8. Opioid Agonist Maintenance Treatment in Central Asia

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Introduction

Opioid agonist maintenance treatment (OAMT) – also known as opioid substitution treatment (OST) or methadone maintenance treatment (MMT) – is an evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates such as buprenorphine or methadone. The term 'substitution' is no longer used, in order to clarify that the term refers to treatment of opioid use disorders, not a substitution of one opioid with another (Wiessing et al. 2023).

This chapter provides an overview of the introduction of OAMT in Central Asia. The chapter discusses the developments in Kazakhstan, Kyrgyzstan, and Tajikistan. Uzbekistan and Turkmenistan do not allow OAMT and are therefore not included in this chapter.

Opioid Agonist Maintenance Treatment in Kazakhstan

The first OAMT pilot project was introduced in Kazakhstan in 2005. The first clients included 50 drug users living with HIV. Three years later, in 2008, the OAMT pilot project was expanded to three cities. 14 years later, in 2019, the OAMT programme still had the status of a pilot project. Kazakhstan had relied on financial support from the Global Fund for a large proportion of its harm reduction funding. When the country gained upper middle-income status, this (combined with its low overall HIV prevalence) led to the country's ineligibility for Global Fund grants in the 2014–2016 allocation period.

Although the national government provided support to needle and syringe programmes (NSPs),[1] only 4.7% of the country's total HIV budget went towards prevention activities and only 2.7% towards targeting people who inject drugs. In 2018, the government of Kazakhstan threatened to close the country's OAMT programmes, highlighting the political vulnerability of the service. The prompt civil society advocacy response appears to have paused this decision (Eurasian Harm Reduction Association [EHRA] 2019).

Table 1: Main indicators of the OAMT programme in Kazakhstan (EHRA 2019)

Population	18,611,100
PWID	120,500
OST	Available at ten operational sites in three cities. Reduced Global Fund funding and limited political support has recently seen OAMT restricted to pilot programmes at all sites, with less than 1% of people who use drugs accessing the programme.
NSP	Available at 144 operational sites. Civil society reports poor-quality syringes distributed by government-funded programmes, leading to the potential for increased unsafe injecting.
HIV	Prevalence among PWID (people who inject drugs) – 8.5%.
Hepatitis C	Prevalence among PWID – 58.8%.
Hepatitis B	Prevalence among PWID – 7.9%.
Tuberculosis	—
Overdose prevention	Naloxone is not accessible in Kazakhstan's pharmacies at all, or without prescription, but ambulances/hospitals have it; harm reduction projects also have Naloxone.

1 OAMT and NSP both belong to harm reduction programmes that are considered to have a potential to reduce HIV incidence among people who inject drugs and can be implemented in low- and middle-income countries (Saing 2023).

Harm reduction in closed settings	– Antiretroviral treatment (ART) is available in prisons – OAMT is not available in prisons – NSPs are not available in prisons
Criminalisation costs	– Money spent on a prisoner/per year – €1,554.90 – Money spent on harm reduction and social services – €1,382 – Average sentence for drug law offence – up to seven years
Drug laws	– Consumption in public places is a criminal offence, punishable with a fine of up to 100 monthly fine units (€0–600) or correctional work for the same amount, or community service of up to 120 hours, or arrest up to 45 days – Available alternatives: those who voluntarily refer themselves to healthcare institutions for treatment without a doctor's prescription are exempted from criminal liabilities

According to official statistics, in 1986, three to four regions in Kazakhstan, with a total of 10,000 officially registered drug users, were affected by drug addiction. In 2004, there were ten to twelve regions with about 50,000 drug users (Kazakhstan Institute for Strategic Studies under the President of the Republic of Kazakhstan 2004).

