Opioid substitution therapy – recognized effective strategy for drug dependence treatment

By Dr. Emilis Subata, Director of Vilnius Center of Addictive Disorders, Founder of EHRN

Scientific research data suggest that opioid dependence is a chronic illness with frequent relapses. Opioid dependence nowadays is often compared with other chronic diseases, such as hypertension, diabetes and asthma. There are no particular ‘cures’ for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, together with behavior change in patients, it is possible to eliminate or reduce symptoms of chronic diseases and reach a high quality of life.

Opioid substitution therapy (OST) in this context is recognized as a cost-effective strategy which achieves high retention rates of injecting drug users in therapeutic programs and significant reductions in illegal opioid use, criminal behavior and injecting risk behavior, with the great potential to prevent HIV and viral hepatitis. Both methadone and buprenorphine were included in the XIV Edition of the WHO Model List of Essential Medicines in 2005.

The WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009) were produced as a result of a thorough synthesis of available scientific evidence and expert consensus. They recommend that OST with methadone or buprenorphine should be used in preference to detoxification for most patients, that methadone be used in preference to buprenorphine, and that both OST and detoxification services be made widely available, including in prisons.

For the past decade OST has been the predominant treatment option for opioid users in Europe, and it is increasingly provided in prisons. It is available in all 27 European Union (EU) Member States. Overall, it is estimated that about half of the EU’s problem opioid users are in substitution treatment (approximately 700,000 patients).

Recent developments in OST in some Eastern European and Central Asian countries have been remarkable. But there are still challenges ahead. One is the quality of OST services, with their greater integration into existing health and social care systems, as well as their coordination with law enforcement. The other is to make OST sustainable from the national health budgets and make it more accessible for potential patients in the region.

For many years EHRN has contributed to the development of OST in the region by offering a platform for professionals, patients and NGOs to exchange information, share best practices and coordinate advocacy actions in countries in the region.

Inside this issue:

- Opioid substitution therapy in Central and Eastern Europe and Central Asia: gaps and ways forward
- Proven effectiveness: 6 experience of implementing opioid substitution treatment programs in Kyrgyzstan
- Methadone maintenance therapy program in Kosova - challenges and successes
- Best practice: transition from donor to budget financing for OST
- Present and future OST treatment in Albania
- Put an end to a sick person's suffering

EHRN: who we are
Despite positive effects of OST programs in many countries of Central and Eastern Europe and Central Asia (CEECA), problems in OST program implementation persist. In 2012 EHRN and the International Drug Policy Coalition (IDPC) prepared a review of the availability and quality of OST in 29 countries in the region.¹

Key findings:

- OST programs have been implemented in 25 out of 28 CEECA countries² since 1989; the exceptions are Russia, Turkmenistan and Uzbekistan. OST is acknowledged as the main treatment for opioid users in all EU Member States, including those from CEECA.

- Countries that achieved success in providing access to OST: in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Montenegro, Poland, Romania and Slovenia, OST is available in the health care system and in prisons (although in some cases limited). OST programs are funded through the health insurance system; in many countries commercial OST services are available. Participation of general practitioners in the Czech Republic enabled the country to provide the highest coverage of opioid users in the region at over 40%.

- In Albania, Kyrgyzstan, Moldova and Serbia, OST is available in health care settings and in prisons, but the program is mainly funded by donors and international organizations (the Global Fund, OSF, UN agencies).

- In Azerbaijan, Lithuania and Slovakia, despite the successful use of OST in the health care system and core funding from the state budget, at the time of the study, OST was not available in prisons.

- In the last group of countries – Armenia, Belarus, Georgia, Kazakhstan, Tajikistan and Ukraine – OST is only available in health care settings. There is still a large proportion of joint funding from international sources (mainly the Global Fund). In Ukraine, in 2011, despite support for OST programs from the government, experts and OST clients, law enforcement conducted raids and detained employees and clients of OST programs. OST program specialists, staff and clients suffered from a lack of consistency in positions of various departments as regards OST.

