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Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality

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Background

Globally, between 12 and 21 million people are estimated to use opiates, 3.4 to 3.8 million of whom live in Europe and Central Asia.[1] The UN Reference Group on HIV and Injecting Drug Use also suggests that there are around 3.7 million people who inject drugs (PWID) in Eastern Europe and Central Asia alone, with Eastern Europe having the highest regional prevalence of injecting drug use worldwide. About one quarter of these PWID are thought to be living with HIV.[2]

Opioid substitution therapy (OST) is known as the most effective currently available treatment option of opioid dependence, when combined with psychosocial assistance.[3] There is strong and consistent evidence that shows that access to OST reduces risky injecting practices and HIV incidence. OST also reduces the use of illicit opioids, criminal activity, death due to overdose, and is associated with improvements in physical and mental health, as well as social functioning.[4] The World Health Organisation added methadone and buprenorphine to its list of essential medicines in 2005.[5]

According to the latest update on the global state of harm reduction published in 2010, OST is available in 70 countries and territories around the world. The global coverage is estimated at the level of between 6 and 12 OST clients per 100 PWID and reaching as high as 61 OST recipients per 100 PWID in Western Europe and 52 OST recipients per 100 PWID in Iran. However, in most countries of Central and Eastern Europe and Central Asia (commonly referred to as Eurasia in this policy brief) coverage is limited due to long-term pilots and the lack of systematic scale-up.[6]

The purpose of this paper is to provide an up-to-date overview of the state of OST service provision in Eurasia, with a particular focus on access and quality issues. It is based on data collected by the Eurasian Harm Reduction Network between August and November 2011, and is therefore intended to capture some of the most recent developments that took place in the region since the release of the 2010 global update. The paper will begin by providing essential information on OST in all 29 countries of the region. The subsequent sections of the

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paper are structured around three distinct sets of countries, which, following initial pilots, either 1) succeeded in expanding OST services, to varying degrees, through their national funding; 2) have some barriers to overcome before going beyond the limited scale of OST availability and sustainability; or 3) have not introduced or have discontinued existing OST programmes, mainly for political reasons.

OST availability can be defined as "sustained" when OST programmes have been substantially scaled-up since they were first introduced in the country; the majority of funding for OST programmes comes from state budgets; and there are no major political barriers undermining the implementation of OST programmes. Importantly, countries with high numbers of OST clients and yet relying almost exclusively on external donor funding to support their OST services are not addressing the crucial issue of sustainability of their programmes. With the recent announcement of the cancellation of Round 11 Call for Proposals by the Global Fund to Fight AIDS, Tuberculosis and Malaria – the source of the largest donor funding for harm reduction programmes in the region – these countries may increasingly find themselves dealing with similar kinds of problems as countries with limited availability of OST. For this particular reason, this paper will discuss the challenges they face and the opportunities they have under the second grouping of countries.

Table 1. Opioid substitution therapy in Eurasia[7]

Country	Year when OST was introduced	Types of OST	Number of clients	Number of sites	Geographic distribution	OST in prisons	Take-home OST	Funding
Albania	2005	Methadone	593	6	Tirana, Korka, Durres, (Elbasan)	Y	Y	OSI, GFATM R5
Armenia	2009	Methadone	147	2, with plans to open 2 more before the end of 2011	Yerevan	OST is provided only at the Central Hospital for Detainees	N	GFATM R8 State budget co-financing (personnel, etc.)
Azerbaijan	2004	Methadone	110–150	2	Baku	N	N	State budget
Belarus	2007	Methadone	450-460	10–13	Minsk, Soligorsk, Gomel, Zhlobin, Svetlogorsk, Mozyr, Grodno, Pinsk, Polotsk	N	N	GFATM R8 RCC State budget co-financing (personnel, etc.)
Bosnia Herzegovina	1989 (re-launched in 2002)	Methadone Suboxone	800 (2010)	8	Sarajevo, Mostar, Zenica, Sanskij Most, Tuzla, Bihac, Doboj	N	n/a	n/a
Bulgaria	1996	Methadone Substitol	3104 (2009)	31	12 cities	Y	Y	State budget; Patient fees (commercial treatment centres)
The Czech Republic	1991 (formalised & standardised in 1998)	Methadone Subutex, Suboxone	Est. 4800; 67 in prisons	Methadone: 72 facilities; Subutex: 150 to 240 psychiatrists and general practitioners		Y 8 prisons provide methadone	OST drugs except methadone sold in pharmacies	State budget – funds from state health insurance
Estonia	1998	Methadone Buprenorphine	1012 enrolled in the programme in 2009; 48 in prisons as of March 2011	8–10 Also available in all prisons		Y	n/a	The National Strategy of HIV/AIDS Prevention, Municipal budget of Tallinn, Penitentiary facilities