The first wave of HIV-infections among PWID was registered in the early 1990s in the city of Temirtau, Karaganda region, and by the beginning of the 21st century, the second wave had begun among PWID in the Almaty, Karaganda, and Pavlodar regions (Myrzagulova et al. 2020). In 2019, according to the Aman-Saulyk Public Foundation and the Kazakhstan Union of People Living with HIV, there were an estimated 94,600 PWID in Kazakhstan and the HIV prevalence among PWID was 7.9%. The estimated number of PWID living with HIV was 7,000 (Country Coordination Committee 2023).[2]

2 The Country Coordinating Mechanisms (CCM) are national committees that submit funding applications to the Global Fund and oversee the implementation of the grants on behalf of their countries. They are a key element in the partnership between the Global Fund and countries. The latest developments on strengthening Country Coordinating Mechanisms' contribution to health governance are in evolution phase. A CCM includes representatives of all sectors involved in the response to the HIV/

Thus, over the past 20 years, the number of people using narcotic drugs and psychotropic substances has increased almost ten times. However, the technologies for social work with PWID are not fully accepted at the state level. For example, as of 14th June 2019, less than 1% of the estimated 263 PWID were covered by the OAMT programme, of which 85 were people living with HIV and 78 of whom were receiving antiretroviral therapy. The coverage of PWID by the OAMT programme does not exceed 2%; this picture has not changed since 2008 and it does not have a significant impact on the HIV epidemiological situation in the country. As world experience shows, OAMT coverage should be at least 40% of the estimated number of opioid-dependent people in order for preventive harm reduction measures to be effective (United Nations Office on Drugs and Crime [UNODC] 2009).

The reasons for the low number of patients (2%) in OAMT in Kazakhstan can be summarised as follows. Firstly, the programme is still running in pilot mode. Furthermore, the programme has very strict requirements for enrolment. Unlike the OAMT programme in Kyrgyzstan, take-home methadone is not provided, which means that patients need to come to the site every day. However, the OAMT sites are situated very remotely, making it difficult for patients to reach them. Sometimes, shortages in the supply of methadone also occur.

In 2022, the socio-demographic characteristics of OAMT clients in Kazakhstan were as follows. 82% of clients were male and 18% were female. The average age was 44.15 years. 18.4% of clients were officially employed, while 51,08% were not working. 0.3% were convicted and 0.15% were remanded and arrested. 3.7% of clients were disabled.

State support for non-governmental organisations (NGOs) is growing every year, in the form of grants and bonuses for the introduction of new forms of work in various areas of the social sphere. This includes funding for the implementation of social projects (Kuzekbay 2021). In Kazakhstan, the development of the social protection system is focused on income protection, the stimulation of the individual's social activities, and the provision of integrated social services for vulnerable population groups. But PWID are not officially a socially vulnerable population group; they

AIDS, TB and Malaria: academic institutions, civil society, faith-based organisations, government, multilateral and bilateral agencies, non-governmental organisations, key populations, community organisations, the private sector, and technical agencies.

mainly receive social assistance and services at the onset of disability and at retirement age.

It should be emphasised that not all specialists providing social services are professional social workers; only 5.8% are qualified specialists, while 30.4% have no diploma in social work. In 2021, the average monthly salary for social workers was 150,000 Kazakh tenge, equivalent to USD 350 (Abisheva 2020). Social workers play a significant role in the primary prevention of drug addiction, in the adaptation and rehabilitation of drug users, and in helping drug users in general.

One of the main barriers to the development of affordable and high-quality social services for people living with HIV and who use drugs in Kazakhstan is the low status of the social work profession. One of the methods of attracting qualified professionals and young people to the field of social work is to raise its status in the public consciousness. Social work with PWID in Kazakhstan is at a formative stage, but development in this direction is slow. Social work with this population group is carried out mainly by local NGOs, which are financed by international donors.

Thus, the following issues need to be addressed to improve drug treatment in Kazakhstan. The low degree of primary computability of drug dependence needs to be addressed. The quality of inpatient care which is currently very low needs to be improved. New social work approaches need to be introduced. The experience of NGOs in drug treatment needs to be strengthened. The forms of interaction between the state and NGOs need to be defined and agreed upon.

In the vast majority of cases, addiction treatment focuses on complete cessation of drug use. In the process of treatment, the main emphasis is on detoxification, with the extensive use of various potent drugs that alter the consciousness of patients and, according to doctors, thus help them to endure severe withdrawal symptoms. Post-detoxification psychosocial care and rehabilitation almost only exist on paper, but are not implemented in practice. Compulsory treatment of drug (and alcohol) dependence, which is ordered by a court order and falls under the direct control of law enforcement agencies, is a common practice. There is no treatment for drug addiction in prisons (Latypov et al. 2010).

