Opioid Substitution Therapy in Selected Countries of Eastern Europe and Central Asia

Oleg Aizberg
Eurasian Harm Reduction Network (EHRN)
Department of Psychiatry and Narcology
Belarus Graduate School of Medicine, Minsk
December 2008
Acknowledgements

This report was prepared by Oleg Aizberg for the Harm Reduction Knowledge Hub of Eurasian Harm Reduction Network (EHRN) on request by the International AIDS Society.

The Eurasian Harm Reduction Network (EHRN), formerly the Central and Eastern European Harm Reduction Network is a regional network the mission of which is to support, develop and advocate for harm reduction approaches in the field of drugs, HIV, public health and social exclusion by following the principles of humanism, tolerance, partnership and respect for human rights and freedoms. Currently EHRN unites over 300 individuals and organizations from 27 countries in Central and Eastern Europe and Central Asia. For more information see www.harm-reduction.org.

Opinions and views, represented here are the result of collaborative research and thus not reflect the views of EHRN, IAS or any individual author.

The Eurasian Harm Reduction Network (EHRN) and the International AIDS Society gratefully acknowledge Oleg Aizberg, the author of the report and reviewers Raminta Stuikyte and Emilis Subata.
Introduction

Until the mid-1990s, opioid use was rare in the post-Soviet countries of Eastern Europe and Central Asia. Opium-based drugs were generally homemade concoctions prepared from the opium poppy, usually injected intravenously. Some users used medical opioids, most commonly morphine, omnipon and codeine. Between 1995 and 1997 the black market was flooded with cheaper heroin, making it available to many lower-income youth. Opioid users now represent 80-90% of the registered drug users seeking medical care.

In most of the Former Soviet Union (FSU) countries, drug dependency treatment is government-funded. The treatment systems include inpatient and outpatient care facilities, data collection and administrative functions. Most centers focus their treatment efforts on total abstinence. Some centers also have harm reduction programs, including needle and syringe exchange programs and methadone substitution therapy.

Over the last several years, HIV infection has been on the rise among injecting drug users in Eastern Europe and Central Asia.

In 2005, the WHO added methadone and buprenorphine to the WHO Model List of Essential Medicines for opioid addiction treatment [1]. These two drugs were added after numerous studies showed that their use in substitution therapy benefits mental and physical health, improves quality of life and reduces high-risk injection behaviors. The studies were completed in countries with different prevailing socioeconomic conditions and different drug dependency treatment systems. All showed methadone/buprenorphine substitution therapy to be safe and effective [2].

According to some estimates, over 3.7 million injecting drug users (IDUs) live in Central/Eastern Europe and Central Asia, most of whom are opioid users (UN Reference Group on HIV Prevention among IDUs, 2008). The data show a high incidence of HIV and hepatitis-C infection among injecting drug users. In most of the countries in this region parenteral transmission of HIV is the most common, representing 50-85% of registered cases (UNAIDS 2008; IHRD 2008). Prevention efforts reach few IDUs, with less than 10% coverage in most countries, and as low as 2% in some (e.g., Russia) (UN Secretary General 2006; Bayern 2006). Regional developments in substitution therapy for drug dependency were first studied by a group of experts (E. Subata, A. Kastelich, T. Zabransky) in 2003.

The purpose of this paper is to examine the introduction of opioid substitution therapy (OST) in selected post-Soviet countries: Belarus, Ukraine, Lithuania, Georgia, Kyrgyzstan, Kazakhstan, Russia, Tajikistan and Uzbekistan. This information was prepared during the period of October to December 2008, by the Eurasian Harm Reduction Network (EHRN) at the request of the International AIDS Society.

Table 1 gives an overview of the opioid substitution therapy situation.
### Mapping of Opioid Substitution Therapy in Individual Countries

Table 1. Opioid Substitution Therapy Situation in Selected EECA Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Year opioid substitution therapy introduced</th>
<th>Number of Centers</th>
<th>Number of opioid substitution therapy patients</th>
<th>Estimated IDUs*</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus</td>
<td>2007</td>
<td>1</td>
<td>50</td>
<td>45,842</td>
<td>Global Fund</td>
</tr>
<tr>
<td>Ukraine</td>
<td>2004</td>
<td>38</td>
<td>1956</td>
<td>400,000</td>
<td>Global Fund, Clinton Fund</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2005</td>
<td>14</td>
<td>410</td>
<td>8,500</td>
<td>Mandatory medical insurance system</td>
</tr>
<tr>
<td>Georgia</td>
<td>2005</td>
<td>3</td>
<td>455</td>
<td>12,420</td>
<td>Global Fund, national government program</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>2002</td>
<td>7</td>
<td>735</td>
<td>44,398</td>
<td>Global Fund</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>2006</td>
<td>1</td>
<td>140</td>
<td>40,000</td>
<td>Global Fund</td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>No opioid substitution therapy, Health Ministry order issued in 2002 called for implementation of a pilot project opioid substitution therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russian Federation</td>
<td>Opioid substitution therapy not used, not allowed by law</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tajikistan</td>
<td>No opioid substitution therapy currently, opioid substitution therapy planned for introduction in 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: IHRD; Harm Reduction Developments, 2008

