

Opioid Substitution Therapy

in Central Asia:

**Towards Diverse and Effective Treatment
Options for Drug Dependence**

EXECUTIVE SUMMARY

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EURASIAN HARM REDUCTION NETWORK

EHRN

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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.

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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.(Lancet, 2009). 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 is due to be introduced in the first 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 executive summary:

- 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 abstinence 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 follow-up 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).

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