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Republic of Tajikistan:

ASSESSMENT OF THE SUSTAINABILITY OF THE OPIOID AGONIST THERAPY PROGRAMME IN THE CONTEXT OF TRANSITION FROM DONOR SUPPORT TO DOMESTIC FUNDING

February-March 2020

Alisher Latypov

"Many of us have parents who are saying their prayers for Emomali Rahmon in gratitude for his approval of the methadone therapy programme, and for the fact that their children are now with them, they work, and they take care of their parents."
Focus group discussion, Dushanbe, February 2020.

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Acronyms and Abbreviations

ART	Antiretroviral therapy
CDC	U.S. Centers for Disease Control and Prevention
ECUO	East Europe and Central Asia Union of People Living with HIV
EECA	Eastern Europe and Central Asia
EHRA	Eurasian Harm Reduction Association
ERSMT	Electronic Registry of Substitution Maintenance Therapy
GDP	Gross domestic product
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria (also The Global Fund)
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IBBS	Integrated bio-behavioural survey
MAT	Medication assisted therapy
M&E	Monitoring and evaluation
MoH	Ministry of Health
MoHSP	Ministry of Health and Social Protection of the Population of the Republic of Tajikistan (Ministry of Health and Social Protection)
MoJ	Ministry of Justice
NCC	National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria
NGO	Non-governmental organisation
OAT	Opioid agonist therapy
OMT	Opioid maintenance therapy/treatment
OST	Opioid substitution therapy
OSTM	Opioid substitution therapy with methadone
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PWID	People who inject drugs
RT	Republic of Tajikistan

STD	Sexually transmitted disease
TB	Tuberculosis
TJS	Tajikistani Somoni (the currency of Tajikistan)
TSM	Technical support mechanism
UAH	Hryvnias (the currency of Ukraine)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

Executive Summary

The opioid agonist therapy (OAT) programme[1] was launched in the Republic of Tajikistan in 2010 with the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (hereinafter, Global Fund). As of January 1, 2020, a total of 15 OAT sites were operating in the country, including 2 sites in the penitentiary system, which provided services to 638 programme participants.

Tajikistan currently continues to be among the countries meeting the Global Fund's eligibility criteria for funding of HIV and TB components. Furthermore, according to World Bank classification, Tajikistan is the only low-income country in the region of Eastern Europe and Central Asia (EECA). According to the Global Fund's projections to 2028, the country is likely to continue to receive funding (The Global Fund, 2019a; The Global Fund, 2019b). In the meantime, the transition from donor support to domestic funding is implemented through a gradual long-term reduction of funding which is made available by the Global Fund to fight HIV/AIDS in Tajikistan.

In 2019, the Eurasian Harm Reduction Association (EHRA) developed a methodology and related toolkit to conduct a country assessment, with a particular focus on the sustainability of OAT programmes in their transition from donor support to domestic funding.

This assessment was conducted in February and March 2020, involving the current situation, progress achieved, the risks and opportunities pertaining to the sustainability of the OAT programme in Tajikistan with an emphasis on programmatic aspects, and a focus on the following three issue areas: policy and governance, finance and resources, and services. This assessment includes an overall summary, a progress review, and an overview of challenges and opportunities within each issue area, as well as conclusions and recommendations for government ministries and agencies, national coordinating bodies, OAT practitioners, civil society, technical partners, and donors.

Grants provided by the Global Fund have been, and still are, the main source of funding for the OAT programme in Tajikistan. Up until now, the Global Fund support has been used to establish and equip nine OAT sites, to purchase methadone and additional equipment as required, to pay remuneration to OAT programme personnel (including on-the-ground service providers working directly with programme beneficiaries, and managers), and to cover the cost of personnel training and capacity building. The U.S. Centers for Disease Control and Prevention (CDC) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) are also among the programme's major sources of international funding which has been used to establish four OAT sites and to ensure their ongoing operation in the country. With the financial support of the United Nations Office on Drugs and Crime (UNODC), two OAT sites have been renovated and properly equipped.

[1] Opioid agonist therapy (OAT) is also referred to as opioid substitution therapy (OST) and opioid maintenance therapy/treatment (OMT). Other terms, such as "opioid substitution maintenance therapy/treatment" and "substitution maintenance therapy with methadone", are also widely used in Tajikistan. In this review, we use the terms "OAT" and "participants of the OAT programme", as well as other relevant terms as used in the officially approved national protocols, guidelines, laws and regulations referred to herein.

Based on this assessment, the **strengths and accomplishments of the programme** can be summarised as follows:

1. There are no legal barriers to the implementation of OAT in Tajikistan.

2. Since its introduction as a pilot project 10 years ago, the OAT programme has been significantly expanded with regard to both its coverage of people with opioid dependence and its geographical coverage and availability throughout the country.

3. There are authorised bodies in place that are responsible for the implementation, supervision, and coordination of the further development of the OAT programme in the country.

4. The country has adopted clinical protocols, guidelines, algorithms, and other regulations and operational documents which are necessary to foster an enabling environment for the implementation of the programme in accordance with the established criteria, rules, and regulations.

5. Methadone and buprenorphine are on the List of Essential Medicines of the Republic of Tajikistan.

6. Since the programme was first introduced, its admission criteria have been simplified and services have been made available in prisons following the introduction of the programme within the penitentiary system.

7. Through the support of, and cooperation with, projects providing technical assistance for the implementation of the OAT programme, the data collection and assessment framework has been significantly improved and the OAT Electronic Registry was established to enable informed decision-making on further OAT programme development.

8. Since November 2014, the country has been successfully implementing a pilot project to provide integrated HIV, tuberculosis (TB), and OAT care in a one-stop service modality. Under this project, four OAT pilot sites, which cover about 40% of the total number of OAT programme participants, provide access to a range of services including HIV and TB prevention, testing, diagnostics and treatment, monitorings of immune status, drug interactions and toxicity, and treatment efficiency, as well as psychosocial counselling, and overdose prevention services.

9. A significant number of OAT personnel received training, which has contributed to strengthening the overall health care system, including improved interaction and cooperation between vertical services (such as HIV, TB, and drug dependence treatment). As the OAT programme is funded from external sources as part of the HIV response, cross-programme coordination between these services is maintained at appropriate levels.

The above achievements serve as evidence indicating that the OAT programme receives political support from the government.

Meanwhile, **the assessment revealed moderate-level risks for the sustainability of the OAT programme in the context of its transition from donor support to domestic funding across all issue areas that were assessed (including policy and governance; finance and resources; and services).** Indicators of particular concern included the following:

- management of transition from donor to domestic funding;
- financial resources;
- availability and coverage.

These three indicators were assigned a high level of risk.

Major challenges and barriers to achieving full sustainability of the OAT programme in Tajikistan are as follows:

1. The national health care system faces significant structural challenges, particularly with regard to its financing and human resources.

2. The government's share of OAT programme funding is very limited and scarcely ever goes beyond covering utility costs; the government also provides premises for OAT sites, with renovation costs paid through external funding.

3. The OAT programme has been established in the country as part of the national response to HIV among people who inject drugs. This is the context in which the OAT programme has been considered up until now, rather than within the framework of building efficient drug policy based on a well-balanced approach to reducing the supply of, and demand for, illicit drugs.

4. The plan for the transition from donor support to domestic funding, which was developed in 2018, has not yet been approved by the government and implementation costs have not been calculated. Also, stakeholders have not yet agreed as to which domestic funding sources should be used for the OAT programme during the process of transition and after transition has been completed.

5. There is an insufficient involvement of the OAT client community in advocacy, education, and awareness programmes and activities aimed at overcoming myths about the OAT programme and in promoting dialogue on public investment in the programme.

6. The anticipated initiation of implementation of the Law "On Health Insurance" in the Republic of Tajikistan in 2022 may create additional financial barriers for OAT programme participants in the event that they do not have all of the required identity documents for health insurance, and particularly if they cannot afford to pay insurance fees.

7. Although OAT programme enrolment is free-of-charge for programme clients, services for diagnostics and treatment of psychoactive substance dependence, which are provided by specialised narcological facilities in outpatient and inpatient settings, are available on a fee-paying basis. This becomes a financial barrier to entry to the programme for potential low-income clients.

8. From a financial perspective, it will be difficult to keep the existing staffing structure (which is currently funded through Global Fund grants) within the context of the OAT programme transition to domestic funding due to limited healthcare spending in Tajikistan.

9. Although it has been quite a while since the National HIV/AIDS Response Fund was established by the government in 2014, it is not yet being fully utilised. How this Fund can be used to support any of the OAT programme components is still an open question.

10. There is no established practice of using the social contracting mechanism to ensure a wider involvement of NGO personnel in the provision of OAT programme services. The social contracting mechanism generally remains significantly underused in the country.

11. Currently, only methadone is used in the OAT programme. Methadone is used in liquid form which is much more expensive than methadone in powdered form. Methadone for the OAT programme is purchased through an international concurrent supply system which operates alongside the national procurement and supply system.

12. There is no comprehensive OAT continuity framework to ensure therapy integrity for transferred patients. If OAT programme clients are arrested or placed in pre-trial detention facilities, they have to discontinue treatment.

13. Both medical staff and OAT programme participants have pointed out that OAT clients may face harassment and abuse when dealing with police; some law enforcement personnel may create barriers for programme clients, discouraging them from programme participation.

14. Coverage of the OAT programme amounts to about 2.9% of the estimated number of people who inject drugs in the country, which is nowhere near the levels recommended by the World Health Organization (WHO) and other international organisations.

15. There is no take-home policy to dispense medication to stable programme customers for self-administered therapy, which has been (and still is) one of the major programming barriers to reaching adequate coverage and sustainability of the OAT programme. Moreover, in the context of the COVID-19 pandemic, a failure to implement the take-home medication policy is at odds with social distancing and other prevention and control measures recommended by the WHO to prevent the further transmission of coronavirus, which calls for urgent action to remove this barrier.

16. Many clients in need of OAT are discouraged from accessing the programme by its linkage to the official narcological registration system which significantly affects the fundamental rights of people who use drugs and is associated with a breach of confidentiality of individual health-related data.

17. According to existing guidelines and protocols, people under the age of 18 are not eligible to access the OAT programme, which is not in line with WHO guidelines.

18. All OAT sites dispense medication only within limited opening hours (from 7am to 12pm), which seriously impedes access to services for many programme clients, particularly those who are employed.

19. There is still a monopoly of specialist narcological care institutions over OAT services in the country. General practitioners/family doctors and other physicians are not explicitly and unequivocally authorised to provide these services under existing laws and regulations. This is the main barrier hindering the decentralised provision of OAT services through primary health care facilities.

20. There is a shortage of motivated and properly qualified health care personnel. Medical education and training of psychiatrists and psychoactive substance dependence specialists (narcologists) is an acute problem. OAT-related issues are not incorporated within the study curricula of medical schools/universities in the required detail and depth.

21. One of the most critical gaps in the provision of high-quality OAT services is an extremely low supply of qualified psychosocial support to programme clients. Most programme participants urgently need assistance with employment and/or capacity building to learn skills that are in demand in the labour market. However, such assistance is not provided within the current OAT programme.

22. Even though the national OAT programme has been successfully implemented for some 10 years, it still has a pilot project status as the completion of its "pilot" or "trial" phase has not been formally confirmed by any of the OAT programme-related regulations enactments.

The table below provides a summary of progress towards ensuring the sustainability of the OAT programme in Tajikistan using the three issue areas reviewed in the course of this assessment.

Issue Areas	*Indicators*		
Policy and governance	**At moderate to high risk**	**Political commitment**	**Moderate**
		Management of transition from donor to domestic funding	**At high risk**
Finance and resources	**At moderate to high risk**	**Medications**	**Moderate**
		Financial resources	**At high risk**
		Human resources	**Moderate**
		Evidence and information systems	**Moderate**
Services	**At moderate to high risk**	**Availability and coverage**	**At high risk**
		Accessibility	**Moderate**
		Quality and integration	**Moderate**

The following recommendations are drawn from this assessment to ensure greater sustainability of the OAT programme in the context of the transition from donor-supported programmes to domestic funding:

1. **To the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria and the Coordination Council on the Prevention of Drug Abuse in Tajikistan:**

1.1. Consider convening an ad-hoc joint meeting to address the sustainability of the OAT programme in Tajikistan in the context of coordination and harmonisation of the HIV/AIDS response and prevention and treatment of psychoactive substance dependence. This joint meeting should be held involving all stakeholders, including OAT service providers as well as OAT programme participants. In the future, such joint meetings should be held regularly.

