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Commentary

Advocating for opioid substitution therapy in Central Asia: Much still to be done

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ABSTRACT

Opioid substitution therapy (OST) was first introduced in the formerly-Soviet Central Asian Republics as an HIV prevention intervention for people who inject drugs (PWID) in 2002. Presently, pilot programs function in Kazakhstan and Tajikistan, and Kyrgyzstan has scaled-up from the pilot phase to the operation of over 20 OST sites nation-wide. All three countries have taken steps towards lower-threshold programs, allowing clients to enroll regardless of HIV status, and, in some cases, without documentation of failure to complete other drug treatment programs. However, OST programs remain exclusively funded by international donors, and political and societal opposition to these programs threaten their stability. In order to counter negative campaigns and political attacks on OST, organized advocacy efforts are needed. This commentary explores efforts undertaken by international donor partners supporting advocacy efforts to scale-up OST and assure a sustainable future for programming. It examines both proactive and reactive efforts, and the variety of target audiences that need to be reached to conduct effective advocacy. Ultimately we find that, while a range of tools are available for OST advocacy in the hostile environments of the former Soviet Union, the strengthening of advocacy groups is needed to assure an optimized platform exists for using the evidence and developing relevant materials in the appropriate languages (including, but not limited to, Russian) for both proactive and reactive efforts; and that more robust monitoring is desirable to bring sharper focus to replicable methods.

Background

In the Central Asian Republics of Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan, the HIV epidemic is concentrated amongst key populations, with people who inject drugs (PWID) representing the largest portion of those infected (Mathers et al., 2008). This cluster of formerly Soviet countries is a part of the Eastern European & Central Asian (EECA) region that is the only region, globally, where HIV incidence is still rising steadily (Global Report, 2013). Within this setting, the struggle to introduce and institutionalize evidence-based methods for treatment of opioid dependence have received attention that they may not have otherwise received: bilateral and multilateral donors and development agencies see opioid substitution therapy (OST) as a critical intervention for preventing further spread of HIV amongst communities of PWID (APMG, 2013). While there are a variety of political, structural and cultural barriers that have created challenges in reversing the tide of the HIV epidemic, attitudes and policies towards drug use, in particular, have complicated efforts to scale up and sustain OST programs (Boltaev et al., 2013; Latypov, Bidordinova, & Khachatrian, 2012; Latypov et al., 2012; Rechel, 2010).

To respond to these barriers that impede programs from full scale-up and government ownership, advocacy efforts by a range of stakeholders have been undertaken. This commentary examines efforts that have been made to date, and provides recommendations for sustained and improved advocacy.

History of OST in Central Asia

The first country in Central Asia to experiment with the introduction of OST was Kyrgyzstan, which started a pilot program in 2002. In 2006, the United Nations Development Programme (UNDP) conducted an assessment of the pilot program, noting strengths in services provided, but recommending further quality improvement and the expansion of OST to the penitentiary system (Subata & Pkhakadze, 2006). A 2008 evaluation by the World Health Organization (WHO) positively reinforced the program's effectiveness in treating opiate dependence, noting reductions in crime and incarceration by OST program clients, as well as improved quality of life and reduced needle and syringe sharing; a further WHO evaluation in 2011 noted positive results from the penitentiary system pilot, and recommended further scale-up (Subata, Moller, & Karymbaeva, 2008; Subata, Karymbaeva, & Mollar, 2011).

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Uzbekistan was next to introduce OST in 2006, though it abruptly closed its pilot program in 2009, when an external evaluation recommended further scale-up (Abrickaja & Boltaev, 2013). Since that time, no significant moves have been seen to reinstate the program. In late 2008, Kazakhstan became the next country of the group to introduce OST, initiating pilots in 2 sites; a third site was added after initial positive results of the pilot program in 2010. However, significant political pressure from both outside sources and local anti-OST advocates have plagued the program through its early years. After threats of program closure throughout 2011 and 2012, in early 2013 the Ministry of Health made the decision to expand the pilot program to 7 new sites; while the expansion to a total of 10 sites is positive, it still allows for very limited coverage in the world's ninth largest country by geographic landmass. Tajikistan introduced OST most recently, starting its pilot in three sites in 2010. While, as of October 2013, three new sites are scheduled to be opened, observers have expressed fears about lack of long-term government ownership of OST and its failure thus far to move beyond the pilot stage in policy terms (Latypov, 2010).

Proactive advocacy – defining advocacy priorities and plans

The Public Health Advocacy Institute of Western Australia's *Advocacy In Action Toolkit* makes the distinction between proactive and reactive advocacy when advocating on health issues such as harm reduction and the treatment of drug dependence (Public Health Advocacy Institute of Western Australia, 2013). Proactive advocacy identifies a health priority that is being sub-optimally addressed, and develops a plan of action to bring about positive change. Reactive advocacy, on the other hand, responds to a negative change or threat in the environment, and usually seeks to restore the situation to the status quo.