**OST programs in CEECA countries: sources of funding and availability in prisons**

Based on: Latypov A., Bidordinova A., Khachatrian A. Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality. EHRN, IDPC (2012)

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<th>Country</th>
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¹ Central Europe: Albania, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Kosovo, Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia; Eastern Europe: Armenia, Azerbaijan, Belarus, Georgia, Estonia, Latvia, Lithuania, Moldova, Russia, Ukraine; Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan.

² Croatia was not included in the survey.
GAPS

Gaps in availability
- OST is not available in three countries of the CEECA region: Russian Federation, Turkmenistan and Uzbekistan.
- All other former Soviet CEECA countries have a low OST coverage that is nowhere near the levels recommended by UN agencies.
- OST is available in prisons in 14 CEECA countries: Albania, Bulgaria, Czech Republic, Estonia, Hungary, Kyrgyzstan, Latvia, Macedonia, Moldova, Montenegro, Poland, Romania, Serbia and Slovenia (available in Croatia as well, but it was not included in the study). Even if OST is available in the country, it is not available in all prisons and in pre-trial detention.
- Lack of integration between OST and TB/HIV treatment programs – failure to adequately provide drug users with OST in health care institutions (e.g. general hospitals and TB hospitals) – results in low access to HIV, TB and HCV treatment and, consequently, increases mortality rates.
- Groundless strict control and inadequate harsh criminal liability for minor violations in drug control at health care institutions hinder the development of OST programs, and complicated systems of purchasing OST medications, agreements and quotas threaten uninterrupted treatment.

Limited access and inadequate quality
- Strict requirements imposed on OST clients – such as the need to pick up medications in a special drug treatment facility on a daily basis (no take-home doses) year after year – are ruinous for the proper integration of drug users and discourage their access to medical services.
- Law enforcement structures remain a serious obstacle for people who use drugs to participate in OST programs.
- A lack of psychosocial services and counseling at OST programs, including weak referral systems between OST programs and other social services (including non-governmental), and poor or absent information about OST medications, possible side effects and the duration of the program.
- The geographic distribution of OST sites – only in big cities and/or difficult to reach by public transport.
- Poor organization of services at OST sites – often patients are forced to queue in the open air for hours to receive a daily dose.
- OST sites do not and/or are not able to take into account the needs of the clients – hours of operation, dosage not personalized, no choice of OST medications.
- Unjustified requirements for acceptance into the program – such as being HIV-positive, above a certain age or having a history of several unsuccessful attempts at abstinence-based treatment.
- Unjustified, arbitrary and punitive grounds for expelling clients from the programs, including a positive urine test for drugs.
- Too often OST programs do not take into account gender-specific issues, including the needs of pregnant clients or those with children.

OST programs in CEECA countries: number of patients
Based on: Latypov A., Bidordinova A., Khachatrian A. Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality. EHRN, IDPC (2012)

<table>
<thead>
<tr>
<th>Country</th>
<th>Patients (Year)</th>
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<td>6517</td>
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<tr>
<td>Czech Republic</td>
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<td>Estonia</td>
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<td>Hungary</td>
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<td>Lithuania</td>
<td>800</td>
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<td>Bosnia-Herzegovina</td>
<td>600 (2009)</td>
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<tr>
<td>Slovakia</td>
<td>593 (2011)</td>
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<tr>
<td>Belarus</td>
<td>450-460 (2011)</td>
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<td>Romania</td>
<td>442 (2009)</td>
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<tr>
<td>Latvia</td>
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<td>184 (2010)</td>
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<td>157 (2011)</td>
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<tr>
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<td>Armenia</td>
<td>147 (2011)</td>
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<td>Uzbekistan</td>
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• The inclusion of OST program clients on drug user registries limits their rights – for example, employment, driving.

