishkek and the Regional Drug Treatment Center in Osh. In Bishkek, the program was financed by a grant from the Soros Foundation Kyrgyzstan and the Open Society Institute; in Osh, it was funded by UNDP. Initially, the program was implemented as a pilot project. Between 2002 and 2006, the program functioned in just two cities, Bishkek and Osh, but since 2007 the number of patients increased, as did the number of institutions that offered OST. Currently, around 948 patients receive OST, and projects have opened in family medicine centers and medical facilities within the penitentiary system. The cost of the program, including the services provided, technical support, and methadone itself, is about $1 per patient per day. Methadone used is a 0.1 percent water solution, made in the laboratory of the drug treatment facilities in Bishkek and Osh, which have licenses from the Ministry of Health for pharmaceutical activities. Methadone is taken by the patient once a day in the presence of a nurse.

OST became available in the penitentiary system in 2008, in three penal institutions: Colony No 47 in Bishkek, pre-trial detention center No 1 in Bishkek, and pre-trial detention center No 5 in Osh. Altogether, 150 patients receive OST in the penal system.

Regulation of methadone deliveries and financing of OST programs

The licit use of methadone was previously under the control of the Drug Control Agency (disbanded in November 2009), which together with the Ministry of Health was in charge of developing procedures and regulations for recording, , storage and distribution of methadone. Currently, the agency's functions are split between the Ministry of Health and the Interior Ministry. The National Drug Treatment Center has control over the delivery of methadone to the place where it is dispensed, as well as its storage. Previously, the Justice Ministry was responsible

for overseeing the licit use of methadone within the penitentiary system. However, at the present moment penitentiary facilities are subordinated to another institution.

Kyrgyzstan does not have any state budget funds earmarked for OST programs. Currently, all the OST programs in the country are financed by the Global Fund. In 2001-2004, the OST programs were financed by the Open Society Institute, Soros Foundation Kyrgyzstan and UNDP. At present their technical support is limited to the provision of trainings. Methadone is included in the list of essential medications, but there is no mechanism to regulate the financing and purchases of the drug.

Evaluation of the OST programs

The OST programs have been evaluated by the staff of the National Drug Treatment Center (Asanov and Parpiyeva, 2005), and as part of joint evaluations conducted together with the regional bureau of the WHO and other experts (Moller et al., 2009). Currently, the European Bureau of the WHO is carrying out an evaluation of OST program in Colony No 47. The expert evaluations showed that the OST program was effective in reducing drug use and risky injecting behavior, and in improving physical health status and social functioning of program participants.

Organizations which influence OST policy

The legal basis for treating and preventing drug dependency in Kyrgyzstan is directly dependent on the position of the parliament, the government and the president. The Kyrgyz Ministry of Health draws up the legal documents that regulate OST. The National Drug Treatment Center initiated the programs in 2002 and still coordinates them and carries out advocacy among decision makers and the general public.

There are a number of NGOs that are active in harm reduction, protecting the rights of IDUs, and offering social, legal and informational support. These organizations do a lot of advocacy work for OST programs. In 2009, there was a threat that the OST programs in the country may be closed down. The threat arose due to the fact that certain journalists and members of parliament spoke out against OST programs and the Drug Control Agency planned to temporarily stop the program. NGOs, as well as an initiative group made up of OST program participants, were able to organize an advocacy campaign in the media to influence the Agency, the government, and the Country Coordinating Committee. Public discussions were organized with the participation of all interested parties which contributed to the OST programs being allowed to continue operating. Public opinion was split on the issue. Some journalists and MPs periodically speak out against OST programs. Their position is partly influenced by the position of Russian media and certain Russian officials who speak out against OST. However, there are no state departments or NGOs that take a concerted position against OST in Kyrgyzstan.