In all the countries where opioid substitution therapy was introduced, program effectiveness evaluations were completed or are now underway. The most detailed study was in Lithuania and Ukraine under the WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV/AIDS [3]. The study proved the effectiveness of opioid substitution therapy programs in reducing the frequency of injecting drug use, reducing crime among drug users, reducing risky injecting behaviors, and improving overall health.

The primary achievements of opioid substitution therapy programs have been obtaining government funding (Lithuania and Georgia), an opioid substitution therapy program launch in a prison system (Kyrgyzstan), and interactions with AIDS treatment programs (antiretroviral therapy adherence support). There have been few reported incidents of methadone appearing on the black market.

The primary challenges encountered during the introduction and rollout of opioid substitution therapy involved complications in the paperwork required for methadone procurement and importation. Other problems encountered during opioid substitution therapy program implementation were poor levels of awareness among specialists and the general public at program start time, and negative reactions on the part of some law-enforcement authorities. There is a real shortage of Russian-language literature about opioid substitution therapy.

The primary responses required to improve the opioid substitution therapy situation are to relax the opioid substitution therapy eligibility requirements, improve physician education and public awareness about opioid substitution therapy, make opioid substitution therapy available to general practitioners, incorporate opioid substitution therapy into undergraduate and postgraduate medical curricula, and campaign to de-stigmatize drug dependent patients.
1. Belarus

The Opioid Substitution Therapy Situation

Efforts to introduce an opioid substitution therapy project in Belarus began in 2000, initiated by drug treatment facility staff members, the Belarus Psychiatric Association, and the local office of UNDP.

Methadone opioid substitution therapy began in September 2007 at the Gomel Regional Drug Dependency Treatment Clinic [4, 5]. Preparations for the project included furnishing facilities, training personnel, and purchasing urine drug screening equipment. Methadone substitution therapy guidelines were published for doctors and patients. Opioid substitution therapy candidates are selected as follows: 1) All applicant patients undergo a medical exam by the drug treatment clinic’s primary care doctors, and a clinic department chief decides whether to refer the patient to a medical consultation commission (“MCC”); 2) lab tests; 3) the MCC completes an examination and decides whether to commence methadone opioid substitution therapy. After full disclosure of all the necessary information, the patient grants informed consent to participate in the therapy, and a treatment contract is signed with the patient. Next, the patient is hospitalized by a doctor from the clinic. During inpatient treatment, withdrawal is brought under control and a maintenance dosage of methadone is determined. The patient is released from the hospital into outpatient care when the patient’s behavior normalizes, there are no symptoms of opioid withdrawal, and the patient feels better mentally and physically. Next, the patient switches to outpatient methadone treatment, under the supervision of a drug dependency treatment specialist. Methadone dosage ranges from 60mg-160mg, with 100mg being the average. The cost of 100mg of methadone is US$180.*

Fifty patients are currently receiving opioid substitution therapy, with 67 in total having taken part in the program. Treatment follow-up shows that one patient died of AIDS, two were imprisoned, and six refused opioid substitution therapy. Three patients were removed from opioid substitution therapy: one for grossly inappropriate behavior in the hospital ward, one for chronic drug and alcohol abuse, and one for attempting to remove methadone for resale. Of the 50 individuals receiving opioid substitution therapy, 15 are women. Twenty of the opioid substitution therapy patients are employed, with 14 of those having gained employment while in the opioid substitution therapy program. Twenty of the 50 patients are HIV positive, with six of those receiving ARV therapy. Five of the opioid substitution therapy patients are being treated for tuberculosis and one for hepatitis-C, with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Once in opioid substitution therapy, urine screening showed most of the patients had stopped taking “street” drugs (primarily injecting opioids and amphetamines) and other psychotropics (benzodiazepines). Some of the patients did still use drugs, but achieved a significant reduction in frequency of use – from daily to once weekly. Additionally, some patients occasionally used alcohol and over-the-counter barbiturates (Corvalol, Valocordin). Virtually all the patients report a more normal lifestyle (time for work, family and recreation) and improved quality of life.