In Kazakhstan, drug treatment services apply a medical approach to addiction. Most staff members have a medical degree and focus on treatment services. Psychosocial support is not provided to the same degree, as most programmes lack staff members with social work training. The introduction of OAMT in Kazakhstan was expected in 2002, in accordance with

the Order of the Ministry of Health of the Republic of Kazakhstan dated 21st August 2002 No. 791, 'On the introduction of substitution therapy', but was not launched due to the fact that for a long time, the Ministry of Internal Affairs of the Republic of Kazakhstan did not give permission for the import of the necessary drug. In comparison, substitution therapy was launched in Kyrgyzstan in 2002 and in Uzbekistan in 2006, financed by international donors (Aizberg 2008).

The first experience of medium-term planning to expand the availability of opioid substitution therapy in the Republic of Kazakhstan within the framework of the National Programme to Combat the HIV/AIDS Epidemic was implemented under the project 'Effective Prevention and Treatment of HIV Infection among Vulnerable Groups of the Population of Central Asia and Azerbaijan (2006–2010)'. The studies showed that the main task was to revise and improve the regulatory framework related to the implementation of OAMT programmes, as well as to finalise and approve the interdepartmental plan to expand the availability of OAMT for 2010–2014 (UNODC 2010).

Between 2006 and 2013, Kazakhstan established a system of services for PWID in all regions as part of the implementation of the national harm reduction strategy, based on the work of state agencies (AIDS centres) and NGOs. The components of harm reduction programmes in Kazakhstan are in line with the recommendations of UN agencies and include nine main components. In accordance with international recommendations and guidelines, the National Policy on HIV Prevention in Kazakhstan is aimed at providing the following services for PWID on the basis of trust points and harm reduction projects in Kazakhstan: needle and syringe exchange programmes, HIV testing and counselling, prevention and treatment of sexually transmitted infections, programmes to provide condoms to PWID and their sexual partners, targeted information, education, and communication (IEC) programmes for PWID and their sexual partners, antiretroviral therapy, vaccination, diagnosis, and treatment of viral hepatitis, prevention, diagnosis, and treatment of tuberculosis, and OAMT and other drug dependence treatments.

In some regions of the country, NGOs provide additional services in the form of social support for clients of harm reduction programmes, which entail greater commitment to the programme on the part of participants and positive results (Rozental et al. 2015). The use of OAMT in places of detention, general hospitals, or other institutions is not allowed in Kazakh-

stan, and all OAMT centres are located at regional and city narcological dispensaries (Latypov et al. 2010).

A large number of publications confirm that the use of methadone substitution therapy is associated with an increase in patient adherence to treatment, a decrease in their use of street opioids, a decrease in cravings for the use of psychoactive substances, and an improvement in their social functioning. There is also a well-documented reduction in the incidence of other drug use among patients receiving methadone substitution therapy (Pikirenia/Kopytov 2018).

There are fears in society that OAMT will lead to an increase in crime and drug use. OAMT does not eliminate addiction, but rather makes the use of the opioids less dangerous for drug users. It is known from clinical studies that the retention rate of patients in substitution therapy programmes is higher than in treatment programmes that focus on total abstinence. A disadvantage of substitution therapy programmes is the possible 'leakage' of methadone to the black market. This happens when patients are given large amounts of methadone to take at home and sell it to other drug users. The appearance of methadone on the black market indirectly indicates that there is a population of patients who need substitution therapy but for some reason are not receiving it.

From a clinical point of view, the biggest medical risk for a patient undergoing OAMT is the concomitant use of psychoactive substances (Ivanets/Altshuler 2014). A review of the literature on drug addiction and drug treatment showed that the main information on OAMT issues is provided by international organisations such as the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

An analysis of methadone and buprenorphine use, as well as the coverage of pharmacological maintenance treatment for opioid dependence, indicates that this treatment is either non-existent or insufficiently available in all countries with large numbers of injecting drug users. This may be due to a lack of recognition of the efficacy of such treatments, resistance due to cultural prejudices or economic or structural problems, and/or inaction by political leadership (International Narcotics Control Board [INCB] 2020).