Legal issues affecting OST programs

All information about patients in the drug treatment register is to remain confidential according to the law on doctor-patient confidentiality. However, medical workers can and do share this information with law enforcement bodies if a request is made. This means that the Soviet system of the drug treatment register has essentially been preserved, and patients' rights are breached. A diagnosis of drug dependency can lead to a revoking of parental rights and limitations on employment. This can make patients reluctant to seek help from state drug treatment facilities. OST programs can only be carried out in state facilities according to a decree of the Ministry of Health, despite the fact that state programs to prevent the spread of HIV/AIDS do not make such a stipulation.

Recommendations on increasing coverage and quality of OST programs:

1. All OST programs are carried out wholly with funds from international donors and, since 2004 with funds from a Global Fund grant. This means that if donors were to leave the country, the OST programs could lose funding and be closed. Provision should be made for state funding of the OST program.
2. OST program delivery education for employees of medical facilities (psychiatrists, family doctors and infectious disease specialists) should include basic training and continuous learning delivered by local experts (Moller et al., 2009).
3. A strategy should be developed to advocate OST among members of parliament, the government, and key figures in the penal system, medical professionals and the general public. . To achieve this, the positive results that have already been achieved due to the availability of OST in the country should be highlighted.
4. The number of medical institutions offering OST should be increased. This can be achived, among other things, by granting non-government organizations with the right to provide OST.
5. Treatment protocols should be changed. Exclusion criteria for patients to receive OST should be minimized in accordance with WHO recommendations (current criteria require a history of treatment attempts, using injecting drugs for a minimum period of two years, or the presence of a serious somatic illness).

Tajikistan

Description of the situation

According to official data, the population of Tajikistan in 2006 was 7.1 million (The Government of Tajikistan, 2007), and according to some estimates, had reached 7.3 million by July 2009. As of 1 January 2009, there were 8645 people registered at national drug treatment facilities, of which 7615 (88 percent) were opiate users and 5430 (62.8 percent) were IDUs (Drug Control Agency, 2009). Over the past eight years, various organizations have proposed several estimates of the number of problem drug users and IDUs in the country. In 2002, the UNODC Regional Office for Central Asia reported 45,000 – 55,000 problem drug users in the country. In 2007, as a result of the follow-up assessment study, the same organization concluded that "more than 0.5 percent of the total adult population [aged between] 15 – 64, or 20,000 people, regularly use opiates", which was the lowest estimate in Central Asia" (UNODC ROCA, 2007b). In 2009, the National Center for Prevention and Fight against HIV/AIDS, based on second generation sentinel surveillance study, estimated that the number of IDUs not currently in prison was around 26,400 (Abdulloyev, Rachabov and Shabonov, 2009).

As of 31 December 2008, there were 1422 officially registered cases of HIV, of which 802 (56.3 percent) were transmitted through injection (National Center for Prevention and Fight against HIV/AIDS, 2009). In 2008, as part of the epidemiological monitoring, 1355 IDUs were involved in a sentinel surveillance study and underwent testing for HIV; of these, 17.6 percent were found HIV positive and 29.9 percent had hepatitis C virus (Abdulloyev, Rachabov and Shabonov, 2009). In another study, carried out in the city of Dushanbe in 2004, the prevalence of hepatitis C among 491 active IDUs was found to be 61.3 percent (Beyrer et al., 2009). UNAIDS estimated that there were around 10,000 people aged over 15, who were living with HIV in Tajikistan in 2007 (UNAIDS, 2008). In any case, the above date clearly point that for Tajikistan, the introduction of OST, as one of the most effective methods of treating drug dependency and preventing HIV among IDUs, is of extreme importance.

The first policy-level reference to opioid substitution therapy in Tajikistan was made in 2002, when the 2002-2005 Strategic Plan against HIV/AIDS included the aim of making OST available to 200 IDUs in the cities of Dushanbe, Kairakum and Chkalovsk by the end of 2004 (The Government of Tajikistan, 2002). In December 2003, the President of Tajikistan signed the Law " On Narcological Care" which referred to the provision of "alternative substituting therapy" as one of the grounds for hospitalization in narcological in-patient facilities. According to this Law, the provision of opioid substitution therapy is considered as one of the objectives of in-patient drug treatment institutions. However, despite the fact that all the legal documents necessary to implement OST were in place, OST only started to be implemented in 2010. One of the reasons for this delay was the negative attitude of Russian authorities towards OST and the pressure which they exerted (and continue to exert) on drug policy in the Central Asian republics. As Utyasheva and Eliott (2009) note, methadone is prohibited in Russia at the level of criminal legislation. Additionally, in 1999, the Security Council of the Russian Federation approved its Guiding Principles and Directions of Counteraction to Illegal Narcotics and Psychotropic Substances and Abuse of Them for the

Period until 2008," which, among other things, define Russian drug policy at the international level as in opposition to attempts to develop and introduce methadone programs.