Opioid Substitution Therapy Regulation

Two documents form the legal regulatory basis for substitution therapy in Belarus:


Republic of Belarus Ministry of Health Order No. 718 of 4 Sep. 2007, entitled “On Implementation of a Substitution Therapy Pilot Project at the Gomel Regional Drug Dependency Treatment Clinic for Drug-* Here and further in this report, the prices shown are the prices at which program organizers procure methadone or buprenorphine from the manufacturer.
Dependent Individuals as Part of the International Technical Assistance Program Known as ‘HIV/AIDS Prevention and Treatment in the Republic of Belarus’.

The following criteria were adopted for patients to qualify for the methadone opioid substitution therapy program: diagnosed opioid dependency; regular injected opioid use for more than two years; two or more unsuccessful attempts at abstinence-based treatment; patient over 18 years old; HIV positive or diagnosed with AIDS.

Country-Specific Issues

The primary problems encountered were caused by administrative difficulties in importing methadone, and apprehension on the part of local public health authorities and pharmaceutical companies. At the outset, the opioid substitution therapy program was subjected to increased scrutiny from the law enforcement authorities. Most press coverage of opioid substitution therapy was favorable. Public advocacy groups and private individuals (relatives of drug-dependent patients) called for expansion of the program to cover drug users without HIV. The primary difficulties during actual program implementation were the lack of a clear plan to evaluate effectiveness, and lack of psychiatric help and social services for the opioid substitution therapy program clients. Another problem is that several days’ doses of methadone cannot be dispensed for use at home.

Table 2. Opioid Substitution Therapy Patient Break-down Comparison between Belarus and Ukraine

<table>
<thead>
<tr>
<th></th>
<th>Belarus</th>
<th>Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Positive Patients</td>
<td>20 (40%)</td>
<td>1001 (51%)</td>
</tr>
<tr>
<td>HIV Positive Patients receiving ART</td>
<td>6 (12%)</td>
<td>239 (12%)</td>
</tr>
<tr>
<td>Patients being treated for TB</td>
<td>5 (10%)</td>
<td>280 (14%)</td>
</tr>
<tr>
<td>Patient Total</td>
<td>50</td>
<td>1956</td>
</tr>
</tbody>
</table>

2. Ukraine

The Opioid Substitution Therapy Situation

Buprenorphine substitution therapy was first introduced as a pilot project in 2004 in the city of Kherson, and later in Kiev. The project was originally funded by UNDP, but has been funded by the Global Fund since 2005 [6]. Buprenorphine opioid substitution therapy access expanded in 2007, when more treatment facilities were brought into the program. Methadone opioid substitution therapy began in Ukraine in June 2008. Currently, buprenorphine and methadone opioid substitution therapy are available at drug dependency treatment centers, AIDS treatment centers, and tuberculosis treatment clinics. The opioid substitution therapy preparations registered for use in Ukraine are methadone solution and tablets, and buprenorphine sublingual tablets 2mg, 4mg and 6mg. The monthly cost of buprenorphine treatment (based on a 14mg daily dose) is the equivalent of 100 US dollars, while methadone treatment (based on a 100mg daily dose) costs 8 dollars. Opioid substitution therapy is currently available at 38 facilities in 24 regions of Ukraine. Eight hundred forty-one patients are currently in buprenorphine opioid substitution therapy and 1115 are in methadone opioid substitution therapy, for a total of 1956 opioid substitution therapy patients [7, 8]. Of these, 1001 individuals are HIV-positive, 1036 are infected with hepatitis B or C, 280 have tuberculosis, and 239 are receiving ARV therapy. The average methadone dose is 65mg (range 15-270mg), and the average buprenorphine dose is 10mg (range 2-28mg). The average opioid substitution therapy patient age is 34.4 years, with an average drug use history of 13 years. Opioid substitution therapy is funded by the Global Fund and the Clinton Foundation, while the Ukraine Government pays the salaries of medical staff. There is no opioid substitution therapy program in the prison system.
Opioid Substitution Therapy Regulation