1.2. Adopt a joint document outlining the position towards OAT as the primary method for opioid dependence management and emphasising commitment to support and promote further development of the OAT programme, particularly through a phased transition to domestic funding. Building upon the successful (as confirmed by country assessments) implementation of the national OAT programme over the past ten years, it is necessary to review the use of outdated wording such as "pilot" and "trial" and to recognise OAT as an evidence-based programme which has proved to be highly effective in the country. This position should be taken into account and used to inform the development of the forthcoming National HIV Response Programme in Tajikistan, as well as the forthcoming National Strategy to Combat Drug Trafficking.

1.3. Request the Ministry of Health and Social Protection of the Population to develop a roadmap to foster the development of the OAT programme in the country.

1.4. To review and approve the plan for the transition from donor-supported to domestic funding of the HIV response in Tajikistan, including its budget and the monitoring and evaluation (M&E) plan.

1.5. Analyse potential opportunities to support the OAT programme with funding from the National HIV/AIDS Response Fund and develop concrete steps to ensure implementation.

1.6. Ensure support for the OAT programme from police and law enforcement agencies. Initiate the development and introduction of special guidelines for law enforcement personnel on harm reduction, covering both general aspects and OAT in particular. Ensure that appropriate measures are taken to operationalise these guidelines, including disciplinary actions and other control measures and penalties for non-compliance.

1.7. Initiate the development and implementation of mechanisms to foster cooperation between law enforcement agencies, the penitentiary service, and health care organisations to ensure that OAT clients can continue receiving medication in case of their arrest and when being placed in pre-trial detention facilities.

1.8. Establish a special working group to review, update, and implement recommendations drawn from the assessment of the Republic of Tajikistan's legislation and policies conducted by UNODC and the Canadian HIV/AIDS Legal Network. These recommendations are presented in the report entitled, "Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform."

2. To the Ministry of Health and Social Protection of the Population (MoHSP):

2.1. Ensure the immediate introduction and implementation of the take-home policy/procedure to dispense medication to stable OAT programme clients for self-administered therapy as authorized by various existing documents.

2.2. In the context of the COVID-19 coronavirus pandemic, develop measures to enable a take-home medication procedure applicable to all OAT programme participants with a stable maintenance dose in the case of social distancing, self-isolation and other prevention and control measures being introduced in the country.

2.3. Ensure that a decree is adopted to enable the provision of OAT and related services on a free-of-charge basis. List 2 in Annex 1 to the "Regulation On Co-payment for Health Services, Provided to the Citizens of Tajikistan by Public Health Care Facilities," passed by a joint Decree of the MoHSP and the Ministry of Finance of Tajikistan No. 938-135 as of November 5, 2014, should be amended by adding people with opioid dependence enrolled in the OAT programme. The amended Regulation should state that people living with HIV/AIDS are entitled to free medical care which is not limited to their underlying disease only.

2.4. Provide opportunities to import methadone in a powdered form into the country to use it for liquid preparations domestically, which would significantly reduce the cost of OAT medication. Reducing the cost of OAT medication (particularly through the use of it in tablet form) is a viable option to enhance the sustainability of the OAT programme and to optimise such costs in the course of transition to domestic funding.

2.5. Prioritise the replacement of personalised data records within the narcological registration system with a case registration system based on unique identification codes. Develop practical guidelines to facilitate the application of this system and to set out procedures to identify a person's drug dependence status, if required and justified in terms of the observation of human rights, but without relying on the narcological registration system.

2.6. Adopt a decree to enable OAT service provision by General Practitioners/family doctors and other health care specialists provided that they have been appropriately trained and certified by duly accredited educational institutions

2.7. Put in place measures to increase the coverage of people who use opiates through the decentralised provision of OAT services at primary health care facilities and the opening more OAT sites in primary health care settings.

2.8. Institutionalise the delivery of integrated HIV, TB, and OAT services in a "One-Stop Shop" service modality, followed by the widespread introduction of this model at all OAT sites.

2.9. If the implementation of the Law "On Health Insurance in the Republic of Tajikistan" starts in 2022, take steps to minimise financial barriers for OAT programme participants. Taking into account that a number of European Union countries have OAT services covered by their national health insurance plans, their (as well as other countries') experiences should be studied to adapt and implement international best practices in Tajikistan.

2.10. Jointly with the Ministry of Education and Science of the Republic of Tajikistan and heads of graduate and postgraduate medical education institutions and universities, take measures to improve professional training of doctors and nurses in the fields of substance dependence and psychiatry, and to include detailed OAT topics in relevant curricula and study programmes/syllabi.

2.11. Intensify efforts to apply the social contracting mechanism and involve NGO personnel to the delivery of OAT programme services. Ensure that all necessary conditions to enable this are in place, including the revision/adoption of appropriate regulatory framework, as necessary.

3. To OAT service providers, including managers of the OAT programme and the Republican Clinical Centre of Narcology named after Professor M. G. Gulyamov that provides operational and methodological support for the OAT programme:

3.1. Ensure that OAT sites establish a more convenient time to dispense medications to patients. One of the possible options is to establish pick-up and take-in hours both in the morning (07:00–12:00) and the afternoon (15:00–18:00).

3.2. Initiate a review of existing OAT clinical protocols to further improve them and to make them fully compliant with WHO guidelines and recommendations, particularly regarding eligibility criteria for OAT programme enrolment, and eliminating age restrictions.

3.3. Make the provision of qualified psychosocial support to clients as a key priority for the OAT programme. Jointly, with technical assistance of partners and donors, develop and implement a range of measures to address this high-priority task.

3.4. To improve the quality of the OAT programme and to ensure higher retention rates within the programme, consider developing an employment counselling and assistance programme to support clients who need such help.

3.5. Examine the financial feasibility of the existing staff structure at OAT sites. Analyse whether, and how, it can be rationalised to adapt to the workload of each particular site, and how it can be optimised given the available domestic funding in a limited-resource setting.

4. To civil society members, and communities of OAT clients and people who use drugs:

4.1. Draft a formal appeal letter addressed to all stakeholders, including the Ministry of Health and Social Protection of the Population; the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria; the Coordination Council on the Prevention of Drug Abuse; service providers, senior management of the OAT programme, as well as technical partners and donors, whereby the following issues should be raised: (i) expression of concern with existing risks which can undermine the sustainability of an OAT programme in the context of transition from donor support to domestic funding; (ii) stressing the serious gaps in the management of the transition; (iii) demanding urgent actions to address the identified challenges and barriers; (iv) calling on the government, technical partners and donors to provide financial, technical and methodological support to civil society members to ensure their meaningful involvement in all processes related to the implementation and sustainability of the OAT programme.

4.2. Together with the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria, the Ministry of Health and Social Protection of the Population, and senior management of the OAT programme, initiate the practice of conducting annual partnership forums to specifically review progress towards OAT programme sustainability in the context of the transition from donor support to domestic funding.

5. To technical partners and donors (including WHO, UNODC, UNAIDS, Global Fund, CDC, PEPFAR, etc.):

5.1. Taking into account the current economic situation in Tajikistan, continue providing funding to the national OAT programme.

5.2. Review the outcomes of the assessment of the sustainability of the OAT programme in the context of the transition from donor support to domestic funding in Tajikistan. In coordination and close cooperation with each other, agree on concrete actions to provide technical and financial assistance to implement the proposed recommendations to enhance OAT programme sustainability in the country.

5.3. Prioritise the provision of financial, technical and methodological support to civil society organizations, including communities of OAT clients and people who use drugs, in order to (i) foster the enabling environment to ensure their more meaningful involvement in the processes of on-going monitoring and improvement of the OAT programme; (ii) support community mobilisation efforts; (iii) strengthen communication and advocacy capacities; and, (iv) support a dialogue between civil society members and government agencies to discuss both investment

and allocation of national financial resources for the implementation of the OAT programme and options for cost optimisation.

5.4. Support the development and operation of various multi-sectoral platforms to facilitate sustainability planning for the OAT programme, to improve awareness on programme development issues among stakeholders, to strengthen policy, and to secure wider support to the OAT programme both at the governmental level and in the society. Encourage more active involvement of the academic sector in such multi-sectoral platforms.

5.5. When conceptualising any future technical and financial assistance, discuss with national partners and develop concrete steps and activities to ensure the continued sustainability of the proposed programmatic interventions.

5.6. Prioritise continued dialogue with the Government of Tajikistan to adopt a Plan for Transition from Donor Support to Domestic Funding with a corresponding budget, as well as to identify domestic funding sources for the OAT programme in transition. Continue to provide necessary technical assistance to cost the Plan.

1 Context

Tajikistan is a former Soviet republic of the Central Asian region with a population of 9,126,600 people (as of January 1, 2019), and of them 7,483,400 (82%) are under the age of 45. Most people—73.7% of the population—live in rural areas. The country's overall poverty rate is 27.4%. Poverty is widespread in rural communities where about one-third of the population lives in poverty (Statistics Agency under the Republic of Tajikistan President, 2019; World Bank, 2019). Life expectancy is 73.3 years for women and 69.1 years for men (2021–2030 Tajikistan National Health Care and Welfare Strategy, draft document, 27.11.2019).

According to a recently published analysis, the health care system of the Republic of Tajikistan (RT) remains heavily centralised, with health services "provided overwhelmingly within the public sector, focusing historically on hospital-based curative care" rather than on prevention services (Ahmed et al., 2019). As of 2016, the role of the private sector remains very small despite recent growths in diagnosis and ambulatory care (Khodjamurodov et al., 2016). However, following the approval of the accreditation process for primary health care facilities in 2018, 14 private primary health care units have received official accreditation to provide services in Tajikistan (2021–2030 Tajikistan National Health Care and Welfare Strategy, draft document, 27.11.2019).

In 2019, public spending on health in Tajikistan increased to 1.7 billion Somonis (1 US Dollar (USD) = approximately 10 Somonis (TJS)) which averages USD20 per capita, per year. Public health expenditure accounted for 2.3% of gross domestic product (GDP) in 2017. These levels are among the lowest among the Europe and Central Asia region countries (2021–2030 Tajikistan National Health Care and Welfare Strategy, draft document, 27.11.2019). Furthermore, the share of out-of-pocket spending (i.e. payments by patients and households directly to service providers) of total health expenditure ranged between 62% and 66% annually during 2013–2017, which is also one of the highest levels in the entire WHO European Region (World Health Organization, 2020). The average monthly wage of a medical worker is TJS831.13 (about USD85), which is 30% lower than the national average monthly wage of TJS1,233.82 across all industries (2021–2030 National Health Care and Welfare Strategy, draft, 27.11.2019). Health financing reform is still on-going. In the meantime, the currently available limited resources are not being allocated efficiently (World Bank, 2018).

In 2008, Majlisi Oli (The National Parliament) of Tajikistan enacted the Law "On Health Insurance in the Republic of Tajikistan", according to which the country was to establish a health insurance fund acting as a single-payer agency in the national public health care system; however, the implementation of this law has been postponed until 2022 (2021–2030 Tajikistan National Health Care and Welfare Strategy, draft document, 27.11.2019).

According to the Republican Clinical Centre of Narcology named after Professor M. G. Gulyamov and the Ministry of Health and Social Protection, drug treatment in Tajikistan is provided by specialised drug treatment facilities. Drug treatment services involve inpatient and outpatient treatment, relapse prevention, OAT, and rehabilitation programmes. Drug treatment facilities are also involved in programmes and interventions to prevent substance abuse (Makhsutov et al., 2019).