In the middle of October 2008, the Ministry of Health in Tajikistan requested the government to make a decision on introducing substitution therapy in the country, and on 20 October 2008 received a positive answer. In the beginning of April 2009, the meeting of the working group on discussing the strategy for the introduction of OST was held at the UNDP Global Fund Project Implementation Unit. The issue of introducing a pilot OST program was considered, and the group proposed to aim at the initial coverage of 200 patients and to raise this to 700 patients by 2014. On 24 July 2009, the Minister of Health of Tajikistan signed a decree on the introduction of OST.

In accordance with the documents listed above, the OST program in Tajikistan will be financed over the next five years using funds from the Global Fund to Fight AIDS, TB and Malaria, as well as other donor organizations. Pilot programs will be introduced in the Republican Clinical Center of Narcology in Dushanbe and the drug treatment centers in the Gorno-Badakhshan Autonomous Region, Sogd region, and Khatlon region. Changes were planned by the end of 2009 to ensure that methadone required by the program is included in the state quota of narcotic substances.

While the OST program has just been started in Tajikistan, there is a clear need to identify key barriers and contradictions which may affect its future implementation.

Key problems, barriers and contradictions

At the legal level:

1. Tajikistan has retained the Soviet-era narcological register, which lists all people diagnosed as "suffering from narcological illnesses". A formal diagnosis of drug dependency, and placement on this register brings with it serious limitations on civil, social and economic rights. A person is not removed from the register for a minimum of five years, even if they are not using drugs. People on the register may not adopt a child or take custody of a child; they may be stripped of their parental rights; they are refused a driving license. Arriving at work in the state of "narcotic drug intoxication" (such formulation in the Tajik Labor Code may also include "intoxication" caused by synthetic opioids) can serve as a reason for unilateral cancellation of labor contracts by the employer etc. Additionally, information about people on the narcological registers is passed to law enforcement agencies and the Prosecutor's Office if they ask for it in writing. In the current conditions, taking part in OST programs is almost impossible without first being placed on the drugs register, and this will prevent people who use opiates but are not yet on the register from signing up for OST.
2. Currently there are at least four institutions (the Presidential Drug Control Agency, the Ministry of Internal Affairs, the National Center for Monitoring and Preventing Drug Use and State Service for Supervision of Pharmaceutical Activities which are both part of the Ministry of Health) which share responsibilities in the field of drug control. This fragmented system will likely detract from the quality of service offered to the clients,

as it means that a significant amount of human and time resources of the OST program will have to be spent on checks from the above bodies, many of which are bound to duplicate each other.

3. Both the process of acquiring a license to legally handle drugs, as well as the requirements themselves are complicated and inadequate to the situation. Due to this kind of "opiatophobia", only a very limited number of entities can receive a license. This might make prices for OST medications significantly higher, as it has already happened in other former Soviet countries.
4. Tajik legislation does not give an unequivocal answer to the question of whether NGOs can carry out OST programs in the country or not. The Law "On Narcological Care" mentions the possibility of providing drug treatment services by privately owned narcological entities as well as by physicians, who run their own private practice. But at the same time, the Law "On Private Medical Activity" gives private medical care providers the right to receive, store and use narcotic substances for medical purposes, though only on in-patient basis . Finally, the Law "On Narcotic Drugs, Psychotropic Substances and Precursors" states that the treatment of drug dependency, except in those cases otherwise specified by the Tajik legislation, should take place only in the drug dependence treatment facilities of the Ministry of Health.
5. Though OST is not prohibited by law, there are also no concrete passages which directly support OST in Tajik law. The non-binding reference to "alternative substituting therapy" in the Law "On Narcological Care" as one of the reasons for hospitalizing people is more the reflection of the interests of particular professional groups rather than adherence to a reform of the drug treatment system and the introduction therein of new approaches.