Country	Year when OST was introduced	Types of OST	Number of clients	Number of sites	Geographic distribution	OST in prisons	Take-home OST	Funding
Hungary	1989	Methadone Suboxone	992 (2009)	10	Budapest (4 treatment centers), Eger, Dyupa, Miskolc, Pecz, Szeged, Vesprem	Y	n/a	the National Health Insurance Fund
Georgia	2005	Methadone Suboxone	1000–1200	14	Tbilisi, Kutaisi, Poti, Batumi, Gori, Ozurgeti, Zugdidi, Telavi	Methadone detox in 1 prison	N	State budget, GFATM Patient fees (commercial treatment centres)
Kazakhstan	2008	Methadone	98	3	Temirtau, Pavlodar, Ust-Kamenogorsk	N	N	GFATM R7 State budget co-funding (personnel, etc.)
Kosovo	N							
Kyrgyzstan	2002	Methadone	1013 including 119 in prisons	17–20 3 prisons	Bishkek, Osh, Chuyskaya oblast, Jalal-Abad, Kyzyl-Kiya, Uzgen	Y	Y	GFATM R7&10 CDC State budget co-funding (personnel, etc.)
Latvia	1996	Methadone Buprenorphine	271 on methadone; 49 on buprenorphine (2010)	10	Riga, Elgava, Liepaja, Jurmala, Olaine, Salaspils, Daugavpils, Kuldiga, Rezekne, Tukums	N	Y (in exceptional cases)	State budget, patient fees, UNODC
Lithuania	1995	Methadone Suboxone Buprenorphine	815 (2009)	19	Vilnius (8 sites), Klaipeda (2), Kaunas, Druskininkai, Telsiai, Mazeikiai, Silute, Siauliai, Kedainiai, Alytus, Svencionys	N	Y	State health insurance, state budget, municipal budget, patient fees (commercial treatment centres)
Macedonia	1992	Methadone Buprenorphine	1272, including 239 in prisons (2010)	10	Skopje, Bitola, Kavadarci, Gevdelija, Stip	Y	Y	GFATM R7 (2008) MoH, Ministry of Labour and Social Policy
Moldova	2004	Methadone	184 including 55 in prisons (2010	10 including 7 in prisons (2010)	Chisinau, Balti	Y	N	GFATM R6 and 8 OST in prisons with support from WB, GFATM, SIDA
Montenegro	2005	Methadone	94 patients in Podgorica (2010) 10 in prisons (2010)	3	Podgorica, Berane, Kotor	Y	N	Institute for Execution of Criminal Sanctions, Central government, municipal governments
Poland	1993	Methadone Buprenorphine	1900 (2009) approximately	22 including 5 in prisons (2009	Warsaw, Chorzow, Lublin, Krakow, Poznan, Kozelec, Gdansk	Y	Y	National foundation for health Ministry of Health Ministry of Justice Patients (commercial treatment centres)
Romania	1998	Methadone Buprenorphine	424 (2009) 18 in prisons	6–8		Y	n/a	State budget, patients (commercial treatment centres)

Country	Year when OST was introduced	Types of OST	Number of clients	Number of sites	Geographic distribution	OST in prisons	Take-home OST	Funding
Russia	N							
Serbia	2008	Methadone Buprenorphine Suboxone	1435 (2011) 103 in prisons (2009)	Over 30 healthcare facilities		Y	Y	GFATM R 8, EU IPA, State budget
Slovakia	1997	Methadone Buprenorphine Suboxon	600 (2009)	2 for methadone; Suboxone through the network of psychiatric outpatient units	Methadone: Bratislava and Banska Bystrica (2009)	N	n/a	Methadone: State budget; Suboxone: patient fees
Slovenia	1990	Methadone, Suboxone Subutex Substitol	3324 172 in prisons	20		Y	n/a	State budget; Slovenian Institute for Health Insurance
Tajikistan	2010	Methadone	157	3	Dushanbe, Khujand, Khorog	N	N	GFATM R8, UNODC
Turkmenistan	N							
Ukraine	2004	Methadone Buprenorphine	6517	131 programmes in 27 regions		N	N	GFATM R6 and 10 – medicines, Clinton Foundation, State budget (part of salaries and office space)
Uzbekistan	N (was available in 2006–09)							

Achievements and challenges in countries with sustained availability of OST programmes

In Europe, OST is provided in all EU Member States and is "the predominant treatment option for opioid users".[8] In many Central, Eastern and Southeast European countries OST with methadone was introduced in the 1990s.[9] This section will focus in greater detail on OST services in four European Countries: Bulgaria, the Czech Republic, Lithuania and Poland. Accessibility and quality of OST will be analysed by looking at several key areas: the policy framework (support of, or lack of significant policy barriers to, OST); service delivery in both community and prison settings; funding; eligibility criteria; and other components of OST regulations, standards and protocols.