In many parts of the world, HIV prevention is weak or non-existent, treatment is inadequate, and there are no adequate mechanisms to combat stigma and facilitate reintegration into society. In addition, stigma is exacerbated by the disproportionate and often unjustified application of criminal

measures against drug users, which is inconsistent with the principle of proportionality.

The WHO database contains information on the following indicators: access to HIV and hepatitis C counselling and treatment in institutions and services; standards of treatment and care in specialised public medical institutions; treatment programmes for women with drug use disorders; special housing services for people with drug use disorders; and employment services for people with drug use disorders (World Health Organization [WHO] 2020). However, when it comes to analysing the current situation, this data is insufficient, as some of the information is outdated. Nevertheless, these indicators can be used to study the current situation and compare it to that of previous years.

Opioid Agonist Maintenance Treatment in Kyrgyzstan

Since 2001, the number of new HIV infections has been increasing in Kyrgyzstan. During this time period, persons who inject drugs accounted for 67% of the total number of detected cases. In response to HIV/AIDS, Kyrgyzstan introduced the OAMT programme for opioid-dependent[3] persons. Since 2002, the programme has been implemented and is part of the comprehensive treatment methods for opioid users in the country.

There are two pharmacological approaches to the treatment of opioid dependence – those based on opioid withdrawal and those based on agonist maintenance therapy. In Kyrgyzstan, pharmacological treatment of opioid withdrawal is provided either through gradual discontinuation of opioid agonists (WHO 2009, p. 5ff.) (methadone is used in the country) or the use of alpha-2-adrenergic agonists to alleviate withdrawal symptoms (clonidine).

There have been a number of positive results and achievements during the time that methadone substitution treatment has been being implemented. One of them is the creation of a legislative basis for the implementation of the programme. Thus, the harm reduction strategy, which includes the implementation of the substitution therapy programme, has been reflected

3 The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) is a version of the ICD classifier developed in 1989 and adopted by WHO in 1990 (Wikipedia 2023).

in the Anti-Drug Programme (Kyrgyz Republic Ministry of Justice 2022)[4] of the Kyrgyz Republic since 2001 (Kyrgyz Republic Ministry of Justice 2001).[5]

Since the Kyrgyz Republic includes methadone[6] in List 1 of narcotic substances subject to national control, it is not prohibited for use for medical purposes, and it is included in the list of the country's essential medicines, the following clinical guidelines and protocols have been developed, which define the procedure for providing therapy: the Clinical Protocol on Methadone Substitution Maintenance Therapy, approved by the joint order of the Ministry of Health (MoH) and the Ministry of Justice of the Kyrgyz Republic No. 147 of 8th April 2008 and No. 66, Clinical Guidelines for the Provision of Methadone Substitution Maintenance Therapy to Opioid-Dependent Persons, approved by the order of the MoH of the Kyrgyz Republic No. 497 of 11th October 2010; the Clinical Guidelines on Diagnosis and Treatment of Mental and Behavioural Disorders Caused by Opioid Use, approved by the order of the MoH, No. 703 dated 25th December 2012; and the Clinical Protocol 'Treatment of Opioid Dependence Based on Methadone Maintenance Therapy', approved by the order of the MoH, No. 372 dated 30th June 2015.

Recently, a new manual and protocol have been developed, which include additions in accordance with new scientifically proven recommendations and data, as well as changes to the order and procedures of providing maintenance therapy. Thus, the guidelines include algorithms for the management of patients using buprenorphine, which is planned to be introduced in the country in the near future, as well as details of ethical standards for treatment. In the Clinical Guidelines, the name of the programme 'Methadone Substitution Maintenance Treatment' (OST/MMT) has been changed to 'Maintenance Therapy with Opioid Agonist' (MTOA), as the use of prescribed methadone and buprenorphine drugs and therapy is understood as a treatment of drug dependency rather than a replacement of illegal opioids, as they are the central element of therapy integrating medical, psychological, and social aspects.

4 Resolution of the Government of the Kyrgyz Republic from 10th August 2022, No. 445.

5 Resolution of the Government of the Kyrgyz Republic from 13th December 2001, No. 785.

6 Methadone hydrochloride has been registered and included in the list of essential medicines of the Kyrgyz Republic in 2006.