To coordinate the activities of ministries, departments, entities, and organisations of any type, public or private, in the field of substance abuse prevention, the Coordination Council on the Prevention of Drug Abuse was established. Several policies and programmes have been developed and put in place in the country with a focus on substance use, including:

- The National Strategy to Combat Drug Trafficking in Tajikistan, 2013–2020;
- The National Programme for the Prevention of Drug Dependence and Improvement of Drug Treatment Care in Tajikistan (operated from 2013 until 2017 and is currently completed);
- The National Programme on Countering HIV in the Republic of Tajikistan, 2017–2020.

These policy documents prioritise drug-related issues, such as reducing the demand for narcotic drugs, prevention of non-medical injecting drug use and HIV, improving drug treatment care, and implementing best practices in the sphere of treatment and rehabilitation of people with drug dependence.

Tajikistan has a long (1,344 km) border with Afghanistan—the world leader in the illicit production of opiates. Cross-border trafficking is a major factor affecting the dynamics and drug-use patterns of the local drug market in Tajikistan. As of 31 December 2017, a total of 6,947 people with drug dependence were registered by the narcological facilities in Tajikistan, of whom 79.2% were heroin-dependent and 11.7% were opium dependent. In 2018, there was an estimated number of 22,208 people injecting drugs (opiates) (mid-point prevalence, with a range of 19,058 to 23,684). The HIV prevalence reached 11.9% in this population group (Makhsutov et al., 2019; Republic Centre for AIDS Prevention and Control, 2019).

In this context, the need to introduce an OAT programme in place in Tajikistan was first discussed at the national policy level in the document, "Strategic Plan to Prevent the Spread of Human Immunodeficiency Virus (AIDS) in the Republic of Tajikistan, 2002–2005," which was approved by a Government resolution in 2002. In 2003, the Law On Drug Treatment Care was put into force (and ceased to be in force following the introduction of the RT Health Code in 2017) by which "administration of alternative substitution therapy to patients with drug dependence" was stipulated as a reason for admission to a drug treatment inpatient facility and also was listed among the assigned tasks of health care facilities providing inpatient drug treatment services. Despite this, the OAT programme was only endorsed by the RT Government's letter of October 2008 (No.18691/16-3); and in July 2009, the Minister of Health signed a decree, "On the Introduction of Substitution Therapy" to implement a pilot programme to be fully funded by the Global Fund and other technical assistance organisations (Latypov, 2010; The Drug Control Agency, 2013). The OAT pilot programme was launched in February 2010 with donor support; its first service delivery site began operating in June 2010 - almost a year after the official Ministry of Health (MoH) decree was signed. Since 2017, OAT programme services have been available in the penitentiary system. As of January 1, 2020, 15 OAT sites were operating in the country, including 2 sites in the penitentiary system, providing services to 638 programme participants (2.9% of the estimated number of people who inject drugs) (Kim, 2020). Since its introduction in Tajikistan, OAT has been provided to programme participants free of charge.

Currently, Tajikistan remains on the list of countries meeting the Global Fund's eligibility criteria for funding of HIV and TB (The Global Fund, 2019a). Moreover, according to World Bank classification, Tajikistan is the only low-income country in the entire EECA region. Global Fund's projections up to 2028 demonstrate that the country will continue receiving the agency's funding (The Global Fund, 2019b).

In the meantime, the actual transition from donor support to domestic funding is being implemented as part of the long-term, incremental reduction of funding available from the Global Fund to support the national response to HIV in Tajikistan in the relevant allocation periods. For instance, the amount of funding allocated by the Global Fund for the HIV programme during 2018–2020 amounted to USD12,939,544, which marks a 43% decrease compared to the previously allocated amount for 2015–2017 (Tajikistan CCM, 2017). The initially allocated funding for HIV for 2021–2023 amounted to USD14,362,894, which is also less than the previously allocated amount for 2015–2017. However, in February 2020, the Global Fund Board approved an additional allocation of funds of USD5,324,308 for 'grant activities optimisation' in Tajikistan.

There is very limited information on financing of the national substance abuse services in Tajikistan; the most recently published the National Report on the Drug Situation in Tajikistan (with a chapter on Budget and Funding) does not provide any data on this matter (Makhsutov et al., 2019). The OAT programme in Tajikistan continues to be funded through grants provided by donors and international organisations. The government's share of OAT programme funding is limited to covering direct costs of utility bills; the government also provides office premises for OAT sites, with renovation costs paid through external funding.

2 Purpose and methodology

Several frameworks have recently been conceptualised within the context of assessment of sustainability of the HIV and TB response and its transition to domestic funding. Almost all EECA countries receiving Global Fund support have carried out such assessments and developed their own national transition plans.

In 2019, the Eurasian Harm Reduction Association (EHRA) developed a country assessment methodology and a toolkit with special focus on the sustainability of OAT programmes. This was developed in response to ongoing calls and requests for support from EHRA members to assess the prospect of OAT programme continuation upon the completion of international projects that provide technical and financial support in their respective countries (EHRA, 2019). For a detailed description of the conceptual approach and all of the tools for such an assessment, please see: https://harmreductioneurasia.org/oat-sustain-method/

The assessment of the sustainability of the OAT programme in Tajikistan was carried out using the EHRA approach and tools in February and March 2020. The assessment highlights the current situation, progress made, and the risks and opportunities pertaining to the sustainability of OAT with an emphasis on programmatic aspects and a focus on the following three issue areas: policy and governance; finance and resources; and services.

The framework concept to assess OAT sustainability in the issue areas of policy and governance, finance and resources, and services involves 2 to 4 indicators for each issue area. Each indicator includes a set of benchmarks, with every benchmark having its components measured through a points system.

A consolidated framework for the assessment of OAT programme sustainability (please see **Annex 1** for a detailed version with benchmarks):

Issue Area	Indicators			
A. Policy and governance	Political commitment		Management of transition from donor to domestic funding	
B. Finance and resources	Medications	Financial resources	Human resources	Evidence and information systems
C. Services	Availability and coverage	Accessibility	Quality and integration	

This assessment includes a section with a summary, an analysis of the progress achieved, an overview of challenges and opportunities within each issue area, as well as general conclusions and recommendations for government ministries and agencies, national coordinating bodies, OAT practitioners, civil society, technical partners, and donors.

Progress towards the sustainability of the OAT programme in Tajikistan is assessed across the three issue areas. It is shown in a general summary table as well as in individual summaries by each issue area. The table below describes the sustainability scale with corresponding percentage values.

Scale for status of sustainability	*Description*	*Approximation of the scale as a percentage*
High	**High level of sustainability with low or no risk**	**>85-100 %**
Substantial	**Substantial level of sustainability with moderate to low risk**	**70-84 %**
Moderate	**Moderate level of sustainability, at moderate risk**	**50-69 %**
At moderate to high risk	**Sustainability at moderate risk to high risk**	**36-49 %**
At high to moderate risk	**Moderate to low level of sustainability, at high to moderate risk**	**25-35 %**
At high risk	**Low level of sustainability, at high risk**	**<25 %**

The OAT programme sustainability assessment - within the context of the transition from donor support to domestic funding in Tajikistan - has been conducted with the involvement of OAT programme participants and a team of national experts (as part of an Advisory Group). The Advisory Group included heads of governmental entities, international projects, and organisations operating in Tajikistan; OAT service providers; representatives of educational institutions, civil society, and technical partners. Please see **Annex 2** for a full list of experts who contributed to this assessment.

The main limitations of this assessment include the following: the assessment had to be completed within a short period of time; a limited number of well-informed experts and OAT programme participants were involved; no field visits were made to sites located outside of the capital city of Dushanbe (although phone interviews were conducted with civil society representatives and OAT programme specialists in Sughd Region and Gorno-Badakhshan Autonomous Region); and no visits could be made to OAT sites operating in the country's penitentiary facilities. Figure 1 presents the assessment methodology and the different stages involved.

Figure 1. Sustainability assessment methodology of the OAT programme in Tajikistan, February–March 2020.

3 Key findings: Policy and governance

Policy and governance	At moderate to high risk
Political commitment	Moderate
Management of transition from donor to domestic funding	At high risk

3.1 *Political commitment*

There is a favourable legislative environment for OAT implementation in Tajikistan. According to the Health Code (put into effect in 2007), OAT is among the drug treatment and social care services guaranteed by the state. OAT is also included in the existing National Programme on Countering HIV in Tajikistan, 2017–2020 (enacted by the RT Government Decree of February 25, 2017, No.89). OAT clinical protocols and clinical guidance, approved and put in force by MoH enactments, are to be implemented in all medical facilities that provide OAT services to people with opioid dependence (MoHSP, 2015; MoHSP, 2019). These protocols and guidelines were developed by the MoHSP Permanent Working Group for Coordination of the Development and Approval of Evidence-Based Clinical Guidelines, and were improved based on the lessons learned during the implementation of the initial operational guidelines on OAT which were adopted in 2009 at the OAT introductory phase (MoH, 2009). There are also clinical guidelines on OAT developed for health care facilities of the penitentiary system (MoHSP and the Ministry of Justice, 2015). In these clinical documents, OAT is described as one of the most effective methods of treatment for opioid dependence. According to the MoH decree "On the Improvement of Drug Treatment Care in the Republic of Tajikistan" (dated 07.08.2006, No.485), OAT is included in a list of basic components of the standard sets of drug services. There are services in place within the MoHSP structure which are responsible for compliance with clinical protocols; the previously instituted office of Chief Narcologist has also been in place and has been continuously operating. In addition, the MoH National Centre for Monitoring and Prevention of Drug Dependence was established in 2008 which historically has been playing a very important role in the development and support of the OAT programme. Both methadone and buprenorphine were included in the National List of Essential Medicines (in 2015 and 2018, respectively).

At the same time, there are some barriers and challenges related to political commitments that have a negative impact on the sustainability of the OAT programme in Tajikistan. Even though the national OAT programme has been successfully implemented for some 10 years, it still has the pilot project status as the completion of its "pilot" or "trial" phase has not been confirmed by any of the programme-related regulations or programme enactments that enabled the initial introduction of the OAT programme. In the National Programme for the Prevention of Drug Dependence and Improvement of Drug Treatment Care in Tajikistan (completed in 2017), the treatment with a "substituting replacement" was referred to as a "trial programme." The Health Code still uses a vague wording of "alternative substituting therapy" which was first introduced back in 2003 when

describing OAT as a method to be used in the inpatient drug treatment facilities (RT Health Code, 2017).

In the National Strategy to Combat Drug Trafficking in the Republic of Tajikistan, 2013–2020 (approved by the Decree of the RT President on February 13, 2013, No. 1409), which particularly prioritises measures to improve the national substance abuse services, drug treatment and rehabilitation for people with drug dependence, there is no references to OAT. It is worth mentioning that this Strategy was approved in February 2013, at the time when OAT may not have enjoyed the same level of political support in Tajikistan as observed thereafter.

The contemporary agenda still has several key issues to be addressed, including the narcological registration system, collaboration with law enforcement agencies, and the compliance of national clinical protocols with the WHO guidelines. Currently, OAT programme enrolment implies having an opioid dependence diagnosis, which, in turn, entails registration with the narcological system. The linkage to the official narcological registration system significantly affects the fundamental human rights of people with drug dependence (Mravcik et al., 2014; UNODC and the Canadian HIV/AIDS Legal Network, 2010) and may lead to a breach of confidentiality of personal medical information in some cases under the law.

According to the Health Code (Article 204), "drug treatment facilities within the health care system and other similar facilities are required to cooperate with law enforcement agencies in the framework of rendering substance abuse services to people with drug dependence in order to prevent them from committing any potentially harmful or life-threatening actions, either self-directed or towards other people." The decision on whether - or not - the risk is life-threatening or potentially harmful lies with law-enforcement personnel and can be subject to subjective interpretation. In the case where there is actually no life-threatening risk, ill-informed law enforcement actions may lead to factual violations of human rights and freedoms which are guaranteed by the Constitution and other national laws. Linking to the narcology registration system also exposes programme clients to blanket discrimination in the employment sphere, without using an ad hoc approach and considering individual circumstances on a case-by-case basis (Article 196).

In this regard, according to both experts and OAT programme clients interviewed, the mandatory registration of clients in the state narcological registration system is one of the main barriers that discourage people with opioid dependence from accessing the OAT programme.