At the programmatic level:

1. OST is implemented in Tajikistan through funding from the Global Fund, and is first and foremost intended for people who have opioid dependency and HIV, in order to minimize the further transmission of the virus and to stabilize their underlying condition. People who do not have HIV will continue to face difficulties in accessing OST. It is possible that in Tajikistan, as in other countries where the situation is similar, people will start to speak out against this controversial practice which can make people with opioid dependence feel that getting infected with HIV is the only way, although entirely unacceptable, to get onto the program.
2. The contribution people with opioid dependence can make to the success of OST programs cannot be overestimated. The experience of other countries in the region shows that factors such as convenient location, convenient working hours, lack of "surveillance" of clients by law enforcement bodies, and the environment in the clinics where OST is provided are all very important to program success. Potential participants in OST programs can provide information and opinions which help improve program quality. Issues to consider include: whether or not metal grilles (which gives the impression of a penal setting) are used; whether or not OST is provided near narcological

institutions; how program workers make sure that methadone is taken and not diverted for black market sale; and the attitudes of program staff towards clients. In Tajikistan, the opinions of drug dependent people have not been yet taken into account during the selection of sites to implement OST programs and during the development of plans and guidelines.

3. According to the current legislative framework, evaluation of OST programs should be carried out by various departments of the Ministry of Health. The methodology and criteria for evaluation of the programs is not yet clear. It is vital that the methodology and criteria be scientifically sound and involve feedback from drug dependent people and other interested communities. Since enrolling patients in OST programs will create broad opportunities to provide them with numerous other legal, psycho-social and medical services, a multidisciplinary team should be involved in efforts to evaluate and improve the quality of OST programs.
4. The issue of implementation of the OST programs in prisons has not been resolved in Tajikistan yet. If clients of the OST program end up in prison, they will be forced to stop receiving OST and undergo compulsory treatment aimed at removing withdrawal symptoms.
5. OST programs in Tajikistan will be carried out within the narcological service that was created during Soviet times and has been originally oriented towards the identification, examination and forced treatment of drug users, with the single goal of achieving complete abstinence, or what is referred to as "enduring remission". Parallel reform of the drug treatment sector, including training for employees (there is a particular shortage of qualified specialists in the field), will be necessary for the programs to produce the desired results.

At the political level:

1. In Tajikistan, the annual state health care budget amounts to about one percent of GDP, which explains why the Ministry of Health has to rely solely on donor funds to implement the OST program. In this situation, even if the political will to broaden OST access is there, this will be possible only if additional funds are secured. As a result of the limited resources, the current plans are to increase the number of those accessing OST to only 700 by 2014 – exactly the amount planned using the budget of the Global Fund. Taking into account the estimated prevalence of opiate use among the population of Tajikistan, this number is inadequate.