The Ukrainian Health Ministry enacted an order in April 2005 calling for implementation of a buprenorphine opioid substitution therapy pilot project. In December 2006 and summer 2007 the Health Ministry issued orders regulating the objectives, treatment locations and funding sources for buprenorphine and methadone opioid substitution therapy. The Ukrainian National Narcology Association issued treatment guidelines in the form of two protocols, one for buprenorphine opioid substitution therapy, and one for methadone opioid substitution therapy. These guidelines cover the roles of various professionals in opioid substitution therapy, health monitoring, dosages, and criteria for removal of patients from opioid substitution therapy programs. Parts of the documents are dedicated to the specific needs of HIV-positive patients, hepatitis-B and C patients, and pregnant patients. There is an opioid substitution therapy working group at the Health Ministry. Opioid-dependent patients must meet at least one of the following programs to be eligible for opioid substitution therapy programs: at least 3 years drug dependency, at least two unsuccessful treatment attempts during the last year, HIV positive, needs tuberculosis treatment, pregnant, hepatitis-B or C, septic illnesses, or cancer. Patients with other conditions may be admitted to opioid substitution therapy programs by decision of a multidisciplinary board.

Country-Specific Issues

Ukraine was a participant in the 2003-2006 WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV. This study showed a 65% retention rate in the opioid substitution therapy program, with improved health and quality of life. There have been problems with the introduction of opioid substitution therapy due to a prevailing conservative attitude among legislators. There is some opposition to opioid substitution therapy from psychiatry and narcology research institution staff members [9].

Chart 1. Proportion of patients being treated with buprenorphine versus methadone opioid substitution therapy in Ukraine and Lithuania

![Chart showing the proportion of patients receiving buprenorphine and methadone opioid substitution therapy in Ukraine and Lithuania.](chart1)

3. Lithuania

The Opioid Substitution Therapy Situation

Methadone substitution therapy was launched in three Lithuanian cities in 1995. 400 individuals are currently participating in methadone opioid substitution therapy [10, 11]. Less than 10% of opioid substitution therapy program patients are HIV-positive. Treatment is offered at four specialized drug dependency treatment centers and 10 primary care facilities. Buprenorphine substitution therapy has been
allowed since 2002, with 10 patients currently receiving buprenorphine opioid substitution therapy. Two 
drugs containing buprenorphine are currently in use, Subutex and Suboxon (a combination of buprenorphine 
and naloxon). 1000mg of methadone costs 10 Euros, whole 16mg of buprenorphine costs 15 Euros. Opioid 
substitution therapy is funded by the mandatory medical insurance system.

Opioid Substitution Therapy Regulation
The first regulatory mention of opioid substitution therapy was in a Lithuanian Health Ministry order from 
1997. The patient qualifying criteria for the opioid substitution therapy program were two years history of 
opioid use, and at least one attempt at treatment. Under a more recent (2007) Health Ministry order, the 
criteria were changed so that anyone with opioid dependence, regardless of duration, now qualifies. The 
decision to admit a patient to the opioid substitution therapy program is made by a panel of three 
psychiatrists. Minors 15 years of age and older may be treated with buprenorphine. In order for a minor to be 
admitted to the opioid substitution therapy program, the medical history must show attempts at abstinence-
based treatment.

Country-Specific Issues
The number of opioid substitution therapy patients was cut in 2005, because of a negative attitude toward 
opioid substitution therapy on the part of certain members of the Lithuanian parliament. Opioid substitution 
therapy was defended by the health ministry, the Lithuanian Psychiatric Association, the Government’s 
Department of Narcotics Control, and non-governmental organizations. Lithuania took part in the 2003-2006 
WHO Collaborative Study of Substitution Treatment of Opioid Dependence and HIV. The study showed 
opioid substitution therapy to be effective in reducing use of street opioids, improving health and quality of 
life, reducing crime and reducing high-risk injection behaviors. As new opioid substitution therapy programs 
are implemented in Lithuania, the number of primary care facilities offering opioid substitution therapy has 
grown, as has the total area of coverage. Patients are allowed to take up to six days’ doses of methadone for 
treatment at home. Buprenorphine and methadone are dispensed to patients only at treatment facilities, not at 
pharmacies. Because of high cost, there are fewer patients using buprenorphine. Buprenorphine is a first-line 
therapy for treatment of withdrawal in both inpatient and outpatient care.

4. Georgia

The Opioid substitution therapy Situation
Opioid substitution therapy began in December 2005 [12]. Currently there are 455 patients on opioid 
substitution therapy [13]. More centers where opioid substitution therapy is available are planned, as is an 
opioid substitution therapy program for the prison system. Methadone doses rage from 80-120mg daily. 
Water-soluble tablets are used. Opioid substitution therapy is available at three facilities in Tbilisi and 
Batumi. Opioid substitution therapy is funded by the Global Fund and government programs. Patients 
receiving government-subsidized treatment pay 100 USD per month. The Opioid substitution therapy 
Program, funded by the Global Fund is administered by the Institute of Narcology; while the government-
funded program is administered by the Department of Health. 1000 mg of methadone costs US $30.