Lack of national ownership and commitment
• National governments remain largely unwilling to fund life-saving harm reduction programs, including OST, that are required to prevent the continued rapid growth of CEECA’s large-scale HIV epidemic among people who use drugs.
• National policies still create barriers to the establishment or expansion of OST programs.
• Countries periodically experience politically motivated debates questioning OST as an adequate response to drug use and HIV prevention (e.g. in Kyrgyzstan, Lithuania and others).
• A lack of national commitment and investment results in gaps in professional and trained staff to provide OST services. This contributes to the stigmatization of OST patients by medical practitioners and social support service providers, which acts as a deterrent to participating in OST programs.
• There are issues of privacy and the sharing of confidential information by medical doctors with law enforcement, schools, and kindergartens.
• An information vacuum at the national level creates myths about OST among the general public as well as among people who use drugs.

ADVOCACY AGENDA

National level
• Increase national ownership of OST service provision through strong political commitment and national funding of OST projects; policy reform to review restrictive and poorly written policies or adopt new policies in support of OST.
• Optimize drug control legislation on a normative basis to ensure that the national regulations, standards and protocols of OST programs are in line with international treatment standards and guidelines.
• People who use drugs and clients of OST programs should take part in developing policies and programs at the national level.
• Adopt and implement legislation and policies, followed by the implementation of OST programs that provide adequate availability, accessibility and quality services, including in prison settings and in-patient health care settings, also by engaging general practitioners, drug treatment specialists, AIDS centers and other health care facilities in offering OST.
• Different factors should be taken into account to increase access to OST services, including the location of sites, more accessible working hours, protection from law enforcement structures, adequate entrance criteria etc.
• Strive for better quality of OST services, including personalized and take-home dosages, psychosocial support (within OST programs or through referral systems), professional and trained staff, choice of medication, gender-sensitive approaches etc. Increased focus on quality is also reflected in the revised WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.

Increased focus on the quality of OST programs
The revised edition of the WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users is now available and has increased the number of OST quality indicators to 26. Among others, important quality indicators include the involvement of people who inject drugs (“The programme has actively involved PWID in the planning of OST services.”) and established referral systems (“Formalized referral pathways between the OST programme and other relevant service providers have been established, and OST clients are referred to these services as appropriate.”).
Regional level

- Ensure the involvement of people who use drugs and clients of OST programs in international and regional bodies that make decisions on legislation and policies related to HIV and drug use.
- Support efforts to promote harm reduction and OST scholarship in Eurasia by expanding the Russian language evidence base by publishing original research from the region and translating peer-reviewed English language literature.
- Develop a set of plans with specific activities designed to respond to OST crises that could potentially unfold in countries of Eurasia under different scenarios.
- Facilitate and disseminate best practices of OST services in the region.
- Conduct regular regional forums on OST to stimulate scientific interest and to recognize the efforts of countries supporting OST. The next great opportunity to discuss OST issues on the regional level is the International Harm Reduction Conference ‘Value(s) of Harm Reduction’ (June 2013).

The section ‘Opioid substitution therapy in Central Eastern Europe and Central Asia: gaps and ways forward’ has been prepared based on:


Latypov A., Bidordinova A., Khachatrian A. *Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality*. EHRN, IDPC (2012)


Consultations with EHRN Steering Committee members

Proven effectiveness: experience of implementing opioid substitution treatment programs in Kyrgyzstan

By Aibar Sultangaziev and Azizbek Boltaev

OST programs in the Kyrgyz Republic were launched in two pilot cities of Bishkek and Osh in 2002. Later, the programs expanded with support provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and in 2012, 20 OST programs were implemented in the country, including in the prison system. The development of OST in Kyrgyzstan is a logical continuation of consistent implementation of national approaches to drug dependence based on humanity and scientific evidence of effectiveness.

In 2012, the International Center for AIDS Care and Treatment Programs (ICAP) at the Columbia University Mailman School of Public Health conducted an assessment of OST programs in Kyrgyzstan; this assessment was funded by the President’s Emergency Plan for AIDS Relief (PEPFAR).

Evaluation results clearly show that the OST program in Kyrgyzstan demonstrates the effectiveness and relevance of providing methadone for opioid dependence treatment and prevention of blood-borne infections, including HIV and hepatitis.