Regional policy framework

European Union Member States base their drug policies on the UN drug conventions, the fundamental principles of EU law and "the founding values of the Union: respect for human dignity, liberty, democracy, equality, solidarity, the rule of law and human rights". The EU drugs strategy sets forth a balanced strategy between law enforcement and health, rights and the well-being of citizens.[10] These balanced drug policies in EU Member States do not create serious obstacles to the implementation of effective drug treatment programmes such as OST. As was documented in the 2011 Annual Drug Report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the recent achievements in EU countries in the field of drug treatment prove the importance of a supportive policy framework for providing

access to effective high quality drug treatment systems.[11] Most Eurasian countries do not have such a supportive policy framework.

OST in the community setting

In Bulgaria, the Czech Republic, Lithuania and Poland, OST availability and coverage vary (see Table 1). The Czech Republic has the highest estimated coverage, with about 4,800 clients receiving OST and accounting for nearly 40% of estimated 12,100 problem opiate/opioid users.[12,13] The Czech Republic is followed by Lithuania, Bulgaria and Poland, where coverage is estimated at approximately 15%, 12% and 7%, respectively.

Higher coverage rate in the Czech Republic can be partially attributed to the fact that OST medications (except methadone) can be prescribed by general practitioners and purchased in pharmacies.[14,15] The first official substitution treatment programme started in Prague in 1991 after a rather unique incident: exceptional permission to provide substitution treatment to heavily dependent opioid users in Prague was eventually granted when a physician from a NGO drop-in centre was arrested after declaring several illegally imported kilograms of methadone hydrochloride from Switzerland to customs. Following a period of unorganised substitution treatment, standardised guidelines for OST were developed by the Czech Ministry of Health in 1998.[16]

In Bulgaria, OST can be provided in specialised licensed centres for drug dependence and staff members of these facilities are required to take courses organised by the Ministry of Health.[17] The total capacity of the 31 OST sites operating across 12 cities is about 5,610 potential clients, although only 1,195 clients can receive OST free of charge through municipal programmes.[18] The quality of services is currently addressed in Guidelines for good clinical practice in substitution treatment, while newly developed standards will come into force in 2012.[19]

In Lithuania, OST first became available in 1995, when both the families of PWID and drug treatment specialists appealed to the government for support. Lithuania was the first country among the former Soviet states to provide OST through primary mental health care and to have established an OST client association.[20] Until recently, OST has been provided in 4 drug treatment centres and 15 (2010) centres of primary health care. Since 2009, buprenorphine and buprenorphine/naloxone can also be bought through private centres owning a license to provide mental health care.[21] Although no legal barriers to expanding OST exist in Lithuania, in 2011 the Lithuanian Parliament drafted a resolution referring to the UN drug conventions and questioning the legitimacy of OST in Lithuania. Having considered a strong and timely feedback on this resolution provided by the WHO and the Lithuanian Association of Psychiatrists, the Parliament eventually adopted a much softer resolution that stated the need to ensure the quality of, and to increase support to, drug treatment services.[22]

In Poland, OST has been available since 1993 in state health care facilities. The new drug law adopted in 2005 authorised non-governmental organisations to run OST programmes, with first NGO-based OST programmes becoming operational in 2007.[23] OST is provided free of charge and is funded by the National Health Fund.[24] OST programmes are running in a limited number of regions and some clients live as far as several hundred kilometres away from the nearest programme.[25] Polish civil society organisations collaborate with medical professionals in advocating for greater availability and geographical coverage of OST. A site newly opened in Gdansk in 2011 serves as the most recent example of successful joint advocacy action.[26, 27]