In accordance with the Law of the Kyrgyz Republic 'On the rules of storage, accounting and reporting of narcotic drugs' (Kyrgyz Republic Ministry of Justice 2011),[7] all methadone points/sites in the Kyrgyz Republic are included in the Register of 'subjects of legal provision of narcotic substances', which is subject to state regulation and control. Thus, the existing legal framework provides an opportunity for the implementation of harm reduction programmes for substance use and is the basis for the functioning of treatment programmes such as detoxification, maintenance therapy, needle exchange programmes, and overdose prevention.

One of the positive achievements of the implementation of the substitution therapy programme is the process of decentralisation and geographical expansion. Thus, since 2005, 34 substitution therapy dispensing points have been opened in Family Medicine Centres (FMC) at the level of primary healthcare, in Bishkek and Osh, as well as in other regions[8] of the Republic. In addition, eleven substitution therapy sites were opened within the penitentiary system.

Another positive aspect was the application of the 'One Window' principle, meaning that, at the substitution therapy sites, located at TB and HIV/AIDS treatment facilities, the patient was provided with comprehensive services for the coordinated provision of treatment of the underlying disease of opioid dependence, care and treatment of HIV infection,[9] and TB therapy.[10]According to an evaluation of the OAMT programme by Subata et al. (2011), medical staff dispensed methadone to patients at home for two or more days, in isolated cases and on an individual basis. Currently, following the Covid-19 pandemic, the practice of providing methadone to a patient's home for five days is allowed.

It is necessary to mention separately the implementation of the OAMT programme in 2008 in the Ministry of Justice in Colony No. 47. The implementation and expansion of the programme into the penitentiary system led to a reduction in drug use in prisons, reduced the risk of HIV

7 Resolution of the Government of the Kyrgyz Republic of 18th February 2011, No. 54.

8 In different cities in Kyrgyzstan, so-called 'Family Medicine Centers' (FMCs) were opened.

9 In the city of Bishkek, the OAMT site is based at the Bishkek City Center for AIDS Prevention and Control. In the city of Osh, the OAMT site is based at Osh Territorial Clinical Hospital.

10 The OAMT is based at the City TB Hospital in Bishkek and at the TB facility at the Penal Colony No. 31.

transmission through injecting practices, and improved the quality of life of prisoners (Subata et al. 2011).

It is also positive that the hospitalisation of opioid-dependent persons in other medical institutions is well organised, in case of somatic health problems (surgery, urology, gynaecology, etc.). The process works as follows. An application is submitted to the Republican Center for Psychiatry and Narcology for the admission of a patient from the substitution therapy programme to a treatment facility, as the patients themselves are trained to provide information about their participation in the programme. The administration of the treatment facility then contacts the coordinator of the substitution treatment programme by telephone. The drug itself is kept in a safe by the head nurse of the department when it is delivered to the treatment facility.

In order to improve monitoring and the quality of record keeping, an electronic register[11] has been set up. Through the register, programme monitoring and evaluation procedures have been improved. Procedures for collecting and analysing data related to both direct service delivery and the impact of the substitution programme on patients have been streamlined. The online entry of primary documentation has been improved, and paperwork for programme staff has been reduced. In addition to storing and processing information on patients[12] enrolled in the programmes, information on patients' health status (such as comorbidities, including HIV, TB, HBV, and HCV) is shared on a tiered basis. According to epidemiological data, the increase in the number of new HIV infections decreased with the introduction of harm reduction programmes in Kyrgyzstan (Asanov 2005).

In Kyrgyzstan, OAMT is provided free of charge to the patients. Since 2002, the work of all existing substitution therapy sites has been fully funded by the Global Fund HIV project, without drawing on resources from national or local healthcare budgets. Thus, a positive moment in the implementation of the substitution therapy programme was the fact that from 2023, funding was switched from international donor organisations to the state, through the Mandatory Health Insurance Fund, according to

11 With technical support of ICAP "Assistance" project, all OAMT sites are equipped with an Electronic Registry of Substitution Maintenance Therapy (ERST).