Opioid Substitution Therapy Regulation
A memorandum was adopted in December 2005. Opioid substitution therapy patient eligibility requirements 
are: age over 21, at least one treatment attempt, total opioid use three years, at least one year intravenous. 
HIV-positive patients are treated free of charge and with top priority. The medical facility director appoints 
an opioid substitution therapy panel of three physicians and a psychotherapist, and a supervisory board 
including members of the public. Urine screening is done at least three times during the first month, and 
twice monthly thereafter. A patient continuing to use drugs during treatment may be excluded from the 
opioid substitution therapy program.
Country-Specific Issues

Both drug dependency treatment specialists and the general public are apprehensive about opioid substitution therapy because of a shortage of information. Experts note that there are more patients seeking opioid substitution therapy than there are places available in the opioid substitution therapy programs. One opioid-related problem specific to Georgia is the popularity of illegal buprenorphine. Another unique feature is that opioid substitution therapy is offered in a private medical center as well as in the state-run facilities.

5. Kyrgyzstan

The Opioid Substitution Therapy Situation

Methadone opioid substitution therapy was launched in Kyrgyzstan in April 2002 in the cities of Bishkek and Osh, at outpatient departments of drug dependency treatment clinics [14, 15]. The program is funded by the Global Fund. Seven hundred thirty-five patients are currently receiving opioid substitution therapy at seven centres [15]. Opioid substitution therapy was introduced to the prison system in 2008.

Opioid Substitution Therapy Regulation

Opioid substitution therapy availability was first regulated by a March 2001 Ministry of Health decree. Patient eligibility criteria are: two years’ opioid dependency, two or more unsuccessful attempts at abstinence-based treatment. Exceptions can be made if the patient is HIV positive, hepatitis B or C positive, pregnant, or gravely ill. A panel of physicians admits patients to the program. Methadone doses are dispensed for home use over weekends and holidays. There is a central register of patients receiving opioid substitution therapy.

Country-Specific Issues

There is a shortage of drug dependency treatment professionals. There were problems importing methadone when the opioid substitution therapy program was being set up. The general public and health care professionals have a favorable attitude toward opioid substitution therapy. Among the problems encountered there have been instances of negative press coverage of opioid substitution therapy. Since 2002, when opioid substitution therapy was available at only two treatment facilities, there has been an increase in both the number of patients receiving opioid substitution therapy, and the number of centers offering opioid substitution therapy. Opioid substitution therapy is available at primary care facilities, where there are special opioid substitution therapy units. NGOs have played a valuable role in supporting opioid substitution therapy patients, especially by providing legal aid [16]. Kyrgyzstan is the only FSU country where opioid substitution therapy operates in the prison system. The UN and the Global Fund have been instrumental in gradually forming public opinion about opioid substitution therapy, and changing the attitudes of health and law-enforcement authorities toward opioid substitution therapy.

6. Kazakhstan

Drug use

According to the Republic Scientific Practice Center for Medical-Social Drug Addiction Problems, approximately 100,000 injection drug users (IDUs) live in Kazakhstan. The most popular injected drug is heroin, at 70% of users, followed by opium extract at 23.1%. Opioid users represent 94.4% of all IDUs. The average user begins injecting at 21.2 years of age (National Study to Evaluate Incidence of Problematic Drug Addiction in the Republic of Kazakhstan, 2007). Twenty-one percent of IDUs use non-sterile needles with varying frequency, and 20.6% of IDUs pass their needles on to other IDUs after use. Among registered HIV positives nationwide, 77% are IDUs [16, 17].
**Opioid Substitution Therapy**

There is no opioid substitution therapy in Kazakhstan at this time. There are two Ministry of Health orders, issued in 2002 and 2007, which refer to the introduction of opioid substitution therapy as a necessity. Opioid substitution therapy programs are slated to be launched in late 2008 in the cities of Pavlodar and Karaganda. Guidelines for methadone opioid substitution therapy have been published by the Republic Scientific Practice Center for Medical-Social Drug Addiction Problems [18] and approved by the Ministry of Health. According to those guidelines, the eligibility criteria for opioid substitution therapy program participation are: patient age at least 18, at least three years’ injecting drug use, and at least two unsuccessful inpatient detoxification attempts at a drug dependency treatment clinic (the last criterion is not required for people living with HIV/AIDS). People living with HIV/AIDS will be given priority for opioid substitution therapy program admission.