In reality, according to recent studies (Alexandrova and Maron, 2019; Sharipov et al., 2017) conducted in Tajikistan, linkage of people with drug dependence to the narcological registration system "always makes people vulnerable to law enforcement actions" and may have highly negative consequences for them. For instance, in the city of Kulyab, "it was noted that the registry of people with drug dependence was used when police needed someone to hang an unsolved crime (theft or robbery) on" (Alexandrova and Maron, 2019). Similar cases were reported by several OAT programme participants in the city of Khujand, where police would detain drug users near OAT service sites for no reason other than to investigate a theft committed anywhere by someone else (Sharipov et al., 2017).

A case reported by participants of a focus group in Kulyab:

"There was one guy, also on methadone. We are not sure about his name. His year of birth was 1999. He was recently detained by police as a suspect for stealing a mobile phone from some woman. He didn't steal it, actually. The woman whose phone was stolen at the market place was the wife of a prosecutor. When she had her phone stolen, she asked her husband to ask the police to find the thief. Policemen failed to find the thief. The prosecutor put pressure on them, demanding immediate actions to investigate and find the thief. Policemen took that innocent guy and charged him with theft. They also brought several of us to the police department to testify against that guy. As we saw, this guy might have been tortured, he had bruises in his upper back. He is still under investigation now. We cannot file an appeal against the police to the attorney's office or to the local administration (Khukumat) accusing them of using torture against us and to force us to testify. If we do this, the government will never fire any police officers for the sake of us. The government will trust them, not us."

(Alexandrova and Maron, 2019)

According to the existing law, the use of drugs and psychotropic substances without a doctor's prescription is deemed illegal and prohibited (Law "On Narcotic Drugs, Psychotropic Substances, and Precursors", Article 15), although penalties for drug use are not set forth in either the RT Code on Administrative Offences or the Criminal Code. An administrative penalty is imposed, in particular, for the acquisition and possession of drugs for personal use if the amount of narcotic or psychotropic substances is below a "small size". Possession of any amount over 0.5 grams of heroin is subject to criminal liability (The Drug Control Agency, 2012; UNODC and the Canadian HIV/AIDS Legal Network, 2010; RT Administrative Code).

In recent years, health workers and civil society representatives have repeatedly reported continuous abuse and harassment experienced by OAT clients at the hands of law enforcement officers. Those officers actively discourage OAT clients from accessing the programme and using methadone because this is "more profitable" to those officers when users consume illicit drugs. Illegal drug users caught by such corrupt officers may then be offered a 'deal', meaning "pay money" or "go to jail." "That's why they say, "Methadone is harmful, take heroin instead" (Interviews with experts, 2020).

A case reported by focus group participants:

"Misguided actions of law enforcement personnel were also reported in Vahdat District. In particular, participants reported the following: "Policemen or counternarcotics officers often watch us coming to the facility to consume our methadone doses. They would even keep an eye on who is coming to see the doctor and who is not. If one of the PWID does not show up at the OAT site for a few days, police or counternarcotics officers would stop us and interrogate us: "Who are you? How long have you been on methadone? Where's that guy (who doesn't show up)? Why is he not coming to the OAT site? Is he taking drugs?" And so on. They usually use coarse language while talking to us. Police and counternarcotics officers usually tell us, "Don't take methadone, it will kill you. You better take heroin. Heroin is better than methadone." It was also reported in Kulyab that, at any time, someone from the police department, Counternarcotics Unit, or the State Security Committee could come in and take pictures of them as they take methadone."

(Alexandrova and Maron, 2019)

As far as clinical protocols and OAT guidelines are concerned, they are not yet fully compliant with the WHO guidelines even though they are reviewed and updated on a regular basis (please see below for details). Existing national guidelines contain very important information; however, in some cases, they are rather general and not instrumental in promoting unified procedures and in improving the quality of services at OAT sites (Sirvinskiene, 2018). Moreover, programme participants receiving OAT services in the community have to discontinue treatment in the event of arrest and when placed in temporary detention facilities because OAT services are not available in such facilities.

Despite the existing challenges, there are opportunities to increase political commitment and ensure enhanced sustainability of the OAT programme. The National Strategy to Combat Drug Trafficking will be completed this year and a similar strategy is expected to be developed for the forthcoming period - this represents a real window of opportunity to unequivocally support and promote the OAT programme as a key treatment approach for opioid dependence as well as a key component of the drug policy based on a well-balanced approach to reducing the supply of, and demand for, illicit drugs. The National Programme on Countering HIV for the post-2020 period should also emphasise the Government's commitment to support and promote the continuous development of the OAT programme, particularly through a phased transition to domestic funding. Building upon the successful implementation of the national OAT programme for ten years, it is important to discontinue the use of outdated wordings such as "pilot" and "trial" and to recognise OAT as a comprehensive, evidence-based programme, which has proven to be highly effective in the country.

Furthermore, existing drug-related legislation needs to be reviewed to remove unjustified limitations and barriers impeding access to the OAT programme and to minimise the stigmatisation of people who

use drugs. The analysis of relevant legislation and policies, conducted a decade ago by UNODC and the Canadian HIV/AIDS Legal Network, provided a detailed overview of existing issues and a vast list of recommendations for reform and overcoming the legislative barriers (UNODC and the Canadian HIV/AIDS Legal Network, 2010). Many of these issues remain highly relevant today, and establishing a special working group to review and support the implementation of proposed recommendations for reform is highly recommended.

It is essential to ensure support for the OAT programme from police and law enforcement agencies and to put an end to the abusive actions of personnel that impede the OAT programme sustainability and encourage the use of illicit drugs. Available studies and information provided by experts and OAT programme participants demonstrate a strong relationship between the expansion of the OAT programme and the disruptive actions of corrupt law enforcement personnel and people involved in drug trafficking. In this regard, the development and sustainability of the OAT programme should be one of the main criteria to assess the success of the country's drug policy, with both health services and law enforcement agencies bearing the responsibility for the OAT programme sustainability.

Law enforcement agencies should adopt targeted, harm reduction- and OAT-related guidelines for their personnel, and appropriate measures should be taken to enforce the implementation of such guidelines. Over the next five years, at least half of law enforcement personnel should receive training on the issues of drug dependence, OAT, and the special needs of people who use drugs. It is crucial to also develop mechanisms to foster cooperation between law enforcement agencies, the penitentiary service, and healthcare services to ensure that OAT clients can continue receiving medication if they are arrested and placed in temporary detention facilities.

Speaking about management and coordination, it should be noted that there are authorised organisations, departments, or administrations in place in Tajikistan that are responsible for supervising and coordinating the development of the OAT programme. In 2004, the Coordination Council on the Prevention of Drug Abuse was established. There is also the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria (NCC) which was established to coordinate the activities of all stakeholders against the three diseases, regardless of the source of funding for these activities. According to updated NCC Bylaws (No. 127 as of February 28, 2015), the NCC comprises representatives of governmental entities, UN agencies, donors, international organisations, civil organisations, and representatives of "people living with/infected with the human immunodeficiency virus/acquired immunodeficiency syndrome, tuberculosis and malaria", as well as representatives of religious organisations. One of the NCC members is the Minister of MoHSP who acts as Deputy Chair of the NCC.

The Chief Narcologist of the MoHSP is not a member of the NCC. The Republican Clinical Centre of Narcology and the Chief Narcologist (drug dependence specialist) of the MoHSP - who is now also the Head of the MoHSP National Centre for the Monitoring and Prevention of Drug Dependence - are directly involved in the organisational and methodological management of the OAT programme. There is also the National Coordinator of the OAT programme whose position is funded through the Global Fund grant.

OAT programme achievements, successes and challenges in Tajikistan are discussed regularly, involving key stakeholders, including civil society, either at the regular NCC meetings or at the ad hoc technical meetings (the latter are conducted more often than the former).

However, there is a number of critical barriers and challenges affecting OAT programme sustainability (including their root causes and prerequisites) which have not been adequately addressed by the national coordinating entities for many years despite the deep concerns expressed by both OAT programme clients and the professional community (for more details, see below). These issues are regularly raised at various meetings and were highlighted in previous assessments of the OAT programme in Tajikistan (Boltaev et al., 2013; Laukamm-Josten et al., 2014; Sirvinskiene, 2018). The lack of transparent feedback and actions to address the barriers and challenges indicates that existing coordination mechanisms are not performing well enough in this regard. Importantly, the OAT programme is planned and budgeted within the context of HIV prevention programme (with a particular focus on HIV-related indicators) but is implemented within the framework of the drug treatment and care programme. As a result of this split approach, many programmatic aspects of OAT - as the main method of opioid dependence management - are being overshadowed.

Civil society representatives and OAT clients play a subordinate role in the existing OAT programme development and coordination mechanisms. Furthermore, programme participants noted that myths about methadone are widespread, not only in the general public but also among those who are in a position to make decisions that immediately affect programme sustainability. Decision-makers often prefer to not "widely advertise" the OAT programme in a society, where both people with drug dependence and people living with HIV are stigmatized. The term "methadone" itself, to a certain extent, remains a taboo for national mass media - partly due to the ban on "advertising of narcotic and psychotropic substances" (the Law "On Narcotic Drugs, Psychotropic Substances, and Precursors"), and partly due the presence of extensive anti-methadone content on the Russian-language websites.

"It is not allowed to advertise the OAT programme. There were journalists visiting several times, and they prohibited me to talk about methadone. They said, "Just say "therapy", that's it. "People might be wondering: what "therapy" they were talking about? Who can guess it's a therapy with methadone? Once you say "methadone", they go and search for information on Russian-language websites - and, oh, there is so much about methadone written there... So unless they talk to us and listen to us, they are not going to know the truth. They will only understand the programme when we explain that methadone does not create the same effects as heroin, and that those people on methadone, who do not additionally use other substances to get high, can live like all normal people."

"It is unlikely that our government will provide funding for us. That's what I think. They're never going to make it a publicly funded programme. There are so many myths about the programme. They receive information from other sources, not from the programme participants. These people who make decisions about the programme's future have misleading information. For them, [we are] "methadone addicts," you know, "drug addicts", "they are all getting high", "human wrecks"... Some of them [decision makers] may not even know what methadone is."

(Focus group discussion, 2020)

To enhance the role of communities of people who inject drugs and OAT clients in the structures and mechanisms responsible for the coordination and development of the OAT programme, donors and technical partners need to continue providing technical assistance to strengthen community capacities at both national and local levels. It is important to foster an enabling environment to ensure community's meaningful involvement in the processes of routine monitoring and improvement of the OAT programme, as well as in advocacy and awareness raising activities targeting various audiences.

3.2 *Management of transition from donor to domestic funding*

In Tajikistan, the National HIV/AIDS Response Fund was established by the Government (Decree No. 591 of September 6, 2014) as a state-run, non-budgetary organisation under the MoHSP. The main goal of the National Fund is to assist in securing funding for HIV prevention, diagnosis, treatment, care, and support activities conducted in the country.

In September 2015, the country's draft Position Paper on the Transition from International to Domestic Funding for HIV and TB Interventions including Harm Reduction Programmes (SPIN Plus, 2015) was presented at the High-Level Regional Dialogue on the Successful Transition of HIV and TB Response Interventions to Domestic Funding in EECA Countries.

In 2018, a plan was developed to transition from donor support to domestic funding for a period up until 2025. Within this plan, measures to increase the coverage of key populations by comprehensive prevention services are expected to be supported by national funding. The OAT programme is not

specifically mentioned or considered in this document. Even if the OAT programme is envisioned as part of the comprehensive service packages for key populations, the programme will be considered within the context of interventions for HIV prevention.

Despite the measures taken, there are significant gaps in the management of the transition from donor to domestic funding in the country. From the very beginning, at the initiation phase of the OAT programme in both the civil sector and the penitentiary system, it has always been emphasised that OAT services are being implemented with donor funds (MoHSP Decree "On the Introduction of Substitution Therapy", 2009; "Plan of Measures to Introduce, Implement and Scale-up Programmes of Substitution Maintenance Treatment with Methadone in the Penal System of the RT Ministry of Justice, 2012–2017", 2013).