OST in prisons

Both in respect of fundamental human rights and in the best interests of public health, "all types of evidence-based treatment available in the community should be accessible in prisons", with OST being especially indicated for opiate dependent people.[28,29,30] While OST is available in community settings of most European countries, its availability and coverage in prison settings varies considerably. In Bulgaria, OST programmes are not implemented by penitentiary institutions. However, since 2008, OST programme specialists can obtain permission from the relevant Directorate of the Ministry of Justice to provide treatment to inmates who were on OST prior to incarceration. In 2009, 30 inmates (0.3% of total prison population) were receiving OST in Bulgaria.[31] Similarly, in the Czech Republic and Poland, new OST treatment programmes are not available for drug dependent inmates who did not have access to OST in the community, only those who had access to OST before imprisonment are able to continue this treatment. In 2010, 67 inmates were receiving OST in 8 prisons of the Czech Republic (0.35% of total prison population), whereas 60 inmates were receiving OST in Poland (0.07% of total prison population).[32,33,34] In Lithuania, OST is not available in prisons settings and is discontinued if the patient is placed in pre-trial detention units under the authority of the Ministry of Justice. The dire consequences of OST termination as a result of detention are vividly expressed in a recent complaint submitted by a Lithuanian citizen to local prison authorities: "Since 2002, before I went to prison, I had been receiving methadone maintenance therapy…Methadone treatment was effective and helped me control my dependency. Currently my health is much worse: I have withdrawal symptoms, bone pain, constant anxiety and insomnia. I thereby request to continue my substitution treatment course in prison".[35]

Funding

The common characteristic of OST programmes in all four countries with sustained availability of OST is the funding they receive from the state. However, not all those in need of treatment can get it on a free-of-charge basis and client fees serve as a major obstacle to increased OST accessibility, often resulting in the emergence of a waiting list practice. In Bulgaria, for example, two of the main concerns are high drop-out rates in programmes that do not receive financial support from the state, as well as the lack of sufficient funding to provide integrated treatment and care for clients with co-morbidities, which are not covered through insurance schemes.[36] In Poland, the level of state funding to OST services is low, with the major public funder, the National Health Fund, unwilling to support OST.[37]

Eligibility criteria

The World Health Organisation recommends agonist maintenance treatment to all patients "who are opioid dependent and are able to give informed consent, and for whom there are no specific contraindications".[38] One of the main restricting criteria that are applied in Bulgaria, the Czech Republic, Lithuania and Poland and in many other Eurasian countries is the 18-year-old age threshold. Although Bulgarian authorities also limit OST provision to patients with a history of at least one unsuccessful treatment attempt, the newly developed standards will no longer impose this requirement.[39]

Key challenges

Many European countries with sustained OST availability face two key challenges of continuing to sustain and expand their existing services as well as making OST available to every inmate with opiate/opioid dependence. While OST funding is mostly provided by national governments or other public funds, a recent analysis suggests that developments in Central, Eastern and Southeastern Europe display the vulnerability of OST programmes

when all major service providers are dependent on funding from their respective national governments. In their words, and especially since the economic crisis first started in 2008 in the European Union, cuts in social and health areas have been convenient for governments, in particular with regards to drug dependence issues, as people dependent on drugs are often marginalised and stigmatised for their health-related behaviour and precarious situation. In Poland and Lithuania, and to a lesser extent in the Czech Republic, the scope of harm reduction services has been either significantly reduced or has been stagnating over the past three years.[40] However, as a review of the transition from donor to national funding in one of the Baltic states underlined, "it may be true that the government *can* afford to allocate new funds to sustain and expand HIV/AIDS services [...], but it may not always *want* or *choose* to."[41] Therefore, as recommended by Zabransky et al., "[c]ontinued advocacy by NGOs with involvement of people who use drugs, experts and other stakeholders will be needed for the Baltic [and other Eurasian] societies and governments to both *want* and *choose* to respect rights of people who use drugs and reduce drug-related harms for individuals and societies at large."[42]

Barriers and opportunities in countries with limited availability and sustainability of OST programmes

Former Soviet countries of the region with limited availability and sustainability of OST include Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan and Ukraine. This section will briefly describe the situation in some of these countries, with a particular focus on Georgia, Kazakhstan, Tajikistan and Ukraine, and discuss political, financial and other barriers to expand OST programmes in those countries. Other countries in this group, which are not discussed here and yet rely on external funding to support their OST services, include three EU candidate and potential candidate countries: Albania, the Former Yugoslav Republic of Macedonia and Serbia.