**Country-Specific Issues**

For a long time the Interior Ministry denied permission to import methadone. Regional health departments are afraid of how the public will react to the introduction of opioid substitution therapy programs. A negative attitude toward opioid substitution therapy is prevalent among the general public, but there have been more favorable attitudes among members of the Anti-Narcobusiness Committee and HIV/AIDS professionals [19]. Approximately 30% of drug dependency treatment specialists are in favor of opioid substitution therapy. A Health Ministry order concerning the introduction of opioid substitution therapy was issued in 2002, but there is no opioid substitution therapy to date. Governmental policy priorities call for promoting abstinence-based drug dependency rehabilitation.

7. **Russian Federation**

According to data from the Russian National Narcology Center, there are 387,197 registered IDUs in the country. Various experts estimate the number of drug users in Russia at between 1.5 million and 5.1 million. In 2007 alone, 42,770 new cases of HIV were registered. 83.5% of all HIV cases and more than 65% of all new cases in Russia are attributed to injection drug use. The abstinence-based treatment paradigm prevails among drug dependency treatment facilities, meaning that they focus on complete abstinence from drug use as the primary criterion for successful treatment. At the same time, there is a shortage of spaces in rehabilitation centers, with only 1100 spaces available in facilities offering rehabilitation free of charge. The existing forms and methods of drug dependency treatment are regulated at the federal level by two documents, where the opioid substitution therapy method is never mentioned:


These treatment protocols contradict the principles of evidence-based medicine, and many of the treatment method recommendations are not based on any scientific research.

Harm reduction programs have been underway in the Russian Federation since the mid-1990s, but with no uniform national-level official policy, the harm reduction programs are regulated at the regional level. The Law on Narcotics and Psychotropic Substances of 8 January 1998 prohibits substitution therapy for treatment of drug dependency. Methadone appears as a Schedule I drug on the List of Narcotics, Psychotropic Substances and their Precursors Subject to Control in the Russian Federation. Schedule I lists the substances that are entirely banned from circulation in Russia. Buprenorphine is a Schedule II substance (“Narcotics and psychotropic substances with restricted circulation in Russia and for which control measures are being established”). However, Buprenorphine cannot be used in opioid substitution therapy, because the
Law on Narcotics and Psychotropic Substances prohibits treating drug addiction with Schedule II narcotics or psychotropic substances. There have been attempts to use opioid receptor agonists-antagonists such as Nalbuphine for opioid substitution therapy, which would not be in violation of the applicable laws.

Drug dependency treatment specialists, patients and the public alike are ill-informed about the objectives of opioid substitution therapy and the opioid substitution therapy situation in other countries. Narcology literature publishes primarily the viewpoint of opioid substitution therapy opponents. The arguments against introducing opioid substitution therapy in Russia are primarily non-medical in nature. Opioid substitution therapy opponents often contend that methadone could appear on the black market and cause a tide of drug addiction. In Russia, opioid substitution therapy is derided by religious organizations, doctors, medical researchers, and sometimes even by public service organizations. According to V. D. Medelevich and N. A. Dolzhanskaya, 25-40% of drug dependency treatment specialists expressed a negative opinion of opioid substitution therapy, and up to 45% were in favor of introducing opioid substitution therapy. V. D. Medelevich examined the arguments of opioid substitution therapy opponents in Russia. In 2004, the primary reasons cited were “spread of narcotics onto the black market” – 23.7% (21.8% in 2006). Another reason given was that the respondents believed it highly likely that use of substitution therapy “would encourage those who never tried drugs to use them” – 19.1% (28.7% in 2006).

A conference held in Moscow in February 2008, attended by practicing drug dependency treatment specialists, university-level psychiatry and narcology educators and members of public service organizations showed that there is some dissatisfaction with the current level of scientific research, and current drug dependency treatment methods. Many methods such as antipsychotic drugs, hypnosis and neurosurgery do not meet the standards of evidence-based medicine.

Researchers have identified six primary obstacles to the introduction of opioid substitution therapy [24, 25]: funding shortfalls, shortage of available Russian-language information about the effectiveness of opioid substitution therapy, the perception of opioid substitution therapy as a culturally unacceptable form of aid, drug dependent patients’ fear of seeking medical help; and opposition from legislators and the Russian Orthodox Church.

To change the false stereotypes associated with opioid substitution therapy, strong efforts will be needed to educate practicing physicians, public health administrators and the general public about the effectiveness of opioid substitution therapy. There is a real shortage of Russian-language literature on the topic.