12 Monitoring includes the effectiveness of therapy, including the monitoring of methadone prescriptions and of changing dosages, the monitoring of illegal substance use, drug omissions, monitoring of timely receipt of antiretroviral and TB treatment, screening and testing, information on changes regarding socio-demographic indicators and patient behaviour.

the order[13] 'On norms for the formation of the budget of health care organizations working in the Single Payer System for 2023' (Compulsory Health Insurance Fund at the Ministry of Health Kyrgyz Republic 2023). This order approved funds for the 'purchase of drugs for substitution therapy' to the value of USD 25,000.

Based on the above, the following conclusions can be drawn about the positive achievements in the implementation of substitution therapy in the Kyrgyz Republic:

1. The existing legislative framework provides an opportunity to implement harm reduction programmes for substance use, including substitution therapy programmes.
2. The substitution therapy programme has been decentralised and geographically expanded.
3. Application of the 'Single Window' principle at some substitution therapy sites located at TB and HIV/AIDS treatment facilities, which enables the provision of integrated services for the treatment of the main disease of opioid dependence as well as TB and HIV through antiretroviral therapy.
4. The practice of issuing the patient with five days' worth of methadone has been introduced.
5. The substitution therapy programme has been introduced and implemented in the penitentiary system.
6. The hospitalisation of opioid-dependent persons with somatic health problems in other treatment facilities is well organised.
7. An electronic register has been established for monitoring and evaluation.
8. HIV infection rates in the Kyrgyz Republic have reduced, including the share of injecting drug users.
9. Since 2023, the transition of funding from international donor organisations to the state has been implemented through the Mandatory Medical Insurance Fund.

Opioid Agonist Maintenance Treatment in Tajikistan

In Tajikistan, the OAMT programme was introduced in 2010. There is a network of 15 OAMT sites covering all regions of the country, including

13 Order of the Mandatory Health Insurance Fund 2nd February 2023. No. 16.

two sites in the penitentiary system. Currently, the only OAMT drug used in Tajikistan is methadone, available only in liquid form. In addition to providing opioid dependency treatment, OAMT sites in Tajikistan encompass additional services for PWID, such as overdose treatment, testing for HBV, HCV, and syphilis, providing psychological support, etc. Despite a well-developed system of OAMT sites in the country, the OAMT programme in Tajikistan is still considered to be a pilot project, and coverage remains low. At present, around 650 people are enrolled in OAMT.

To explore the reasons for the underutilisation of the potential of OAMT sites operating in the country, research on drug use and barriers to OAMT in Tajikistan was conducted between February and April 2023. Sixteen focus groups comprising 65 PWID who were both receiving OAMT (30 people) and not receiving OAMT (35 people) were held in eight cities across Tajikistan. Three main obstacles were outlined by the respondents: the insufficient appeal of the OST programme, e.g. the need for daily visits to OAMT sites; the lack of staff capacity at OST sites; and misinformation circulated among PWID about OAMT (Kaspirova/Malikov 2023).

It should be noted that in 2023, the main institution coordinating the OAMT programme in Tajikistan, the Republican Clinical Narcology Center, adopted the OAMT Expansion Plan for the years 2024–2026, with an ambitious goal of increasing programme coverage to 2,000 people by the end of 2026. In order to achieve this goal, the aforementioned barriers must be addressed.

Conclusions

Since the beginning of the 2000s, harm reduction programmes have been introduced in Central Asia. OAMT and NSPs are key strategies in harm reduction as they are believed to be able to significantly reduce HIV and hepatitis infections among the vulnerable group of PWID. Kyrgyzstan and Tajikistan have been pioneers in the adoption of harm reduction programmes as both countries have opened OAMT programmes and NSPs in the community and in the penitentiary system. However, both countries also face problems in the implementation of OAMT as coverage remains very low. In Kazakhstan, OAMT was started in 2005 but was never expanded beyond a pilot project, with less than 1% of PWID having access to OAMT in the country. In 2024, the introduction of OAMT is being actively discussed among policy makers in Kazakhstan. In line with international

evidence, many argue that access to OAMT needs to be extended to effectively address the spread of HIV and hepatitis C among PWID.

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