Among the key findings of the evaluation are that:

- the vast majority of patients of OST programs that participated in the evaluation reported reduced frequency of heroin use – from more than once a day to

Figure 1. Heroin use

CFM – Center for family medicine; P – Prison; PDC – Pre-trial detention center

Figure 2. Injecting behavior

CFM – Center for family medicine; P – Prison; PDC – Pre-trial detention center
one time a week and less and to complete abstinence (Figure 1); and

- participation in an OST program for at least three months resulted in a significant reduction in risk of HIV infection associated with drug use: the percentage of people who injected drugs in the 30 days before the start of the OST program decreased in all OST programs (Figure 2). These results are statistically significant.

- The proportion of people who shared injecting equipment when using drugs has decreased in all OST programs.

- Criminal behavior among OST patients decreased in all OST programs compared to the period before the start of therapy.

- In all OST programs, patients reported an improvement in their perception of their health status; in six of the seven OST programs, results were highly statistically significant.

- Participation in OST programs significantly reduces patients’ consumption of non-prescribed substances. Without OST these expenses can reach $700 per month per patient. Taking into account the estimated number of injecting drug users in the country (25,000 as of 2006), we can calculate that over the course of a year injecting drug users living in the Kyrgyz Republic spend up to $210 million, thus causing serious social harm in the form of criminal activity associated with the need to find money to buy drugs (Figure 3).

At the same time OST programs face a number of problems; these challenges present restrictions for greater efficiency:

- OST programs are not implemented in all prisons.

- There is a lack of staff who have received training to work in OST programs.

- Politicized debates about the appropriateness of OST as a form of drug treatment occur periodically in the country.

- There are opponents of OST in the country, but often their arguments are based on unreliable information about the treatment with opioid agonists, including information about their clinical and pharmacological characteristics.

- Some myths about methadone are still circulating among people who inject drugs and the general population. These myths reduce the motivation of people who use drugs to apply for this type of medical support.

- A major obstacle to the expansion of OST program coverage is law enforcement’s counteraction to the participation of people who use drugs in OST programs.

- Poorly developed social support systems mean that there are limited interactions between OST programs and other services for people who use drugs, including NGOs.

After years of striving, the Republic of Kosova finally managed to start the implementation of a methadone maintenance therapy (MMT) program on 26 April 2012. It is delivered at a local NGO “Labyrinth”, which deals with the treatment of drug addiction and harm reduction services in Prishtina, and is part of a project funded by the Global Fund, in cooperation with the Ministry of Health and a local Community Development Fund agency.

The MMT program was first planned to start in 2009, when the Global Fund project ‘Prevention of HIV among most-at-risk populations’ started, but due to some legal gaps it took three years of endeavor to finally deliver this treatment to people in need. NGO “Labyrinth”, as a member of the Working Group on the National Strategy against Drugs, has had an active role in lobbying for and accelerating the initiation of the MMT program. “Labyrinth” is also one of the implementing partners of the strategy.

Between April and October 2012, 63 injecting drug users were included in the MMT program at NGO “Labyrinth”. The public health sector (psychiatric clinics in Prishtina, Gjakova and Gjilan) started the implementation of an MMT program in May 2012, and up to October, 30 injecting drug users benefited from the therapy. The waiting list of injecting drug users who needed and wanted to receive MMT was long, and the number of people who could receive the therapy was limited due to budgetary restraints. Despite this, it was a great achievement to be able to offer MMT to the most vulnerable group of injecting drug users. Priority was given to homeless people, women, young injecting drug users and those infected with Hepatitis C.

Some immediate results of introducing MMT can already be observed: a small analysis made by NGO “Labyrinth”, based on injecting drug users’ self-reporting, has showed that the level of involvement of MMT program clients in theft, burglary, robbery and other crimes has declined.

However, the story of enthusiasm and success of the MMT program in Republic of Kosova did not last for long. At the beginning of October 2012 the program was canceled. This was presumably due to delays in the methadone procurement process and administrative barriers to transporting methadone from the UK to Kosova. This was a really challenging period for MMT clients, as they were forced to interrupt their treatment for an unknown period of time.