8. Tajikistan

Drug use
Traditionally, the most popular drugs of choice in this country were hashish and opium. Its geographic position and unstable socioeconomic status have made Tajikistan a lucrative pipeline for drug trafficking to other countries. With all the transit traffic, drugs are cheap and widely available in the country. 1997 saw the first recorded cases of heroin addiction. In 2001, there were estimated 45,000-55,000 drug users in the country. As of 1 June 2008, there were some 8,732 registered people who are dependent on drugs, of whom 89.7% were opioid dependent. IDUs represent the majority of people living with HIV (621 individuals as of end 2007, or 59.2% of the total). In cities where sentinel surveillance was implemented, the HIV infection rate among IDUs was 23.5%.

The Opioid Substitution Therapy Situation
There is no opioid substitution therapy in Tajikistan at this time. Opioid substitution therapy advocacy efforts have been ongoing for the last 10 years. A government decision has been made to initiate opioid substitution therapy in two cities, one Dushanbe and the other either Khorugh or Khujand. Plans are for 400 patients to be admitted to opioid substitution therapy by the end of 2009, with program funding to come from the Global Fund. Until recently opioid substitution therapy was opposed by the health ministry, primarily because of the adversarial stance taken by senior officials in the Russian narcology services [26, 27].
Country-Specific Issues
Drug dependency treatment is available to drug users only at special drug dependency treatment centers. The treatment focuses on complete abstinence, with drug-assisted detoxification, acupuncture and psychological support. There is a serious shortage of qualified drug treatment specialists.

9. Uzbekistan

The Opioid Substitution Therapy Situation
In 2001, Uzbekistan’s Supreme Council passed recommendations paving the way for a pilot project. In 2003 the State Commission for Narcotics Control adopted a resolution to initiate a pilot project in Tashkent. Buprenorphine opioid substitution therapy was launched in February 2006 at the Tashkent City Drug Dependency Treatment Clinic, with methadone opioid substitution therapy following in October 2006. Currently, 80 patients are receiving buprenorphine opioid substitution therapy, and 60 are receiving methadone [28]. 60% of program participants are HIV positive, with 25% receiving antiretroviral therapy. Initially, the program was open only to HIV positive patients. Program funding comes from the Global Fund. 100 mg of methadone costs US$1.10, while 12mg of buprenorphine costs US$6.00. Buprenorphine has been officially registered for use in the country, while methadone is imported under single permits.

Opioid Substitution Therapy Regulation
In 2005 a health ministry order implemented interim guidelines for opioid substitution therapy. The eligibility criteria for opioid substitution therapy include two years’ opioid dependency, pregnancy, HIV infection, history of failed treatment attempts, age over 18 years. Relatives are allowed to pick up two days’ dose for patients hospitalized at inpatient facilities elsewhere (12 patients receive their treatment this way, most of them tuberculosis patients).

Country-Specific Issues
The primary problems are the distance patients must travel from their residence to the drug dependency treatment clinic, and the lack of any system for expanding opioid substitution therapy to other treatment facilities. Patients have attempted to steal and later inject buprenorphine tablets, which required more vigilant patient supervision. The Tashkent City Drug Dependency Treatment Clinic is the only place where opioid substitution therapy is offered in Uzbekistan.

Table  3. Country Specific Opioid substitution therapy patient eligibility requirements**

<table>
<thead>
<tr>
<th>Country</th>
<th>Patient Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belarus</td>
<td>-at least 18 years of age&lt;br&gt;-diagnosed opioid dependency&lt;br&gt;-regular injected opioid use for more than two years&lt;br&gt;-two or more unsuccessful attempts at abstinence-based treatment&lt;br&gt;-HIV positive or diagnosed with AIDS</td>
</tr>
<tr>
<td>Ukraine</td>
<td>must meet at least one of the following criteria: -drug use for at least three years&lt;br&gt;-at least two unsuccessful treatment attempts during the last year&lt;br&gt;-HIV positive, needs tuberculosis treatment, hepatitis-B or C positive, septic illnesses, cancer, or pregnant&lt;br&gt;-with approval from a multidisciplinary board</td>
</tr>
<tr>
<td>Lithuania</td>
<td>-anyone with opioid dependence, regardless of duration qualifies&lt;br&gt;-minors 15 years of age and older may be treated with buprenorphine. To be admitted, a minor’s medical history must show attempts at abstinence-based treatment. &lt;br&gt;-the decision to admit is made by a panel of three psychiatrists.</td>
</tr>
<tr>
<td>Country</td>
<td>Patient Criteria</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Georgia        | - at least 21 years of age  
                 | - total opioid use for three years with at least one year injected drug use  
                 | - at least one attempt at treatment  
                 | - people living with HIV/AIDS are given priority |
| Kyrgyzstan     | - opioid use for at least two years  
                 | - two or more unsuccessful attempts at abstinence-based treatment  
                 | - HIV positive, hepatitis B or C positive, gravely ill, or pregnant |
| Kazakhstan     | no opioid substitution at this time  
                 | eligibility criteria is for 2009  
                 | - at least 18 years of age  
                 | - injection drug use for at least three years  
                 | - at least two unsuccessful attempts at abstinence-based treatment (not required for people living with HIV/AIDS)  
                 | - people living with HIV/AIDS will be given priority |
| Russian Federation | opioid substitution not allowed by law                                                                                       |
| Tajikistan     | no opioid substitution therapy at this time                                                                                          |
| Uzbekistan     | - at least 18 years of age  
                 | - two years’ opioid dependency  
                 | - pregnancy  
                 | - HIV infection  
                 | - history of failed treatment attempts  
                 | - relatives allowed to pick up two days’ dose for patients hospitalized at inpatient facilities elsewhere (for example tuberculosis patients) |