Recommendations to overcome barriers to further development of OST programs

1. Pay special attention to the creation of concomitant positive legal, programmatic and informational environment related to OST program.
2. Continue the work aimed at replacing the narcological register with a system that registers cases rather than individuals and uses unique identifier codes. Develop guidelines for implementing this system and work out a way to determine dependence status when it is both necessary and justified from the human rights point of view, and at the same time without having to rely on the narcological registration. Until the new system is introduced, ensure not to place OST program participants on the narcological register by referring to state guarantees with regard to the anonymity of drug treatment and to the right of patients to anonymous treatment.
3. Add methadone and buprenorphine to the list of essential medications.
4. Determine one agency that will be responsible for control over the licit use of drugs in the OST programs. This agency should coordinate checks with all the other agencies and keep them informed of the results.
5. Ensure that the process of procurement of methadone for use in OST programs is transparent, and initiate a mechanism for monitoring prices.
6. Allow private and NGO-run drug treatment facilities to use narcotic substances and to provide outpatient OST programs in accordance with permissions issued on the basis of the requirements of the Tajik legislation.
7. Increase financing of the drug treatment service by reallocating a certain part of funds earmarked forcounternarcotics activities.
8. Continue the process of reforming the drug treatment service, and also include a module on organizing and carrying out OST programs in the training of medical and social workers.
9. Increase the coverage of OST programs and do not allow them to become "perpetual pilot" programs. Both government money and donor funds should be used and be allocated according to detailed plans which consider various aspects such as financial and technical sustainability, the spectrum of services provided at each individual site, accessibility, patient recruitment, personnel and training, potential challenges and risks and ways of minimizing them etc.
10. Provision of OST should not be limited to drug users who have HIV/AIDS. Ensure low-threshold access to OST, as recommended by the WHO (2009).
11. Develop a mechanism to transfer medications to other medical institutions for situations where patients on the OST program are hospitalized elsewhere.
12. Make a concerted effort to include drug dependent people and other interested communities and professional groups in the planning, evaluation and improvement of OST programs.

13. Ensure that OST is available in the penitentiary system. People with opioid dependency who were not taking part in the OST program prior to their incarceration should also be allowed to take part in the programs.

Uzbekistan

Description of the situation

Uzbekistan, with a population of over 27.5 million, is the most populous country in Central Asia. There was positive population growth of 1.8% in 2008 (State Statistics Committee, 2009). Like the other countries in the region, Uzbekistan, which directly borders Afghanistan, has encountered a dual epidemic of drugs use and HIV. According to data from the Ministry of Health, by the end of 2007, there were 19,868 drug dependent people in the country. However, a study in 2006 suggested that the real number of those using drugs in Uzbekistan was 131,000, including 80,000 IDUs (Niaz, 2007). The number of new registered HIV cases continues to rise, and reached a cumulative total of 16,500 by 1 January 2009, compared with just 154 cases at the beginning of 2001. In 2008, the proportion of parenteral transmission was around 60 percent of all new infections (Ministry of Health, 2009).

The sharp growth of injecting drug use and HIV among drug users served as a stimulus for the Ministry of Health to look for alternate ways to bring the situation under control. At the beginning of the last decade, through the assistance from international organizations, the local heads of narcological and drug control authorities got acquainted with OST programs in India, Latvia, Switzerland and Hong Kong. As a result of studying this international experience, in 2000, the Uzbek parliament recommended that a pilot OST project should be implemented. In October 2003, the State Commission for Drug Control under the Cabinet of Ministers adopted a decree that provided for the implementation of a pilot methadone OST project. Based on this, the Ministry of Health ordered that a pilot project should begin at Tashkent Municipal Drug Treatment Facility, and approved the decree on carrying out OST in Uzbekistan.

After determining a source of financing, and carrying out other preparatory work, the first patients were treated in February 2006 and received buprenorphine (Ednok). Because methadone was an illegal narcotic substance according to the country's laws, it took extra time to receive a special license to provide it. Later, in October 2006, the methadone component of the pilot project was also initiated. By February 2007, at the single project point in Tashkent, with financing from the Global Fund to Fight AIDS, TB and Malaria, 147 patients had received buprenorphine and methadone. Of these, 82 were HIV-positive and 34 were receiving antiretroviral therapy (Subata et al., 2007).

The start of the OST project and subsequent implementation was opposed by the chief drug treatment specialist at the Ministry of Health and some other conservative specialists. Their arguments against OST were based on the fact that giving out a legal drug in return for abstinence from illegal drugs is an unethical way to help people, as it promotes retaining opioid dependence. Additionally, these opponents of OST stated that the goal of drug dependence treatment should be ensuring that patients fully abstain from using any psychoactive substances.

In 2007, WHO experts carried out an evaluation of the pilot project aimed at drawing up recommendations to improve the OST service in Uzbekistan. In their report, the experts noted a range of issues showing that patients had improved in a number of ways after beginning the treatment. The indicators included a move away from illegal drugs, and lowered criminal activity.