Although the draft country Position Paper on the Transition from International to Domestic Funding suggested that USD127,100 would be allocated by the national budget to support methadone procurement and to pay wages to OAT programme personnel in 2017 and 2018, this Position Paper has not been formally approved and the funding was never allocated.

The plan for the transition from donor support to domestic funding for the period until 2025, which was developed in 2018, has not yet been formally approved and costed. It is planned that by the end of 2023, the costs will be calculated for prevention service packages for key populations, and that from 2024 (or from 2022, according to a different version of this document), these services will be funded or co-funded by the government. However, the OAT programme is not specifically mentioned in this plan, even though for the transition planning these programmes require much more political support and technical expertise (in all areas including planning, programme management, training, finance, and procurement, etc.) as compared to other low-threshold prevention services for key populations. There is also no approved cost calculation methodology to estimate the costs of OAT programme and its components. Also, stakeholders have not yet agreed as to which domestic funding sources should be used for financing OAT services during, and after, the completion of the transition process. Therefore, the conclusion drawn is that there is currently only a formalised, but not duly approved, document outlining a roadmap for the transition to domestic funding; however, there is clearly a lack of a holistic vision and leadership in promoting the financial sustainability of the OAT programme.

As a whole, the prospects for domestic budget allocations to fund the OAT programme are not very optimistic at present. Tajikistan is the only low-income country in the region; public health expenditure recently accounted for only about 2% of GDP, and public health expenditure per capita does not exceed USD20 per year; the health financing reform has not been completed yet; currently available resources are limited, highly fragmented and not allocated efficiently; the OAT programme does not appear to be a top priority within the framework of the national response to HIV and to other public health challenges.

However, there are a number of opportunities to address these challenges and to mitigate the impact of the transition to domestic funding.

Measures to address existing challenges should, first of all, promote dialogue on public investment and cost optimisation, and include the development and implementation of advocacy activities for various

budget cycle stages, actively involving OAT clients and other civil society representatives (EHRA, 2018). It is important to provide technical and methodological support to communities of people who inject drugs (PWID) and to engage them in the dialogue on financing of key services (ECUO, 2016).

Although it has been quite a while since the National HIV/AIDS Response Fund was established, its potential has not yet being fully studied and utilised. As highlighted by other authors, it will also be important to pay attention to the Fund strategic management issues (Varban et al., 2015).

Implementation of the Law "On Health Insurance in the Republic of Tajikistan" is expected to start in 2022. According to this law, the country will establish the Health Insurance Fund, serving as a single-payer agency in the national public health care system. Taking into account that a number of European Union countries have OAT services covered by their national health insurance plans (Subata, 2012), their lessons should be learned to inform the adaptation and implementation of international best practices in Tajikistan. Many potential OAT programme clients do not have all of the required identity and other documents, and they will need free legal and social support services to obtain and/or restore such documents. For people who cannot afford health insurance, or who are not eligible to apply for it for any reason, the OAT programme will have to remain fully accessible and funded from domestic sources.

While making decisions regarding the OAT service package components and subsequent cost calculations, it will be important to build upon the relevant experience of other countries of the region which have established health care service packages and allocated national funding for OAT services. For example, in Ukraine, as of February 1, 2020, OAT services were being provided to 12,548 clients at 215 healthcare facilities (OAT sites) in that country. In 2020, within the framework of the Programme of State Guarantees of Healthcare Services, the National Health Service of Ukraine purchases OAT services from health care providers in 2020, using new funding mechanisms (please see **Annex 3** for details on Ukraine's experience).

Figure 2. The main stages of building OAT programme sustainability in Tajikistan (past, present, future)

- OAT is implemented as a pilot programme
- Initial protocols and guidelines are developed
- Personnel received training, new service sites are opened, and OAT participants are enrolled

- Increased coverage, expansion of the OAT programme, particularly through primary health care and in penitentiary facilities
- Programme admission criteria are simplified
- An integrated service delivery model is implemented
- The data collection and analysis system is improved
- Methadone and buprenorphine are on the National List of Essential Medicines

- A phased transition to domestic funding
- Legislative and regulatory barriers are removed
- Further expansion of the programme, quality improvement
- The role of the community is strengthened
- The take-home policy is implemented
- The narcology monopoly over the provision of OAT services is ended
- Ensuring full continuity OAT programme across systems, services and institutions
- Collaboration with law enforcement authorities to prevent abuse and harassment of OAT programme participants

4 Key findings: Finance and resources

Finance and resources	**At moderate to high risk**
Medications	**Moderate**
Financial resources	**At high risk**
Human resources	**Moderate**
Evidence and information systems	**Moderate**

4.1 *Medications*

Methadone (MoHSP Decree No. 118, dated 12.02.2015) and buprenorphine (MoHSP Decree No. 326, dated 03.03.2018) are both included in the List of Essential Medicines of the Republic of Tajikistan. Both medicines are also on the National List of Narcotic Drugs, Psychotropic Substances, and Precursors, as strictly controlled drugs that can be used medicinally.

Currently, only methadone in liquid form is used by the OAT programme. The procurement of methadone for the OAT programme is implemented by UNDP which is the main recipient of the Global Fund grant on HIV in Tajikistan.

Purchases are made through a concurrent international supply system which operates alongside the national procurement and supply system. According to UNDP, upon delivery from the exporting country to Tajikistan, the supplied and received drug is stored at a UNDP warehouse facility and distributed to OAT sites as required. The volume of purchases is planned based on projections provided by the authorised national agency, making sure that there is a sufficient supply to avoid stock-outs. As a result, no stock-outs or systematic interruptions in the supply of drugs to any region of the country have ever been reported by clients and service providers.

In 2012, the recommended average daily dose of methadone (100 mg) cost USD0.77 (Boltaev et al., 2013), which amounted to some USD281 per client, per year. According to the annotated calculation tables presented in the country Position Paper on the Transition from International to Domestic Finding (2015), the cost is USD183.50 per client, per year, which equates to about USD0.50 per client, per day.

Many experts believe that the cost of medication in the OAT programme in Tajikistan could be significantly reduced if it was possible to supply methadone in powdered form so that the liquid preparation could be then produced domestically.

Reducing the cost of OAT medicine (including through the use of the tablet form) is a viable option to enhance the sustainability of the OAT programme and to optimize programme cost as the country undergoes a transition to domestic funding. For instance, in Ukraine, methadone is produced

domestically and is used in the national OAT programme in both liquid and tablet form, with the estimated annual cost of methadone amounting to USD50 (in tablet form) and USD143 (in liquid form) per programme participant (Ivanchuk, 2019).

4.2 *Financial resources*

Publicly available information on OAT programme funding (either by line-item or in total) is very limited in Tajikistan.

The government's share of OAT programme funding is known to be limited to covering direct costs of utility bills, and in providing office premises for OAT sites, with renovation costs paid by external funders (Country Position Paper on the Transition from International to Domestic Funding for HIV and TB Interventions, including Harm Reduction Programmes, 2015).

Global Fund grants have been, and continue to be, the main source of funding for the OAT programme in Tajikistan. Up until now, the Global Fund support has been used to establish and equip nine OAT sites (including 2 sites in the penitentiary system); to purchase methadone and additional equipment as required; to pay remuneration to OAT programme personnel (including on-the-ground service providers working directly with programme beneficiaries, and managers); and to cover the cost of staff training and capacity building. With the financial support of UNODC, two OAT sites have been renovated and equipped.

In addition, several OAT sites have been established with the support of the U.S. CDC and PEPFAR, including 3 fully operational sites and one "satellite" site (which only dispenses medication) within the national programme. One more "satellite" site is scheduled to be launched soon (as of the time of this assessment, work was nearing completion). During the opening phase, support (worth USD35,000) was provided to renovate and refurnish service site premises (covering expenses for renovation, alarm system, furniture, and equipment) to ensure that storage rooms, waiting-halls for patients, doctor's office and other rooms used for drug dispensing were in proper condition. Following the launch of sites, CDC/PEPFAR continues to support their operation by fully covering the expenditures for personnel wages, running costs, test kits, and mentoring visits (Muzafarov, written communication with the author, 2020).

The only publicly available source of information on the amount of funding for the OAT programme is the Implementation Plan of the National Programme on Countering HIV in Tajikistan, 2017–2020 (approved by the Government in 2017). The OAT-related tasks and activities (as shown in Table 1), as well as financial data presented in this document, are anticipated estimates only rather than factual data, and they do not reflect the real situation with OAT programme funding.

According to this Plan, OAT services should be co-financed from both public and donor funds. By the end of 2020, OAT is expected to be provided to 4,620 clients (20% of the estimated number of people who inject drugs). The volume of necessary funding for all OAT-related activities for 2017–2020 amounts to

TJS23,811,816, which is equal to USD3,052,797 (about USD763,000 annually)[2]. As a total, the Plan's budget for the implementation of the National Programme has a significant deficit amounting to 58.2% of the total funds required to implement activities planned for 2017–2020.

As noted above, this financial information is presented below as an illustrative example of national intentions only, while in a real situation, the vast majority of the OAT service costs are covered by international funding.

Table 1. OAT-related tasks and activities, the amounts and sources of funding under the Implementation Plan of the National HIV Programme, 2017–2020 (MoHSP, 2017), in TJS.

№	Tasks/planned activities	Years				Source(s) of funding
		2017	2018	2019	2020	
1	Purchase methadone for the OAT programme	1 794 592	2 182 400	2 291 888	3 024 800	GF, MoHSP
2	Establish and equip new OAT sites	374 400	378 300	350 000	499 200	MoHSP, GF, PEPFAR
3	Purchase additional equipment for existing OAT sites	0	367 536	0	0	GF, PEPFAR
4	Financial support for new and existing OAT sites	538 200	709 800	801 700	954 720	MoHSP, GF, PEPFAR
5	Develop and implement the roadmap to develop syringe exchange and OAT services	53 040	0	0	0	Republic AIDS Centre
6	Review, implement and operationalise new OAT-related clinical guidelines and protocols	17 160	17 160	17 160	17 160	MoHSP, GF, PEPFAR, civil society associations
7	Ensure regular monitoring of the quality of OAT services and provide training OAT health personnel	234 000	234 000	292 500	292 500	MoHSP, GF, PEPFAR
8	Purchase methadone for the OAT programme in penitentiary facilities	973 440	1 123 200	1 497 600	1 647 360	MoHSP, GF

[2] Based on an exchange rate of TJS7.80 per US Dollar.

№	Tasks/planned activities	Years				Source(s) of funding
		2017	2018	2019	2020	
9	Training for penitentiary personnel on the basic issues of harm reduction and OAT	111 540	113 100	113 100	113 100	MoJ, MoHSP
10	Training for medical personnel in prisons on case management of sexually transmitted infections and OAT	71 760	71 760	81 900	85 800	MoJ, MoHSP
11	Make the case for 5 OAT sites in the penitentiary system and introduce them, as required	57 720	70 200	171 600	234 000	MoJ, MoHSP
12	Expand HIV rapid testing among key populations at higher risk of HIV at OAT sites, voluntary counselling and testing services, STD clinics, and TB facilities	0	284 700	0	200 300	MoHSP
13	Introduce an integrated service delivery system covering HIV/tuberculosis/ OAT/antenatal clinics/ primary health care facilities for people living with HIV	182 520	171 600	171 600	171 600	MoHSP, GF, PEPFAR, UNICEF
14	Training on antiretroviral therapy (ART) administering and/ or case management at tuberculosis centres, infectious disease hospitals, reproductive health centres and OAT sites	0	195 000	0	197 200	MoHSP, GF, PEPFAR

№	Tasks/planned activities	Years				Source(s) of funding
		2017	2018	2019	2020	
15	Administering antiretroviral therapy at all OAT sites	59 000	39 000	39 000	39 000	MoHSP, GF, PEPFAR
16	Establish pilot centres of excellence for provision of integrated care to people living with HIV (including antiretroviral therapy, OAT, tuberculosis, and opportunistic infection treatment services)	81 900	0	0	0	MoHSP, GF
TOTAL BY YEARS (in TJS):		4 549 272	5 957 756	5 828 048	7 476 740	
TOTAL FOR ALL OAT-RELATED TASKS/ACTIVITIES for 2017–2020		TJS 23 811 816 or USD 3 052 797				

According to OAT participants, some of them have paid out-of-pocket for certain tests that they needed (between TJS20 and TJS200, according to experts and programme participants) during the programme initiation phase. This is related to the Governmental Decree No. 600 of 02.12.2008, the Regulations on the Provision of Health Services to the Citizens of the Republic of Tajikistan by the Public Health Facilities, and other relevant decrees and regulations issued and enacted in 2014. This decrees and regulations have established, among other things, a list of free-of-charge health services provided to citizens by public health facilities, the co-payment rules in health care, as well as a range of medical services to be provided, with specified scopes of services and costs.