But after three months of interruption and due to mutual efforts of NGO and government specialists, on 26 December 2012 the delivery of MMT was restarted. All injecting drug users who had previously been receiving MMT were included in the program again, and new people were also covered. The most important thing is that now the program has been provided with methadone until December 2013. At the same time MMT delivery has also started at three other public health centers. The total number of injecting drug users included in MMT programs in all four MMT centers in the Republic of Kosova is 119 (75 of whom are covered by “Labyrinth”). Further efforts are being made by NGO “Labyrinth” in collaboration with the Ministry of Health, Ministry of Internal Affairs and the Community Development Fund agency to ensure its permanence.
Best practice: transition from donor to budget financing for OST

By Dmitry Kolosov, Sergey Zhuk, “Svet Nadezhdy” (БА «Сеem надежды»), Poltava, Ukraine

Four integrated care centers (ICC) work today in the Poltava region; these centers work with people who use drugs in Poltava, Kremenchug, Lubny and Komsomolsk. More than 350 target group representatives receive services in these centers. The ICs provide a standard set of medical-social management services and the additional services of a phthisiologist, infectiologist and gynecologist. Here clients can start OST, ART and treatment for tuberculosis. The ICC in Poltava also has the social dormitory and homeless registration center. All these services ensure low-threshold access to treatment services for people who use drugs.

A total of eight OST program sites operate in the Poltava region and district centers, providing treatment to 480 clients (350 of whom receive OST at ICs).

In addition there are 10 harm reduction service delivery programs: six stationary and four mobile sites serve 2200 clients. Through joint efforts of physicians and the association’s social support service, effective support was provided to more than 200 patients of the nursing service in a drug treatment clinic.

Until recently, most of these services worked only with the support of international donors, through grants to non-governmental organizations. But representatives of the NGO sector actively promoted a different approach and succeeded in their efforts.

What seemed impossible only a year ago became a reality. For the first time in Ukraine, harm reduction programs, including substitution treatment, began to receive funding from the regional budget, and Poltava became the first region where the efforts of representatives of civil society made the difference, as changes to the regional drug policy were made.

This became possible due to the adoption of ‘The regional targeted program to combat drug use, illicit trafficking of narcotic drugs, psychotropic substances and their precursors for 2012–2015’ – the first program of its kind in Ukraine. Not only did the government support this program, but also a specific amount was allocated in the regional budget to fund activities planned under the program.

Program activities are designed according to international standards and set out activities in three strategic areas: demand reduction, supply reduction and harm reduction.

Certain amounts of funding have been allocated for the implementation of program activities under each strategic area. In particular, US$525,000 (of the total program budget of $1.25 million) has been allocated for the implementation of the harm reduction component. These funds will support activities at four syringe exchange sites and three ‘community centers’ for people who inject drugs in Poltava, Kremenchug and Lubny. Due to this initiative, in addition to the six existing OST sites, another three new sites will be opened in small towns in the Poltava region.

Procurement of domestically produced buprenorphine since September 2012 confirms that the regional program will work. Also, access to substitution therapy has been improving - the capacity of the OST programs has increased to include new five participants on buprenorphine in addition to the previous 32 participants, so 37 patients now receive this therapy (from the total of 480 patients on OST, 37 are on buprenorphine). Next year coverage is planned to increase to 50 participants, accounting for nearly 10% of the total number of participants in the Poltava region.

Activists of the Charitable Association “Svet Nadezhdy” initiated these innovations. Their example shows that despite obstacles, the NGO sector can and should influence the situation in the field of drug policy and HIV services. Different ‘tools’ were used to achieve these results.

First, NGO representatives took an active position at the regional meeting of the Coordination Council on HIV/AIDS. From the beginning the program’s concept and activities were developed together with medical specialists. Thanks to experts from NGOs, harm reduction was included in the program. Second, it was necessary to follow up on the draft program while it went through further approvals, arguing the need for this treatment approach, and, finally, to convince members of the regional council during the hearings of the Council’s committees.