A low access to OST programmes

All former Soviet countries in Eurasia have a low OST coverage that is nowhere near the levels recommended by UN agencies.[43] For example, while Ukraine has the highest absolute number of patients receiving OST as of November 2011 (n=6,517), this number represents only about 2.2% of the estimated 290,000 people who inject drugs in the country.[44] In Kyrgyzstan, the number of clients in OST treatment ranges to around 1,000 people, comprising about 3.8% of an estimated 26,000 opiate users.[45] Similarly, about 1,200 patients were reported to receive OST in Georgia in 2010, where the estimated number of PWID is approximately 40,000.[46] Against the backdrop of developments in these three countries, the number of clients in Armenia, Azerbaijan, Kazakhstan, Moldova and Tajikistan is still below 100 or 200 people, with some programmes turning into 'perpetual pilots'. Even though many OST programmes in the region have very low coverage, treatment interruptions and stock-outs do occur every now and then. For example, interruptions in the supply of OST drugs have led to stock-outs in Ukraine (2007), Azerbaijan (2005), and Kyrgyzstan (2005).[47] In 2009, Kyrgyzstan was again on the verge of OST interruption due to stock-outs of methadone. To address the situation, the dosage of methadone was temporarily reduced while Kyrgyz authorities took the necessary steps to increase the national quota for methadone.[48] Aside from logistical problems, some interruptions of OST services were caused by the activities of law enforcement agencies. For example, as a result of the 2010 police persecution of OST service providers in Ukraine (see the case of Dr Podolyan), OST procurement was interrupted and programme clients in the city of Odessa were forced to return to using street drugs.[49]

BOX 1. Intimidation and harassment of OST practitioners and patients by the police in Ukraine: The case of Dr Podolyan

After a year and a half of persecution and four months of incarceration, Dr Ilya Podolyan, a physician providing OST in Odessa (Ukraine), was acquitted in November 2011. His persecution was initiated in March 2010, when the police raided and temporarily closed the OST clinic in Odessa leaving over 200 OST patients without treatment for several days.[50] Dr Podolyan was charged with ostensibly committing 44 counts of drug-related 'crime', including 'illegal' distribution of buprenorphine to the patients of his clinic.

This was one of several documented cases of "systematic unlawful criminal prosecution of narcology doctors" and a violation of human rights of OST providers and patients in Ukraine.[51] Both domestic and international public health communities and organisations, including the International HIV/AIDS Alliance, Human Rights Watch, the World Health Organisation and the Global Fund, condemned these violations in their letters and appeals and urged the Prime Minister, the General Prosecutor of Ukraine and other authorities to release Dr Podolyan and to stop prosecutorial harassment and abuses against OST patients.[52]

In June 2011, the regional court dropped all charges against Dr Podolyan. Subsequently, in November, the Court of Appeal overruled the prosecutor's appeal for 5 years of imprisonment for alleged crimes.[53] Importantly, as a result of strong advocacy campaigns against police abuses and unlawful detention of OST service providers, and based on the positive results of OST implementation in the country, in February 2011, the Prime Minister of Ukraine produced a resolution requesting the Ministries of Health and Interior, in partnership with non-governmental organisations, to expand OST programmes and to revise respective policies.[54]

Very low availability of OST in prisons

Only two countries in this group, Kyrgyzstan and Moldova, have OST programmes in prisons. The results of the most recent assessment of the OST programme in one Kyrgyz penitentiary institution indicate the consistent improvement of health and quality of life among OST patients, as well as a significant reduction of injecting risk behaviour and infections of HIV and other blood-borne viruses.[55] Even then, the expansion of OST, following the programme's launch in Kyrgyz prisons in 2002, is slow for various reasons, such as the need to provide extensive technical assistance to prison staff.[56] In Georgia, one prison runs a 2-month detoxification programme with methadone; no OST treatment is provided beyond this detoxification programme.[57] In Belarus, the subject of introducing OST in prison settings is being discussed but no active steps have been taken to address this issue and the lack of designated funding remains a major problem.[58] Difficulties with organising OST services in prisons may also be related to a common belief that prisons should be "drug-free" zones and the reluctance of prison administrations to admit the presence of drug use in their facilities.[59] In addition, as it was well-documented in Tajikistan, some of the prison staff may also be heavily involved in supplying illicit opiates to inmates and introducing OST in prisons may run against their venal interests.[60]

Obstacles created by attempting to fit OST into the post-Soviet narcological paradigm