The story of methadone advocacy in Central Asia starts with proactive advocacy, as most of the advocacy that assisted governments in the region to consider and eventually start OST came from Open Society Institutes (OSI, now known as Open Society Foundations), particularly through OSI's International Harm Reduction Development activities from the late 1990s. WHO was also an early supporter of OST and, early this century, the United Nations Office on Drugs and Crime (UNODC) began to promote OST as both an effective drug treatment methodology and for HIV prevention among PWID. Apart from very limited "seed" funding from OSI, grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria have been the main source of financing for OST in the region – and indeed for most of the developing and transitional world. Across EECA, Eurasian Harm Reduction Network has consistently argued for greater access to OST for PWID for more than a decade (Sarang, Stuikyte, & Bykov, 2004).

However, a sustained misinformation campaign has been waged by a number of actors about the effects of OST – and methadone, in particular – on individuals and post-Soviet societies (Latypov, Bidordinova, et al., 2012). This campaign is generally hidden, in that specific sources and motivations are difficult to identify, but typing "methadone" in Cyrillic into a search engine will result in well over 1000 web pages, the vast majority devoted to describing "evils" of methadone and OST that are not supported by evidence. It is assumed by the authors, and by many other OST advocates in the region, that at least one source of this misinformation is within the Russian government, which has demonstrated a virulent opposition to any form of OST over the past two decades (Krasnov et al., 2005). Though, as we will show below, this is not the only source of misinformation.

To defend OST against this these negative campaigns, a number of attempts have been made to use the evidence of OST pilots in these countries to assist policymakers in making informed and reasonable decisions. These efforts were hampered for several years by the lack of coordinated, standardized analysis of pilot implementation, which would provide policy makers with a clear body of evidence that OST works in their local context. In 2012, a series of assessments addressed this short-coming: the United States Centers for Disease Control and Prevention funded Columbia University's International Center for AIDS Care and Treatment Program (ICAP) to conduct assessments of OST programs in Kazakhstan, Kyrgyzstan and Tajikistan, for the purpose of informing the planning, coordination and implementation of improved programming (Boltaev, Deryabina, & Howard, 2012a, 2012b, 2012c). These assessments – which examined program structures, political environments, financing, supply chain, human resources, infrastructure, and monitoring and evaluation – provided a snapshot of the barriers facing scale-up and sustainability of OST throughout the region. Key findings of the assessments included positive reviews of programmatic impact (citing reductions in non-prescription opiate use, reduced criminal activity, and increased perceptions of health by patients), as well as the financial feasibility of providing OST – messages that can and should be used in advocacy efforts for maintaining OST programs.

The assessments also provided several recommendations that serve as opportunity points for advocacy: all funding for OST currently comes from the Global Fund to Fight AIDS, Tuberculosis and Malaria, threatening programmatic sustainability as Global Fund eligibility criteria change (Kazakhstan has recently become the first to pledge government funds for OST, though results of that pledge have not yet been seen (UNODC, 2012)); monitoring of programs remains weak and overlooks critical qualitative aspects including patient satisfaction with services, potentially jeopardizing program effectiveness and creating opportunities for anti-OST campaigners to manipulate data; knowledge of health care providers about OST remains low in many places, leaving gaps for misinformation to create inaccurate perceptions of OST; and engagement of civil society, including OST client support networks, could be strengthened to improve both adherence to and retention on OST and the broader community perspective.

These messages are well suited to proactive coordination and advocacy efforts that have taken place in Kazakhstan, Kyrgyzstan and Tajikistan in recent years. Most notably, the Central Asia Drug Action Programme (CADAP), funded by the European Union, has convened donor partners throughout the region (SDCMMAT, 2013) to coordinate support efforts to strengthen implementation of OST. However, coordination has been focused primarily on avoiding duplication of efforts, and has not focused on priority setting or message coordination, nor on assuring that a sufficient range of audiences is targeted. Additionally, while individual donor projects coordinate with local partners outside of this mechanism, a single mechanism to regularly bring together international and local OST advocates does not exist.

Capacity-building efforts, such as expert dialogues between international and local experts, have been supported with funding from the United States Agency for International Development (USAID, 2011) to assist in building the knowledge and skills of OST service providers, NGO partners who engage with clients, and potential clients for OST, but further efforts of this sort are needed to assure ongoing positive exchange.

Reactive advocacy – responding to attacks

In the absence of sufficient proactive advocacy mechanisms, OST advocacy has often been characterized by reactive efforts. One vivid example was the 2011 effort to counteract the anti-OST propaganda film "The Trap" produced in Kyrgyzstan by noted Kyrgyz film-maker Ernest Abdyjaparov. The film, produced with the support of Citizens' Committee on Human Rights (CCHR), a spin-off of the Church of Scientology, presented highly orchestrated

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