4.3 *Human resources*

Before the introduction of the Health Code in 2017 (when the Law "On Narcological Care" became void), it was explicitly illegal under Tajikistan's legislation to provide drug treatment services to patients with substance use disorders in outpatient and inpatient settings outside of specialised drug treatment/narcological facilities, except for cases of compulsory treatment. Although this provision has not been included in the more recently enacted national Health Code, there is still a monopoly of the state narcology service over drug treatment provision in the country, including OAT services. The Health Code and existing MoHSP decrees (for example, "On improving drug treatment care in the Republic of Tajikistan"), guidelines and protocols refer to drug treatment solely as to specialised medical care to be provided in drug treatment facilities ("drug treatment hospitals, centres, rehabilitation units or social rehabilitation centres for drug-dependent patients, narcological offices in municipal and district health centres, where specialised medical care is provided in close cooperation with primary health care services to persons with psychoactive substance use

disorders") by narcologists/drug dependence specialists and psychiatrists, and in compliance with official drug treatment standards. General practitioners/family doctors and other physicians are not explicitly and unequivocally authorised to provide substance use services under any of these laws and regulations.

As reported by national agencies in 2019, there were 71 specialised drug treatment facilities in the country by the end of 2017, including 5 drug treatment centres, 52 local drug treatment offices, 1 drug treatment office for adolescents, 12 drug treatment inpatient facilities, and 1 Republican Centre for Medical and Social Rehabilitation, with a total staff of 67 drug dependence doctors (narcologists) (Makhsutov et al., 2019).

Some of the 15 OAT sites operating in Tajikistan are located at primary health care facilities, such as Health Centres. However, these sites do not employ general practitioners/family doctors on their staff.

Human resources of the national OAT programme, which is funded with a GF grant, currently involve two categories: (i) managerial personnel; and, (ii) direct service providers on-the-ground. The managerial team of the national OAT programme has a staff of 6 full-time employees, including coordination, management, capacity building, and administrative staff.

In addition to these national-level positions, each OAT site is staffed with one executive Site Manager position, and the following positions of frontline service providers:

- drug dependence specialist
- psychologist
- social worker
- pharmacist
- medical laboratory assistant
- medical attendant
- nurse
- security guard

There is also a peer-to-peer consultant — a NGO employee who is hired to facilitate service navigation for programme participants. This staff position is funded by ICAP to foster the integration of HIV, TB, and OAT services and cross-institutional integration of drug treatment facilities and NGOs. The number of programme clients varies widely from site to site, ranging from 15 (narcological dispensary clinic in the city of Istaravshan) to 109 (the Republican Clinical Centre of Narcology in the city of Dushanbe; data as of 31.12.2019). Therefore, workloads also vary significantly among employees depending on the site.

From a financial perspective, it will be difficult to maintain the existing staff structure within the context of the OAT programme transition to domestic funding due to limited healthcare spending in Tajikistan. It will be necessary to examine the feasibility of the existing staff structure and to analyse whether, and how, it can be streamlined to adapt to the workload of particular sites, and how it can be optimised to adjust to the limited resources currently available.

It is critical to recognise the significant challenges in respect to skilled human resources for national health care, including the lack of a system for strategic planning of human resources, the shortage of medical personnel, large scale migration and the outflow of high skilled personnel, significant disparities in the distribution of medical personnel between different geographical regions within the country, and the unfavourable working conditions (the average national healthcare wage amounts to some USD85 per month). An acute issue in Tajikistan is the professional training of medical specialists in some areas of expertise, particularly substance dependence specialists (narcologists) and psychiatrists (2021–2030 Tajikistan National Health Care and Welfare Strategy, draft document, 27.11.2019), as well as a national shortage of social workers and psychologists in medical facilities (Interviews with experts, 2020).

These healthcare human resource-related challenges affect the OAT programme in Tajikistan. As noted in earlier assessments, none of the OST sites included in the analysis "had a specially educated staff member with a degree in social work…most frequently these tasks were performed by doctors and nurses. Furthermore none of the MAT sites had a staff psychologist" (Boltaev et al., 2013). A recently conducted assessment of OAT sites also pointed out that "working at opioid substitution treatment sites is about having large workloads, it is stressful. Most employees reported having large numbers of patients they work with, shortages of personnel, and feeling underpaid" (Sirvinskiene, 2018). Currently, the situation remains very much unchanged; the fact that there are certain staff positions included in the staffing plan does not mean (1) these positions are actually filled, and (2) that these positions are filled with the right people who have the required professional knowledge and skills (Interviews with experts, 2020).

> "The potential of medical workers who work on the OAT sites is very weak, there are no drug dependence specialists, and no social workers. Doctors are leaving for Russia under resettlement programmes. Employees are friendly, but often not competent enough as professionals."
>
> (Interviews with experts, 2020)

Currently, the lack of specialists is especially critical for the OAT sites operating outside of the capital city, Dushanbe, and two particular sites in Dushanbe which are based in municipal health centres (No. 14 and No. (3). Another acute issue that the OAT programme also has to deal with is the outflow of professional cadres due to the lack of financial incentives (Interviews with experts, 2020).

Although it was recently reported that the state narcology service would have 5 interns and 2 clinical residents (specialty trainees) trained annually, the real situation is not so optimistic. In the course of their graduate medical training, students only have a very brief exposure to OAT-related issues through lectures on psychiatry and substance dependence. Students also have field visits to OAT sites for a short introduction to the organisational and practical aspects of the programme (Interviews with experts, 2020). Even those students who are intending to become narcologists/drug dependence specialists do not have the OAT subject in more detail within their course of study. OAT is currently not included in the curriculum of those students who "have almost completed general medical training and are now having an internship" (Interviews with experts, 2020). Therefore, OAT programme personnel have to be provided with specialised training at the workplace, involving training sessions on various subject issues, seminars, mentorship visits, and capacity-building activities, as well as study tours that are organized by the Global Fund and other donor and international organisations providing technical assistance. Nurses remain largely underserved by such educational initiatives (as these primarily target doctors), which has a negative effect on their capacities.

> "Well, in general, people do not go into the narcology field. Last year, we had one intern trainee, but he left. He stopped attending, switched to another specialty, just stopped showing up, and that's it. This year, it looks like we have one intern trainee again, but I do not know for how long he is going to stay... Why don't people choose this field? Well, they may be having lots of different reasons, but I think one of the main reasons is that they don't want to work with people with mental disorders and substance dependence issues. At the same time, maybe they are willing to go and work somewhere else, [a better place] more promising in terms of income from out-of-pocket payments and large flows of patients."
>
> (Interviews with experts, 2020)

A general situation in the field of psychiatry and drug dependence treatment over these past two decades has been reported as follows: a proportion of the qualified professionals have left the country, while the others who have stayed - to some extent this group consists of people who are "of senior age" or "the youth who are less and less willing to work in this field." "All qualified narcologists that we have can be counted on the fingers of one hand." "If this dynamic continues, in some 20 years we're screwed" (Interviews with experts, 2020).

It is evident that, with the state narcology service facing such human resource challenges, its continuous monopoly over OAT programme services in Tajikistan will be a significant barrier to programme sustainability and to achieving an adequate coverage level (programme coverage is still extremely low at

present). It is important to ensure, as soon as possible, that general practitioners/family doctors and doctors of other specialties are authorised to provide OAT-related medical services. The only special requirement for medical personnel to be authorised to provide such services (within their scope of practice) should be for them to have received a specialised, duly accredited, course of training, confirmed by the relevant certificate. Such training can be provided in a range of formats, including in-person (as a more traditional training format) and in format that combines both in-person and distance learning using video lectures, practical assignments, individual study, and testing material. Upon the completion of the distance learning component and having successfully passed the test, the trainee would be admitted to the full-time in-person training component held by an accredited postgraduate education provider. This intensive and short-term training component would involve practical workshops and seminars. Upon the completion of all training components, trainees would have to pass a final exam. It is worth noting that similar in-person and distance learning training programmes are already being successfully carried out in the region, therefore the implementation of such a specialised training programme in Tajikistan is feasible with some course adaptations (which are not likely to require the development of a totally new course).

WHO recommends that pharmacological treatment of opioid dependence should be widely accessible and include treatment services delivered in primary care settings. Patients with comorbid disorders can be treated in primary care facilities if these can provide specialist consultations as needed (WHO, 2009).

OAT services based at primary health care facilities are available in many countries implementing such programmes (Basenko et al., 2017; Subata, 2012). The advantages from a wider integration of the OAT programme into the primary health care services include the following: greater geographical accessibility integration of drug dependence medical and psychiatric services into mainstream services; reducing the stigma of drug dependence and the professional isolation of medical staff; decrease in waiting times (and congregation of clients at programme sites) for OAT clients; and reduced financial costs (WHO, 2009). At the same time, the diagnosis of opioid dependence continues to be the responsibility of substance dependence specialists and psychiatrists who may also perform other important functions (including initiation of OAT, safe induction and dose stabilisation, management of patients with complicated comorbid conditions, etc.).

4.4 *Evidence and information systems*

Since the introduction of the OAT programme in the country, several assessments and studies of programme implementation in Tajikistan have been conducted and published over the past 10 years, including the following ones (in the chronological order):

1. Opioid Substitution Therapy in Central Asia: Towards Diverse and Effective Treatment Options for Drug Dependence (Eurasian Harm Reduction Network. Authors: A. Latypov, D. Otiashvili, O. Aizberg, and A. Boltaev. 2010);
2. Opioid Substitution Therapy in Eurasia: How to Increase the Access and Improve the Quality (this briefing paper involves a review of programme implementation in Tajikistan) (International Drug Policy Consortium. Authors: A. Latypov, A. Bidordinova, and A. Khachatrian. 2012);

3. Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan (ICAP. Authors: A. Boltaev, A. Deryabina, S. Kholov, and A. Howard, 2013);
4. HIV/AIDS in Tajikistan. Mid-term Review of the National AIDS Programme 2011–2015 (involves a review of particular aspects of the OAT programme) (WHO. Prepared by: Ulrich Laukamm-Josten, Lali Khotenashvili, Baktygul Akkazieva, Svetlana Antonyak, Svetlana Cebotari, Lella Cosmaro, Sayohat Hasanova, Sowmya Kadandale, Iurii Kobyshcha, Jadranka Mimica, Otilia Scutelniciuc, and Emilis Subata. 2014). [In English];
5. Factors influencing the adherence to the opioid substitution therapy programme in Khujand, Tajikistan. Study report (NGO "Khujand". Authors: A. Sharipov, I. Nematov, and A. Abdugaffarov. 2017);
6. The analysis of activity of opioid substitution therapy sites in Tajikistan (UNODC. Author: A. Sirvinskiene. 2018).

All of these studies were produced with financial support from international donors without the direct involvement of the local research community. Although these country assessments were not directly led by the OAT client community, programme participants and professional staff were actively involved in the assessment process, sharing their views and opinions of the related issues. Their voices were heard, used in the analysis, and duly presented in the final reports. In 2015, the community of people who inject drugs, in partnership with the Republic AIDS Centre, has produced a national report entitled, "The National Harm Reduction Programme in Tajikistan: Who Is Going to Pay for the Nation's Health", to promote a set of recommendations to improve the harm reduction programme at country level (NGO "SPIN Plus", 2015). In addition, ICAP conducted an assessment in 2017 entitled, "Assessment of the Pilot Programme for Integrated OST, TB and HIV Services for People Who Inject Drugs in Tajikistan".