They also said it was impossible to provide a proper analysis of the results of the pilot project, because the WHO-recommended standard forms for monitoring and evaluation were not used properly and systematically by the pilot project team. Nevertheless, it was recommended that access to OST be broadened in the country by opening other points offering the treatment in different regions of Uzbekistan, as well as removing shortcomings in the pilot project (Subata et al., 2007). These shortcomings are listed in the section explaining barriers to OST in the country.

Later in 2008, the Ministry of Health carried out its own evaluation of the pilot project. The evaluation was run by the chief drug treatment specialist, who, as has already been noted, was one of the main opponents of the introduction of OST to the country. The results of this evaluation were presented at a meeting of partners, including state structures, NGOs and international organizations working on HIV prevention and drug dependence. According to the representatives of international organizations present at this meeting, the report on the pilot project was mainly negative, often had a subjective character and was prone to a very liberal interpretation of facts (Sultanov, 2009).

In the middle of spring 2009, the government unexpectedly raised the question of the future of the OST project in Tashkent. This occurred after the participation of the Uzbek delegation in the 52nd session of the UN Commission on Narcotic Drugs. An interagency working group was urgently set up to develop recommendations on whether or not to continue the pilot project. The working group contained representatives from the Ministry of Health, the Interior Ministry, the Information and Analytical Center on Drugs Control, and a range of other state bodies. By May 2009, the group had decided that OST should be discontinued in the country. A month later, the Ministry of Health circulated a letter among international organizations notifying them of the working group's decision and the official termination of the project. On 25 June 2009, patients stopped receiving substitution medications, having their doses reduced gradually over the course of a month.

As part of the consultative meeting entitled "Drug Control Policy and Public Health" which the UNODC organized in Tashkent on 18 August 2009, the participants asked the representatives of the Ministry of Health to share the report of the working group, which recommended closing the Tashkent project. This would allow the methodology of the evaluation to be studied, the conclusions to be verified, and the approaches used could be compared with international standards. Unfortunately, the request was turned down on the grounds of the fact that, as the report was written "for internal use only".

Key problems, barriers and contradictions

At the legal level:

1. The legislation of Uzbekistan does not directly allow or forbid OST. There are contradictions in the legislation which make it harder to take innovative approaches to preventing diseases. One law ("On narcotics and psychotropic substances") states that in the treatment of drug users, all methods not forbidden by the Ministry of Heath may be used. This allowed the OST project in Tashkent to go ahead. However, in another law,

("On the protection of citizens' health"), it is stated that: "In the health system, only those prevention, diagnostic and treatment methods that are cleared for use in the required legal way are to be used". Methadone is included in List 1 by Uzbek law – the list of substances which are prohibited in the country.

2. There is a legal system for registering patients when they present at drug treatment facilities. Although the law "On the protection of citizens' heath" guarantees the confidentiality of patients' personal information, there areis a whole range of bylaws which require the drugs treatment systemproviders to share information with law enforcement bodies, to prevent "social threats" related to drug and alcohol use. Drug treatment facilities are obliged to collate monthly lists of their patients and cross check them with lists from the Interior Ministry. This practice makes it impossible to ensure the confidentiality of personal information, which the law supposedly guarantees. Being placed on the drugs treatment register can therefore lead to the loss of parent rights, refusal of driving license, and result in rejection from a number of specialist professions. This breach of rights also goes against the law "On the protection of citizens' health", which in Article 13 guarantees absence of discrimination, whether or notregardless the presence of any kind of infection or disease is present.
3. There is a possibility that as a result of enrollment in the OST program and subsequent registration in the narcology database, patients could be forced into treatment, according to the law "On the compulsory treatment of alcoholics, drug and toxic substance addicts". This perspective discourages many potential patients from participating in the OST program.
4. Taking part in OST may also restrict the freedom of movement of patients, as they were required to attend the treatment facility daily to receive their dose of the substitute medication. It was forbidden to take medication home, and the law also had no provision for transferring the medication to a different medical institution, if a patient receiving OST was hospitalized there.
5. The law "On narcotics and psychotropic substances" forbids the promotion of narcotics, including the dissemination of information about how to take them. This significantly limits possibilities to inform the target audience (including potential patients and their relatives) about issues relating to OST.