All post-Soviet countries have inherited a shared legacy of addressing drug and alcohol-related problems within a discipline of narcology, which has strongly viewed drug dependence as a personal failing that is best treated through psychiatric and drug free methods. The provision of OST services has been, and remains, a prerogative of narcology specialists in many Eurasian countries. Hence, OST is often unavailable in hospitals, where people who use drugs with other co-morbidities receive in-patient medical care, as well as in maternity houses. Attempts to contain OST provision within the boundaries of narcology also result in the inability of other health care service providers to prescribe OST medication. To some extent, they may serve to explain a widespread reluctance to authorise take-home doses, although other factors such as unjustified fear of diversion of OST medicines to illicit markets possibly play a greater role. Furthermore, for most patients in the region, a history of unsuccessful narcological treatment attempt(s) is among the criteria they have to meet to be eligible for OST. However, since many people who use drugs seek to avoid narcological registration and related consequences and perceive standard narcological care as ineffective, they normally have experiences of receiving drug treatment from other formal and informal service providers which remain undocumented and are not accounted for. Finally, just as in Soviet times, some countries continue to rely on special "commissions" to decide on each patient's access to OST. Occasionally, these commissions include members without any medical background and expertise in drug treatment, and representatives of the "organs of power" and law enforcement, whose opinion tends to have a much heavier weight.[61]

Political ambivalence, weak financial commitment and strong opposition

In most countries with limited availability and sustainability of OST, this treatment option has been introduced through ministerial decrees rather than legislative acts, which makes OST programmes more vulnerable to both changes in political situations and external pressures of various opposing groups. As Stuikyte and Bonnell wrote recently, "[t]he challenges in Kyrgyzstan revolve around the fact that OST is governed by government decree, not legislation. This means that all decisions on OST are totally up to the present will of current politicians in power – leading to the situation when every few years there are calls to stop OST and outlaw methadone. At these times, civil society and partners backing the use of OST must aggressively plan and advocate for "saving" OST, taking time, funds and effort regularly away from other needed activities".[62]

Yet, in neighbouring Uzbekistan, with a much weaker civil society, OST supporters were not in a position to 'save' OST as the Uzbek government shut down the programme by issuing a ministerial decree. In view of such instances, there is a common belief among experts that legislations with explicit support of OST play an essential role in helping to achieve political stability of OST programmes in the region.[63,64,65]

In many former Soviet countries, OST programmes are either primarily funded by international donors, most notably, the Global Fund (e.g. Armenia, Belarus, Kyrgyzstan, Moldova, Tajikistan), or receive only partial financial support from the state (e.g. Georgia and Ukraine). In some republics, OST pilots were actually introduced under the influence of the Global Fund (e.g. Kazakhstan and Tajikistan), with governments subsequently relying on external grants to run their OST services (e.g. Tajikistan).

Quite often, the presence of powerful opposition groups with overt and covert interests may serve to significantly undermine political and financial support of OST programmes. On the other hand, political ambivalence to support OST does very little to curb the widespread abuse of people who use drugs by the police.

According to recent reports, in Moldova, police officers arrest OST clients and force them to take drug tests.[66] In Georgia, OST clients declared that continuous harassments from the local police demotivated people who use drugs from participating in OST programmes.[67] In Ukraine, law enforcement agencies were reported to collect personal data from OST clients all over the country and on some occasions telling OST clients that their future participation in the programme depended on their willingness to serve as informants for the police.

Furthermore, in 2011 alone, OST services in at least two countries of the former Soviet region were under a significant threat of closure due to fierce opposition and lobbying from groups opposed to OST. In Kazakhstan, in response to the Government's plans to roll out OST and scale up both patient and geographical coverage, a campaign against OST was organised by a group of medical specialists, who called for the closure of substitution therapy. Among the key people behind those calls was a doctor, who was in charge of an abstinence-based clinic for drug users. The Kazakh Ministry of Health, supported by the UN agencies and other international organisations, did not discontinue existing OST services, although plans for further expansion were put on hold. In Kyrgyzstan, the Presidential Administration first received about 30 letters against OST, which were later found to be falsified. Then, in October 2011, a popular Kyrgyz film director produced a documentary against methadone, which portrayed a heavily biased and negative image of methadone maintenance programmes, calling it "a trap". In response to these attacks, the Kyrgyz medical community and civil society organisations joined their efforts and organised numerous high-profile activities to effectively protect OST programmes from possible termination. However, with the Government of Russia banning OST and aiming to influence drug policies in Eurasia, one can also suggest that any forms of opposition to OST in the region may not only be welcomed but also supported by this major external player.