We hope that our government will recognize the need for such programs and continue to provide the necessary funding and that measures announced to address the HIV/AIDS epidemic in Ukraine will not be just another declaration lacking appropriate actions and funding. Under this scenario, representatives of nonprofit organizations will not only be able to count on grant competitions and international donor funding but will also be able to ensure funding for their activities at the national level. Only in this case, together can we make a difference and change things for the better.
Present and future OST treatment in Albania

By Genci Mucollari, Head of Methadone Center in Albania

Aksion Plus was established in 1992 and is the first youth non-governmental organization in Albania working actively on HIV and drug prevention through education, information, training, publications and other activities. Provision of access to services and treatment for vulnerable groups is one of the main directions of Aksion Plus activities. In 2000 Aksion Plus opened the first harm reduction/needle exchange service for drug users in Tirana, supported by OSF/IHRD. Outreach workers are providing clean needles, leaflets, condoms and multivitamins to some of the Roma injecting drug users in poor health, and offering referral to other services. And, of course, provision of methadone maintenance therapy (MMT) is one of the important parts of Aksion Plus harm reduction activities.

MMT in Albania

In August 2005, as part of our harm reduction strategy, Aksion Plus introduced methadone maintenance therapy (MMT) for injecting drug users – licensed by the Ministry of Health (MoH) and supported by the Global Fund. Initially this program was based in Tirana; later, through Global Fund support, it scaled up to another six regions. Buprenorphine and naloxone programs have not yet been introduced in the country.

Aksion Plus dispenses methadone to about 200 patients daily in Tirana, and has opened five satellite clinics in major cities across the country. In almost all the centers the space is provided for free by the local government or health authorities. All the MMT programs offer friendly spaces for clients, psychosocial support, group and family therapy, referral to other services, vocational courses (in cooperation with the state vocational centers) and testing for HIV, hepatitis, syphilis and other blood-borne infections. Aksion Plus operates an accessible, non-judgmental program using a target maintenance dose of 80mg/day of methadone, performing regular urine tests, with almost all doses supervised. About 500 clients benefit daily from these services nationwide.

In agreement with the Ministry of Justice, General Directorate of Prisons (MOU signed in 2006), MMT is also provided in prisons and police stations to continue treatment of patients who have been incarcerated. In general, imprisoned patients are tapered off some prisoners with serious mental health problems, Aksion recommends to prison authorities that methadone is continued indefinitely.

When people are first arrested, they are held in pre-detention or at a police commissariat for up to 72 hours before transfer to the prison system. Aksion Plus also provides some methadone to arrested patients in pre-detention.

Sustainability of harm reduction and MMT programs in Albania

Since 2012 Albania has no longer been eligible for Global Fund grants. But under the Continuity of Services of Round 5 Grant Agreement, Albania managed to receive a two-year extension (1 April 2012 to 31 March 2014) to continue MMT to 474 patients and second-line antiretroviral therapy to 50 patients.

After March 2014 Aksion Plus sees the way forward as obtaining funding from local councils. We are encouraging people and, especially, our clients and their siblings to ask for their rights. We are asking patients and parents to advocate and to have meetings with local officials to try to argue the case for MMT. This is how, despite limited funding, we were able to establish a number of satellite centers.

The first necessary condition for sustaining access to MMT is funding from the Albanian Ministry of Health to purchase methadone supplies. Whether regulatory or legislative change is necessary, this is required to ensure methadone is reimbursable medication, and that government will supply medication for treatment programs.

Last year the Albanian Parliament approved the National Drugs Strategy 2012–2016. This strategy accepts that the fight against drugs can be successful only if we coordinate the efforts of the government, civil society and international partners. For the first time it has been accepted that it is indispensable to pay the same importance to reducing the demand for drugs, so that it receives the same priority as reducing the supply.