At the programmatic level:

1. There was no system of methodological support for those carrying out the OST project. Because drug treatment in the country has traditionally been low quality and ineffective, implementing innovative approaches that require a broader component of social and psychological care for patients requires more intensive and focused technical support than it was provided by the WHO and other international agencies.
2. The monitoring and evaluation system was weak. According to WHO experts, the project managers did not use the correct, recommended forms for registering bio/psycho/social/behavioral changes in the patients. This meant that improvements in patients

were not tracked. This information could have been compared with results of patients in other countries, and could have been used to make a factual case for the effectiveness of OST in Uzbekistan as well.

3. For opponents of OST to carry out evaluation of the program using non-scientific methods is at the very least professionally unethical.
4. Focusing advocacy only on government officials limits its potential. There was a situation in Uzbekistan, when officials who had been subjected to years of preparation, information and training, and who had started to support the introduction of OST, then changed their jobs and lost their ability to influence the situation around OST. This has delayed the start of the project for a considerable amount of time.
5. The focus of the drug treatment system on promoting complete abstinence from all drugs as the only possible goal is left over from the Soviet approach to drug dependency. Despite this, there is still an ideological subtext to decisions in this field in Uzbekistan.
6. The inadequacy of the measures against the illegal removal of medications by patients of the OST program led in a number of cases to buprenorphine ending up finding its way onto the illegal market. This discredited the program in the eyes of many decision makers, including those within the law enforcement bodies.
7. The working schedule of the OST program was inconvenient for many patients. Many patients lived far from the OST site; some had to travel for up to 1.5 hours each way to get their dose, which meant they often did not arrive in time for the dispensing of medication.
8. The training system for drug treatment specialists, psychologists, psychotherapists and social workers is weak, and still doesn't include adequate information about how to deal with patients with HIV and drug dependence, or about OST.
9. Patients of drug treatment clinics, including participants in the OST programs, were followed by the police, which significantly broke down trust between the medical institution and the patients.

Recommendations on removing barriers to the further development of OST programs:

1. Continue dialog with the government, aimed at increasing understanding about OST and its importance in preventing the spread of HIV.
2. International programs and organizations that give humanitarian and technical support to Uzbekistan to prevent HIV and treat drug dependency should not pay isolated attention to OST but should advocate for the comprehensive development of the whole system of drug treatment in the country.
3. When programs like OST, which are innovative for the country, are implemented, there should be high-quality scientific and methodical support for those who execute it. International agencies should aim to increase the potential and skills of employees of universities and scientific institutes in order to create a pool of

local OST experts and to ensure scientific support for further projects. A training system for drug treatment specialists should be developed that includes OST as part of the course.

4. An effective evaluation system should be set up for drug treatment programs, based on international best practice. To improve the objectivity of evaluations of OST and all other kinds of medical intervention, there must be groups of researchers that include representatives of several disciplines.
5. Communities linking drug patients and their families should be developed, which are able to play a role in monitoring the quality of the medical support they receive. Allowing representatives of these community groups to take part in the development, implementation and evaluation of drug treatment will help to increase their quality and effectiveness.
6. Legal regulations in the field of drug treatment should be improved to ensure that the rights of patients are protected, guaranteeing that their personal information is confidential when they report to a treatment facility. It is also necessary to remove the above mentioned legal barriers that prevent the effective implementation of OST.
7. Advocacy on OST should be broader in focus, and should not only focus on officials that deal with drug treatment policy, but also on people who are not decision makers but have scientific or other professional status, and work on psychology, psychiatry, neurology and drug treatment. This will allow the circle of professionals with reliable information about OST to be broadened, thus helping to create a more reasonable attitude to the issue among specialists.