Overall, in countries with limited availability and sustainability of OST programmes, many barriers to increased coverage and improved quality may be referred to as 'self-induced', with key programmatic, policy and funding decisions often inhibiting rather than encouraging the development of this effective treatment option. The opportunities to overcome these barriers lie, therefore, at the heart of domestic policy-making. OST clients, their families and civil society organisations play a key role in advocating for evidence-based drug policies that respect fundamental principles of human rights, and investing in building their capacities represents another clear opportunity for donors and providers of technical assistance. As skills and expertise of OST service providers remain limited, major improvements in quality can also be achieved by prioritising OST over outdated and ineffective drug treatment approaches and mainstreaming both internal and external resources to strengthen human and technical capacities of the former.

Denial and resistance in countries with no OST programmes

As of end of 2011, OST programmes were not available in four countries of the region: Kosovo, Russia, Turkmenistan and Uzbekistan. While the EMCDDA Country Overview working group from Kosovo suggests that the "barriers and problems facing implementation of methadone maintenance treatment have been overcome and it is expected that in 2011 this treatment will be initiated in Kosovo", the situation in the remaining three countries is more complex and outlook is less optimistic.[68]

OST is prohibited in Russia by a legislation that does not allow the use of methadone and buprenorphine (and other opiates) for the treatment of drug dependence.[69] The Russian Government vehemently opposes OST and harm reduction, considering them as "threats" in the newly adopted Strategy for

the Implementation of the National Anti-Drug Policy of the Russian Federation for the Period until 2020.[70] The official position of the Russian Government contradicts not only a substantial body of evidence on the effectiveness of OST and harm reduction interventions internationally, but also the evidence that has emerged within Russia, both in Soviet and post-Soviet eras. Maintenance therapy of people with opioid dependence was available in Russia until 1977, when this so-called "vicious" practice of administering "narcotic allowance" was discontinued through the USSR Ministry of Health decree.[71] Yet, an earlier six-year study from Leningrad documented "good" and "satisfactory" outcomes in as much as 72 percent of clients receiving OST.[72] Similarly, a recent analysis of the effectiveness of harm reduction programmes conducted by a prominent group of Russian scholars was branded as a "science-like attempt" to "prove the effectiveness" of harm reduction programmes "under the pretext of HIV prevention".[73,74]

In the absence of effective treatment and prevention strategies for PWID and with an estimated 1.825 million people using drugs intravenously, Russia is facing one of the world's most significant HIV epidemics driven by the shared use of non-sterile drug injecting equipment.[75] Opioid overdose is the second leading known cause of death among people who use drugs in Russia, where in 2006 the annual mortality rate due to overdose was at the highest level documented in any country.[76] According to the most recent data from the Bureau for Medical and Forensic Examinations at the Russian Ministry of Health and Social Development, there were 7,726 fatal drug overdoses registered in 2010 – nearly a 2% increase compared to 2009 (n=7,592).[77] Russia also has the world's second highest rate of prison inmates per 100,000 residents, while a substantial proportion of people who use drugs report a lifetime history of incarceration.[78,79] The introduction of OST is urgently indicated to address these issues: a dynamic model of HIV transmission among PWID in Russia suggests that at a baseline HIV prevalence of 15% increasing the coverage of OST from 0% to 25% could decrease HIV incidence by 44 to 53%.[80] Instead, as the most recent Russian Shadow Report to the UN Committee against Torture concludes, "Russian State authorities, officials or other persons acting with consent, at the direction or with the acquiescence of the State, are intentionally causing a large group of people [who use drugs] severe physical pain, suffering and humiliation with the purpose of punishing them for using drugs, to intimidate and coerce them into withdrawal, completely disregarding the chronic nature of dependency and the scientific evidence…"[81]

In Turkmenistan, the Government denies the existence of any HIV/AIDS problem in the country, reporting a cumulative total of only two cases to the WHO and UNAIDS. Despite the change in leadership following the death of Turkmenistan's first President, Turkmen officials continue to reassure external visitors that there are currently no people living with HIV in Turkmenistan.[82] Other Turkmen specialists, as the most recent International Crisis Group's study suggests, "just smile awkwardly and lower their eyes" whenever the issue of HIV is raised with them.[83] Both anecdotal reports and historical evidence from Turkmenistan suggest that opiate use may be rampant and shared use of needles and syringes widespread.[84,85,86] The number of registered people using drugs by the end of 2007 has increased by about 7.5 times compared to the number of people who used drugs registered in Turkmenistan by the end of 1987, while the population of Turkmenistan increased only by some 50% during these two decades.[87,88] Despite earlier suggestions that Turkmenistan was considering introducing OST, no such changes have taken place yet.