In addition to studies with a special focus on the OAT programme, an Integrated Bio-Behavioural Survey (IBBS) among PWID has been conducted in Tajikistan on a regular basis with support from donor organisations. One of the goals of such surveys was to produce national estimates of the size of the PWID population. These estimates are used to make projections of the current needs and to calculate the demand for services. These estimates are also used as a denominator in calculating OAT service coverage and gaps. The most recent assessment was conducted in 2018 and its results were published in November 2019.

One of the findings of the ICAP assessment (2013) was that "the system of monitoring and evaluation of MAT in Tajikistan has a number of deficiencies, including those related to the collection and analysis of data from the MAT sites. The system fails to enable proper evaluation of quality of the services provided, patients' satisfaction with the program and the actual effect of MAT on their sexual, drug use, and criminal behavior." Recommended response measures involved the following: "Improve monitoring and evaluation procedures for MAT, ensuring the collection and analysis of data related not only to program implementation, but also to MAT impact on patients"; and "to ensure standardization of data collected from various sites; simplify reporting forms; and introduce an electronic MAT program monitoring system that will increase data quality and reduce paper work for employees" (Boltaev et al., 2013).

These recommendations were later implemented with the help of donor support and ICAP technical assistance. The tasks were identified, background analysis was implemented, the forms, design, and architecture of the information system were developed, and the OAT Electronic Registry (ERSMT) was put in place. As part of the implementation of the MoHSP Decree No. 333 "On the introduction of the Electronic Registry of patients on substitution maintenance therapy with methadone in the Republic of Tajikistan" (dated 16.04.2015), the OAT Electronic Registry was introduced at all OAT sites throughout Tajikistan (Ivakin, 2015; Malikov, 2020a).

According to the Electronic Registry Manual, this "Registry is a web-based medical information system for the collection, storing and processing of data on all patients receiving OAT programme services. ERSMT is a full-range tool which is used to monitor OAT sites activities, to provide remote quality assurance of OAT services, and to assess OAT performance at different levels (such as individual sites, regional, and national levels) by generating data aggregation and disaggregation with any degree of detail. The OAT Electronic Registry contains socio-demographic characteristics of patients receiving opioid substitution therapy with methadone in a dynamic observation (including their sex and age, social and family status, education, marital status, criminal record), history of participation in the programme; dosage, dose adjustments and why adjustments were made; information about patients living with HIV (registered for follow-up with AIDS centres ("D-registry"), HIV clinical stage, antiretroviral therapy (ART) and treatment efficiency/outcomes, CD4 counts and viral load); data on TB cases, treatment and treatment outcomes; programme dropout reasons, cause of death, etc."

"The ERSMT is an on-line system available at: https://emr.icapapps.tj. To use the Registry, Internet access is required. For maximum security, a secure connection to the website is established using the TLS 1.2. protocol, and ECDHE-RSA is used for key exchange. To receive access to the web site, each user must have a certificate installed on each user's computer; access without the certificate will be denied. Each certificate is valid for one year only; when it expires, a new user certificate needs to be generated and installed."

(Malikov et al., 2018)

This information system has been fully handed over to the national partners implementing the OAT programme. These national authorities are responsible for the quality of the data in the system and its use to analyse the situation and progress made, as well as to inform policies and decisions of relevant local or national authorities to improve the OAT programme.

However, despite the presence and operationalization of this information system, there are no regularly published reports on OAT programme implementation. It is common practice to prepare presentations that are delivered by leading programme officers (members of the managerial team) at technical meetings with stakeholders. Such presentations are hardly available to the greater public, professional community, and/or the OAT programme client community.

Moreover, as shown in the table with comparative data below, many recommendations which were developed by previous OAT programme assessments in Tajikistan have not been implemented or were implemented only in part. In this regard, the Tajikistan OAT programme can be described as having "chronic" structural deficiencies which were often inherited from the regulatory and legal environment that was already established in the country by the time the programme was first introduced, and/or which were rooted in the organisational, methodological and procedural foundations of the programme that were put in place during the initial implementation stages. Many issues are also related to the limited capacities and the shortages of human resources. Please see **Annex 4** for a summary of data on all previous assessments of the OAT programme in Tajikistan, including identified weaknesses and gaps, proposed recommendations and opportunities for programme improvement.

5 Key findings: Services

Services	At moderate to high risk
Availability and coverage	At high risk
Accessibility	Moderate
Quality and integration	Moderate

5.1 *Availability and coverage*

As noted above, OAT services that are currently operated in Tajikistan are based primarily within specialised drug treatment and psychiatric facilities, such as the Republican Clinical Centre of Narcology, regional drug treatment centres, psycho-neurological facilities, drug dependence units, and, in addition, in health centres and two penitentiary system facilities.

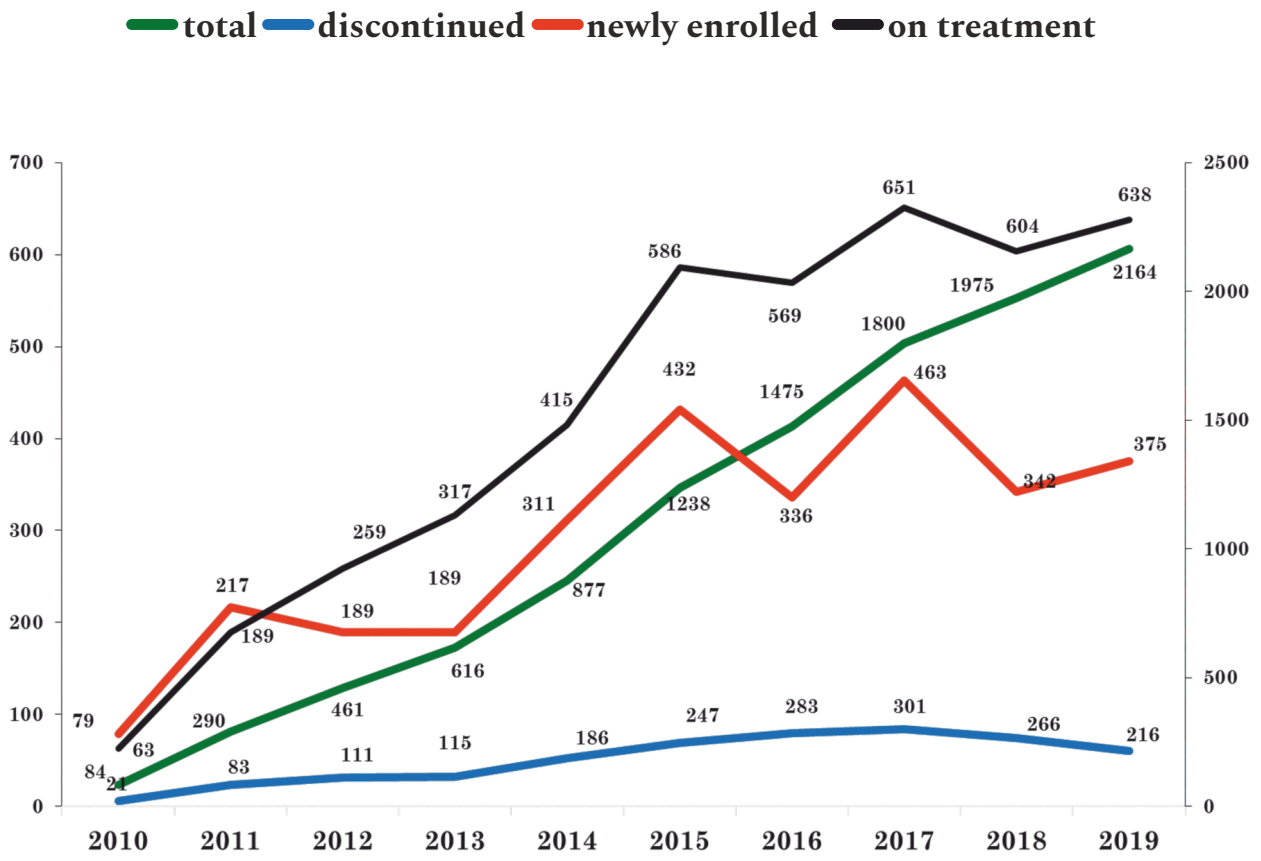
OAT services are provided in outpatient settings. If programme participants are hospitalised to inpatient health facilities for any health reason, programme staff facilitate uninterrupted services to ensure that the patient continues to receive treatment in inpatient settings.

Although several OAT sites are now operating in the primary health care network, general practitioners/family doctors are not involved in the provision of services in these facilities. Services are provided by drug treatment specialists. OAT services are not provided in private sector, although there is currently a project under consideration to establish an OAT site in the framework of a public-private partnership.

Although existing guidelines and clinical protocols support a take-home policy for self-administered therapy, this procedure is not applied in practice.

According to the data presented in January 2020 at a partners meeting to review successes, gaps and plans for further development of the OAT programme, a total of 638 people were receiving OAT at the 15 existing sites (as of December 31, 2019), including 32 (5%) women (there can be minor discrepancies in these numbers (several clients) due to recently updated OAT Electronic Registry data)

Figure 1. The numbers of OAT programme clients in Tajikistan, 2010-2019.



Source: Kim, 2020. Republican Clinical Centre of Narcology.

Given that in 2018 the estimated number of PWID who use opiates was 22,208 people, the coverage rate of the OAT programme amounts to around 2.9%, which is nowhere near the levels recommended by the WHO and other international organisations (any level of coverage below 20% is considered low).

OAT is provided in two facilities of the national penitentiary system to a very limited number of inmates with opioid dependence (about 20 people). No OAT services are available in temporary detention facilities. Programme clients who receive OAT in the community are unable to continue treatment in the case of arrest and when being placed in pre-trial detention facilities; they have to discontinue treatment. OAT is currently not provided to female inmates.

> "The programme faces a lot of challenges in prisons. Many drug traffickers are serving their time in prison as allegedly "drug addicts" because, in this case, they could get a shorter sentence, but they actually do not need any OAT. Those who are really drug dependent often serve their time for theft. They are unwilling to disclose their status and to access the programme, as this might cause more unnecessary attention and direct supervision from prison personnel. Besides that, many drug dependent people would have already gone through withdrawal at the first stage, in pre-trial detention facilities. After that, they might not want to go to the programme to take methadone, not at all."
>
> (Interviews with experts, 2020)

Therefore, regarding the overall availability and coverage rates of the OAT programme in the country, the situation can be described as having low level of sustainability and at high risk.

The centralised provision of OAT services through specialised drug treatment facilities can fuel stigma against people with drug dependence, which discourages a certain number of potential clients who would otherwise be willing to enrol in the programme. The lack of decentralised OAT services provided through the primary health care network has a negative impact on service availability and geographic coverage. But the major operational and organizational barrier to increased coverage and sustainability of the OAT programme might be the lack of implementation of a take-home policy to dispense medication for self-administered therapy to clients with a stable maintenance dose, even though this is not deemed illegal under the law nor prohibited by any other rules or regulations. This barrier has been reported by almost all national experts. It was also emphasised by all previous assessments of the country's OAT programme. These concerns are most vividly expressed by programme participants themselves, as made clear by their statements:

"Most folks are suffering [from this]. No take-home doses, people have to come to the programme site every day to pick up medication. These rules have us bound hand and foot, you cannot travel anywhere. Methadone makes life easier for us, but at the same time more complicated. It turns out like a vicious circle..."

"If we could change one thing within the programme, what would we change? To have a take-home policy for methadone implemented! If we could have take-home doses at least over weekends... Some people are sick, disabled, they need to stay at home, they walk with crutches. But even they have to come to the site daily to pick up a dose. It costs TJS20-30 to come to the site by taxi, this is terrible. We have a lot of these guys... Because of someone's reluctance to put a signature and to authorise [this policy], so many people are suffering. We don't know what to do about it."