Conclusion

Although the governments of Kazakhstan, Kyrgyzstan and Tajikistan have decided to introduce OST programs in their respective countries, there remain a number of obstacles preventing further development of these programs. In all countries of the region, normative and legislative acts related to OST are adopted with short-term goals in mind. In some cases there are contradictions between various legislative acts related to drug treatment issues. OST was introduced in Kazakhstan, Kyrgyzstan and Tajikistan by orders of ministries and other governmental bodies. No government in the region provides legal guarantees concerning access of people dependent on opioids to OST, and this may influence the programs' sustainability. With the exception of Kyrgyzstan, no country has included methadone and buprenorphine in their lists of essential drugs. Aiming to further ensure sustainability of OST programs, it is necessary to include methadone and buprenorphine in the national lists of essential drugs, as well as to provide legislative definitions of key aspects of OST provision.

No country in Central Asia provides access to OST programs for more than 5 per cent of estimated numbers of IDUs (Mathers et al., 2008), while coverage levels below 20 per cent are considered low (WHO, UNODC, UNAIDS, 2009).The current system of registration of patients with drug dependence, allowing dissemination of patient information beyond healthcare systems, is one of the factors limiting OST program development. To attract patients it is necessary to ensure confidentiality of information.

Countries in the region generally employ a narrow range of indications for OST provision. One of the conditions for acceptance into the program is the history ofunsuccessful attempts at treatment; this condition does not correspond with guidelines on treatment of opioid dependence that were recently developed by WHO (2009). Indications for OST provision should be amended to reflect WHO recommendations (presence of opioid dependence and a patient's informed consent). Another important factor contributing to patients' adherence is the option of take-home medications for a period of several days. Successful development of the programs require that permission to provide OST be issued to a wide range of organizations, including general practitioners, HIV/AIDS treatment facilities, non-governmental treatment centers, as well as institutions of the penitentiary system. Kyrgyzstan is the only country in Central Asia where OST is provided by family medicine centers and institutions of the penitentiary system. In Kazakhstan and Tajikistan OST provision is a prerogative of specialized medical facilities which can lead to limited access for those in need of treatment. Feedback from patients and their family members is currently rarely used to improve the quality of OST programs. Involvement of patients in monitoring and evaluation of programs would lead to significant quality improvements.

Both the assessment of programs' effectiveness and the technical support of the OST programs are especially important during the pilot phase, when these programs attract increased attention from policymakers, specialists in the field, representatives of legislative and executive bodies, and the general public. To overcome negative attitudes toward OST programs it is necessary to document their effectiveness. Provision of technical and financial support to evaluate the results of OST introduction is very important. Furthermore, there is a lack of professional literature that would describe various aspects of organization and implementation of OST and that would be written in the Russian and local Central Asian languages. Most Russian-language publications available on the Internet aim to undermine the credibility and effectiveness of the OST programs, which is related to political opposition to OST in Russia and is not in compliance with contemporary scientific evidence showing that such programs are more effective than other methods of treatment of opioid dependence. Efforts should be made to increase the body of accurate, accessible, up-to-date literature on OST and to translate it into Russian and other national languages, as well as to work with mass media to overcome myths and misconceptions related to OST.

Full-scale and long-term funding of OST programs remains a crucial task. Currently programs in the region are funded exclusively by the Global Fund. The countries' own funds are not attracted and are largely used to combat illegal drug trade. It is necessary to work with National coordination mechanisms and principal recipients in order to ensure sufficient funding for expansion of OST programs. To ensure long-term sustainability of OST programs it is necessary to advocate for national funding.

Finally, one more important tendency is observed in all countries of the region." Regardless of the position of international organizations and donors, OST programs are more successful and attract more patients in those countries where drug treatment specialists themselves are supportive of substitution therapy and where the introduction of OST becomes a component of drug treatment system reforms. In those countries where drug treatment specialists oppose OST, or adopt an ambivalent, wait-and-see approach, OST programs do not take off, are closed down, or remain at the pilot stage. Future efforts need to be focused on the adoption of modern approaches to drug treatment in Central Asia, including the method currently considered as the most effective one – opioid substitution therapy in combination with psychosocial support.

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