As for Uzbekistan, the Government discontinued its OST programme in June 2009, and the only operational OST site, which was opened in 2006 in the capital city of Tashkent, was closed. Before its closure, 142 clients were receiving OST in Tashkent. The decision to shut down

an OST pilot as ostensibly "inappropriate" was made regardless of the positive findings of an earlier WHO evaluation, and since then no tangible progress has been achieved to re-open the programme.[89,90]

In countries with no OST, the opposition is often a political one. While efforts relying on public health arguments to persuade the governments to support OST should be continued, they often end up falling on the deaf ears of resisting parties who deny solid and extensive evidence in favour of OST. This can be seen clearly from the recent statement of the Russian Minister of Health during her meeting with the UN High Commissioner for Human Rights in February 2011, when she declared that, "till now, we have no evidence from the world community on the effectiveness of OST".[91] Given the above, both public health and human rights-based approaches to overcome the fierce opposition to OST need to be taken simultaneously.

When politically biased national bodies in countries such as Russia and Uzbekistan declare OST to be "ineffective", "inappropriate" or a "security threat" (one of the most recent conclusions from a supposedly independent evaluation commission in neighbouring Kazakhstan) based solely on ideologies and personal interests, the opponents of OST should be provided with a straightforward response: any possible indications of local deficiencies in OST programmes call for improving the quality of the programmes and bringing local OST services and policies in line with internationally accepted standards that have proven to be effective for treating opioid dependence.

In addition, any formal ban on OST directly contradicts national Constitutions that guarantee the protection of human rights for all in accordance with internationally accepted standards and principles, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. By appealing to national and international judicial authorities and human rights bodies, the unwillingness of governments to provide OST should be strongly challenged in order to make sure that such prohibitive polices are reviewed through the lens of human rights. Such evaluation, as experts from the Canadian HIV/AIDS Legal Network suggest, "will have a significant impact, as long as its results are reflected in judicial decrees and resolutions passed by national and international human rights agencies, in relation to a specific country".[92]

Conclusions and recommendations

In 2008, the International Harm Reduction Development Programme identified a range of barriers to access to OST falling under three larger domains: the high costs and low supply of medication, restrictive entry criteria for treatment programmes and the lack of government commitment to scale up pilot projects.[93] While some progress has been made and more countries introduced OST over the past three years, numerous challenges still exist, as do the opportunities for increasing access to and improving quality of OST programmes.

These opportunities are broadly related to:

- national ownership of OST service provision that can be achieved through strong political commitment and national funding of OST projects;
- policy reform through comprehensive analysis and advocacy action to review restrictive and poorly written policies, or adopt new policies in support of OST;
- protection from police harassment and violation of human rights of OST clients and service providers;
- strengthening technical and human resource capacities and developing national standards and protocols in line with international best practices to ensure adequate quality of OST programmes;

- dissemination of up-to-date evidence-based information on OST programmes, which is tailored to the needs of various target audiences;

- engaging with, and gaining support from, policy champions, the media, OST specialists, clients and their families to effectively promote OST and address the claims and concerns of the opposing groups.

The recommendations below are addressed to national policy makers, OST specialists and advocates, donors and technical assistance providers, and clients of OST programmes. These stakeholders need to consider:

- Investing in building local capacities for OST advocacy in the region.

- Producing OST model legislation tailored to the legislative realities of the region.

- Developing a decision model that outlines various funding options and ensuring increased national funding to OST services through transparent mechanisms.

- Advocating for and ensuring the provision of take-home OST doses for stable clients motivated to continue their treatment.

- Increasing coverage of OST programmes by engaging general practitioners, drug treatment specialists, AIDS centres and other healthcare facilities in offering OST.

- Ensuring continuity of OST services in community and prison settings by integrating OST programmes into in-patient facilities and introducing OST programmes in both pre-trial detention centres and prisons.

- Establishing a comprehensive system for monitoring and evaluation of OST programmes in non-EU countries of Eastern Europe and Central Asia, with active participation of OST clients.
- Ensuring better quality of OST programmes through increased provision of psychosocial support and integration with other services.

- Conducting regular regional forums on OST to stimulate scientific interest and to recognize the efforts of countries supporting OST.

- Establishing a formal scientific community of distinguished scholars with knowledge and expertise in OST-related issues in Eurasia, who could be mobilised to respond to possible attacks of opposing groups on OST.

- Supporting efforts to promote harm reduction and OST scholarship in Eurasia by expanding Russian language evidence base through the publication of original research from the region and translation of peer-reviewed English language literature.

- Developing a set of plans with specific activities designed to respond to OST crises that can potentially unfold in countries of Eurasia under different scenarios.

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