**Eligibility requirements are based on: age, injecting drug use/duration, previous attempt at abstinence, HIV status, other infectious disease/illness, pregnancy, and approval mechanism**

**Conclusion**

Opioid substitution therapy has been introduced in the majority of the former Soviet Union (FSU) countries. Opioid substitution therapy was first introduced through pilot projects. Based on their evaluated effectiveness, decisions were made to expand opioid substitution therapy programs. There is a low opioid substitution therapy patient coverage level compared to Western European countries. In six of the FSU countries (Belarus, Lithuania, Kyrgyzstan, Georgia, Uzbekistan and Ukraine) 3,746 patients are currently receiving opioid substitution therapy. Lithuania is the only country with coverage level close to 5% of the estimated number of IDUs, with the other countries achieving even lower levels. Opioid substitution therapy programs will need to be expanded significantly for effective HIV prevention, which will entail recruiting more patients into national programs, establishing more medical care facilities offering opioid substitution therapy, and relaxing eligibility requirements for opioid substitution therapy.

Opioid substitution therapy regulation in all the countries is accomplished by health ministry directives. In Belarus and Ukraine, there is additional regulation at the level of the regional (oblast) public health departments. Admission to and exclusion from opioid substitution therapy programs requires sign off from a panel of physicians (usually at least three). The admission process also involves signing treatment contracts between the patient and the care facility, which includes agreement for periodic testing to exclude concurrent drug use.

While progress has been made in establishing opioid substitution therapy programmes in six of the countries surveyed (Belarus, Ukraine, Lithuania, Kyrgyzstan, Georgia and Uzbekistan), Kazakhstan and Tajikistan have yet to enroll patients into pilot programmes, and the treatment remains illegal in the Russian Federation. This report clearly shows that treatment with opioid substitution therapy in EECA region is not keeping pace with the scale of the IDU epidemic. The data gathered shows that less than 2% of IDUs have access to this.
life-saving treatment, in a region where there is still a fast growing HIV epidemic driven by injection drug use. The IAS commissioned mapping of the status and availability of opioid substitution therapy in order to bring together information that is not readily available and not adequately disseminated to catalyze necessary action. There is an urgent need to develop surveillance and monitoring of injecting drug use in the EECA region; to raise visibility of the status and availability of evidence-based treatment of injecting drug users including opioid substitution therapy; disseminate information more widely to policy makers, medical community, civil society and the public; and to mobilize the scientific community and other key actors in the development of responsive advocacy, policy and programmes for injecting drug users. The mapping exercise also established that opioid substitution therapy programmes are stuck in pilot phase with numbers of patients enrolled remaining fairly stable over the years. This finding calls attention to the need for operations research on the mechanisms for scaling up pilot programmes, development of strategies to overcome identified barriers, and strengthening capacity to meet the challenges faced in expanding access to opioid substitution therapy for injecting drug users in Eastern Europe and Central Asia.

References


8) Ukraine Institute on Public Health Policy resource center: http://www.uiphp.org.ua/resourcenter.htm


13) Sikharulidze Z., Director, Uranti Drug Dependency Treatment Center, Tbilisi. Personal communication, November 2008.


20) Federal AIDS Center http://www.hivrussia.ru/

21) Kirzhanova V. V. “IDU population estimated by single-pass nomination method.” Presentation at joint meeting to assess the progress towards universal access to HIV prevention, treatment, care and support in the Russian Federation, held in Moscow 13-14 May 2008.