One of the activities planned within this new strategy is the establishment and operation of the Polyvalent University Center of Drug Addiction Treatment based on the existing toxicology service, through its adaptation, strengthening and supply with the necessary sources. This center will offer a number of services including retention long-term treatment with agonists and meta-agonists (methadone, subutex, suboxone etc.). Such developments give us hope that the government will support MMT programs after termination of the Global Fund program.

But, as the Albanian drug strategy envisages allocation of resources to expand drug treatment capacity, it will be critical to ensure that funding for MMT is clearly identified. Whatever funding is allocated to the development of services for drug users, there needs to be transparency and accountability to ensure that funding goes to providing the most useful services.
Put an end to a sick person

By Igor Bogush, Russia

On 23 January 2013, the Head of the Ministry of Health, a corresponding member of the Russian Medical Academy of Sciences and a fifth-generation doctor, Veronica I. Skvortsova said at the Government Hour in the State Duma: “Our country was one of the first in 1998 to oppose substitution therapy and methadone...Methadone treatment puts an end to patients' health immediately and sentences them to a quick death within a year and a half after the beginning of therapy.”

Leaving aside the words about an imminent death, as for opioid substitution therapy (OST) putting an end to the patient – I must say that yes, indeed, substitution treatment (methadone as well as buprenorphine and diacetylmorphine (medical heroin) also used for OST in the world, chosen as treatment by Switzerland, the UK, Canada, Germany, Australia, Denmark and other countries) does put an end to the sick person. But in a slightly different sense than that meant by Mrs. Skvortsova.

OST aims to put an end to a sick person's being a source of uncontrolled spread of HIV and hepatitis. People who have access to OST can finally get out of the endless cycle, start antiretroviral therapy or treatment for tuberculosis, even drug-resistant TB, and adhere to treatment. OST also puts an end to overdose, which is the main cause of mortality among drug users. It puts an end to the numerous infections and complications such as liver cirrhosis, tuberculosis, hepatitis C or new cases of HIV infection in infants and the arrival of thousands of new orphans whose mothers are sitting in camps or are deprived of parental rights.

And thanks to substitution therapy, people who use drugs will no longer be a source of statistics demonstrating the success of police departments and the object of blackmail by police. State OST programs can put an end to a sick person and his/her distressed relatives as cash cows for the police officers, investigators, lawyers, forensic experts, members of the Federal Justice Service, drug treatment specialists and all those who often use someone else’s misfortune to their advantage.

In Russia, however, methadone is included in a Schedule I list of narcotic drugs, psychotropic substances and their precursors that are subject to control in the Russian Federation, i.e. its turnover in any form or for any purpose, including medical, is prohibited. So, Minister Skvortsova, Russia gives up on methadone, thus subjecting many drug-dependent people to rapid death from overdose, HIV, tuberculosis and other consequences of illegal drug use in our country.
The Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programs and their allies from across 29 countries in the region of Central and Eastern Europe and Central Asia (CEECA). Together, we work to advocate for the universal human rights of people who use drugs, and to protect their lives and health.

The network was established in 1997 and is governed by its Steering Committee. The Steering Committee is formed of elected representatives from CEECA sub-regions and the community of people who use drugs. In 2001 the Steering Committee established the Secretariat, which is based in Lithuania and carries out the network's programmatic and administrative activities. EHRN holds a Special Consultative NGO status with the Economic and Social Council of the United Nations (ECOSOC).

The network unites over 350 institutional and individual members, tapping into a wealth of regional best practices, expertise and resources in harm reduction, drug policy reform, HIV/AIDS, TB, HCV and overdose prevention. As a regional network, EHRN plays a key role as a liaison between local, national and international organizations. EHRN ensures that regional needs receive appropriate representation in international and regional forums, and helps build capacity for service provision and advocacy at the national level. EHRN draws on international good practice models and on its knowledge about local realities to produce technical support tailored to regional experiences and needs. Finally, EHRN builds consensus among national organizations and drug user community groups, helping them to amplify their voices, exchange skills and join forces in advocacy campaigns.

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