(Focus group discussion, 2020)

The lack of implementation of a take-home medication policy is seriously impeding access to the programme in both urban and rural areas. For clients living in remote rural districts (15–20 kilometres from the treatment site) with underdeveloped transport infrastructure, daily travel to pick up a dose of medication can be unfeasible, particularly in winter. This can be the main reason for programme drop-outs in some areas (Sirvinskiene, 2018).

According to national experts, the reluctance of public decision-makers to authorise take-home doses can be explained by their concerns about potentially increasing the risk of diversion of OAT medicines to the illicit market. Potential risks of non-authorised use of controlled substances may exist within any programme modality. However, with due measures taken, the social, economic and public health benefits from the implementation of a take-home policy, to enable stable patients to pick up medication for self-administered therapy, will vastly outweigh the risks.

"They don't authorise take-home doses, they think it will cause some diversion. Let those who do it be brought to justice. Why do we all have to suffer because of this?"

(Focus group discussion, 2020)

Opioid agonist therapy and COVID-19

Nowadays, when the world is facing the COVID-19 pandemic, the OAT service modalities in Tajikistan are at odds with social distancing, self-isolation and other prevention and control measures recommended by the WHO to prevent the further transmission of the coronavirus. Programme policies require that clients attend OAT sites at drug treatment and other facilities on a daily basis to pick up medication. Many clients may have a weakened immune system, lung disease and other co-morbid conditions.

In light of the coronavirus pandemic, in order to enforce quarantine measures and social distancing policies in Georgia, a decision was made to introduce a take-home procedure for programme clients (which came into effect on March 18, 2020). Under this procedure, all OAT programme clients can pick up 5 daily doses of medication once a week for self-administered therapy at home (Otiashvili, communication with the author, 2020). In Ukraine, the professional community and programme clients are also actively discussing and implementing additional procedures to simplify the take-home policy and to streamline the delivery of programme services in compliance with the quarantine rules, and sanitary and epidemic control regulations. In this regard, the Ministry of Health of Ukraine issued recommendations on March 18, 2020, to implement the following measures (Ministry of Health of Ukraine, 2020; Ivanchuk, written communication with the author, 2020):

- switch all patients to a take-home self-administered therapy mode using a "clinic-at-home" service modality;
- ensure that medicines for self-administered therapy are dispensed in a way that there is only one patient in the room at a time, and the distance between other patients waiting in the line is not less than 1.5 metres;
- establish individual schedules for patients to visit OAT programme sites, and to extend the site operating hours;
- provide all consultations in an online mode as much as possible.

These examples (see also, "The Position of Correlation—European Harm Reduction Network and the Eurasian Harm Reduction Association on the Continuity of Harm Reduction Services During the COVID-19 Crisis") illustrate emergency response approaches adopted in some of the EECA countries which are building on flexible and well-informed decisions to ensure that benefits of preventing the spread of coronavirus will vastly outweigh any possible risks of diversion of negligible amounts of controlled substances.

In the current situation, it is essential to immediately reconsider and approve the introduction of the take-home policy/procedure to dispense medication to Tajikistan's OAT programme customers for self-administered therapy.

5.2 *Accessibility*

OAT programme sites are open in several regions and cities of Tajikistan, including the capital, Dushanbe, as well as other cities such as Khujand, Khorog, Bokhtar, Kulyab, Penjikent, Vahdat, Buston, Istaravshan, and Rudaki District. Several sites are operating in the cities of Dushanbe and Khorog. Although these sites provide for significant geographic coverage, some parts of the country are not covered by this network, including the north-eastern part of the Republic and some of the major cities and local communities in Sughd Region, Khatlon Region, and Gorno-Badakhshan Autonomous Region, and particularly in the areas along the border with Afghanistan. As was pointed out in previously conducted assessments, in the Gorno-Badakhshan Autonomous Region, "many people with opioid dependence are not residents of Khorog. They live in other cities, such as Porshinev, where opioid use is widespread. Therefore, most people with opioid dependence do not have access to these programme services because of long distances" (Sirvinskiene, 2018).

At the time of this assessment, it is not required for programme enrolment to have a confirmed history of previous unsuccessful treatment attempts for opioid dependence (which used to be one of the admission criteria at the initial phase of the programme). Moreover, it is clearly stated in the national guidelines and protocols that illicit drug use cannot be a criteria for exclusion of participants from the OAT programme. Most OAT sites comply with these rules as outlined in national guidelines, which was confirmed by both experts and programme participants ("it used to be tougher previously, now they are more tolerant").

According to the guidelines and protocols currently in effect, there should be monitoring and evaluation, individually tailored treatment and testing plans, as well as individual support plans for each programme participant. However, it was reported that in practice, treatment plans, individual support plans or withdrawal strategies for programme discontinuation may have been developed in a rather formalistic way, rubber stamped with no patient-centred approach and no attention to individual needs and behaviour changes (Sharipov et al., 2017; Sirvinskiene, 2018).

> "When you came to the programme for the first time, did they explain to you what is methadone, its advantages and disadvantages?
> No, they didn't, they just produced an agreement for me to sign. It's only later, over time, that we have started learning things."
>
> (Sharipov et al., 2017)

There are also no discriminative restrictions in the OAT programme guidelines and protocols against any populations with special needs. The needs of pregnant women are particularly underlined in those policies. However, as pointed out by national experts and as highlighted in a recent survey of OAT sites working at the local level, the needs of women who use drugs and the needs of younger clients may not always be taken into account.

"This can be illustrated by one interview with a female patient who is receiving treatment at one of the OAT sites. In this interview, the female patient answered openly about the challenges she faces, including raising three little kids, her partner's dependence, her constant mood swings, and her anxiety. However, she said she could not talk to her dependency doctor about it because he's a male, and she thought the doctor would not understand her. The social worker in her programme is also a male. Other programme personnel working at the site, such as nurses, did not understand all her problems; she said they would only offer a formal reply, for example, 'brace yourself and go on, you have to live for the sake of your children."

(Sirvinskiene, 2018)

According to the guidelines and protocols currently in effect, a restricting criteria for programme enrolment is the 18-year-old age threshold because (according to these guidelines) young opioid users will be unable to provide informed consent. The same applies to people with mental disorders who are also barred from OAT programme enrolment. Non-injecting opioid users are not considered for programme enrolment either.

Despite the age-based restrictive criteria in the existing guidelines and protocols, national experts noted that, in practice, decisions are guided by the Operational Guidelines on Opioid Substitution Therapy (MoH, 2009), according to which, "in exceptional cases, patients under the age of 18 can be admitted to the OST programme on a case-by-case basis and only with the written consent of their parents or legal representatives, which requires a special decision to be made by the special consulting committee for each particular case."

Given the estimated number of PWID in the country and the need to significantly increase OAT programme coverage, the state narcology service does not currently have sufficient capacity to meet the potential demand. According to the most recently available data, there are no waiting lists for OAT programme enrolment in the country. However, national experts have already reported some cases whereby programme admission was refused under pretexts such as "no spots available", with the actual reason being to avoid an additional workload (from expert interviews, 2020).

It is important to note that diagnostic and treatment services in outpatient and inpatient settings, rendered by specialised narcological facilities, are provided on a fee-paying basis in Tajikistan (MoHSP, 2014). This also includes detoxification services.

According to List 2 in Annex 1 to the "Regulation On Co-payment for Health Services, Provided to the Citizens of Tajikistan by Public Health Care Facilities," passed by a joint Decree of the MoHSP and the Ministry of Finance of Tajikistan No. 938-135 as of November 5, 2014, people living with HIV/AIDS are only entitled to free medical care for their underlying disease. Accordingly, opioid dependence treatment services are provided on a fee-paying basis to them, as well as to people with opioid dependence with negative HIV status.

Client fees for drug treatment services serve as a barrier impeding access to drug treatment in general (Makhsutov and co-authors, 2019) and OAT services in particular, as out-of-pocket payments are required for certain tests at the initiation of the treatment phase (Interviews with experts and a focus group discussion, 2020).

The OAT programme is currently provided on a free-of-charge basis to programme clients, which is an exception to the rules (made possible with donor support). However, many people have to pay for certain tests that are required to be admitted to the programme at the initiation phase. These regulations could become a major obstacle to achieving the sustainability of the OAT programme during their transition to domestic funding. To overcome this barrier, the adoption of a resolution that explicitly provides for the provision of OAT and related services on a free-of-charge basis is needed.

In previous assessments of the OAT programme, a number of key national experts have also noted that the country should consider the feasibility of providing OAT services on the basis of co-payment by programme clients (Boltaev et al., 2013). This mechanism is used in OAT service models in Australia, Bulgaria, the Czech Republic, Cyprus, France, Georgia, Hong Kong, Indonesia, Iran, Latvia, Mexico, Poland, and Ukraine; it is used to dispense medication through pharmacies and/or private sector sites/clinics, as well as some government sector facilities (Basenko et al., 2017).

Full or partial co-payment by clients provides them with the opportunity to have a better customer experience from programme enrolment with some preferential terms, such as: collection of medication from a pharmacy nearest to their place of residence; collection of take-home doses for a longer period of time; collection of medication at any time most convenient to them (for example, at 6am or 11pm, when most sites may be closed); using prescriptions to collect their doses from a pharmacy in any city of the country of residence, which gives greater freedom of movement; and/or collect medicine in more private and confidential settings, without seeing any other programme clients, which (as demonstrated by the quote from programme participants in Khujand) may be particularly important for people seeking to not disclose their status to any other people except programme personnel. For all other programme clients enrolled on general terms (which must nevertheless be in full compliance with the WHO recommendations), programme services should be provided for free. This requirement must be met when considering the feasibility of introducing the co-payment mechanism within the programme.

> "When you go to the narcology [site], you can be seen by someone else. Before coming any closer, I try to leave my car as far away as I can. If there are other cars around, I am waiting for them to leave, and this is what feels like a huge waste of time. They made a parking lot at the hospital, you can run into someone else there, too. You can say you just stopped by to get a medical certificate, but how many times can you say that? Once, twice, and at the third time it would ring a bell for someone: "hey, why you're here so often?" Some guys don't care. Not me, I have kids, and I don't want them to hear tomorrow that their father is a drug dependent or a methadone user."
>
> (Sharipov et al., 2017)

According to the guidelines and protocols currently in effect, OAT sites are supposed to be open 7 days a week, operating for at least 7 to 8 hours per day, except for holidays and Sundays (when sites may have shorter opening hours). In practice, all OAT sites dispense medication only within limited opening hours — from 7am to 12pm (some sites are reported to start working at 8am). Occasionally, when programme personnel are absent from their workplace, there could be delays in opening the service and programme clients must wait at closed doors until staff members arrive, and then they can pick up their medicine (Interviews with experts and a focus group discussion, 2020). Such opening hours may be an obstacle for many clients, which was also pointed out in previous assessments of OAT operating sites that suggested to split opening hours at some sites in two shifts: morning (07:00–12:00) and afternoon (15:00–18:00) (Sirvinskiene, 2018).

> "The opening hours at the sites are not convenient for everyone. It used to be more convenient when they worked until 3pm. Now some guys cannot make it in time. If you come at 12 o'clock, it's closed already."
>
> "People who have a working day starting at 8am, they are late to work. I personally know one guy who always has to be late for work, getting reprimanded all the time. All the time, he's always in trouble because of this."
>
> (Focus group discussion, 2020)

5.3 *Quality and integration*

With regard to the quality and integration of services, it should be noted that the OAT programme in Tajikistan is guided by the WHO recommendations to determine medication dosages. For instance, the optimal dose for methadone as set in the clinical protocol for most clients ranges between 80 and 120 mg/day (MoHSP, 2015). For buprenorphine, it is suggested that efficient daily doses usually range between 8 and 16 mg (MoHSP, 2019).

As noted above, buprenorphine is not currently used, but efforts are being taken to introduce it in the OAT programme.

As of the end of December 2019, the proportion of OAT clients receiving methadone dose of 60 mg or more for higher retention in the programme was 64%. Therefore, according to the WHO guidelines, Tajikistan is at an average level for this indicator. However, a patient-centred approach is important when the dosing regimen is selected and adjusted to determine an optimal maintenance dose for each client. In the course of this assessment, both national experts and the OAT clients pointed out a flexible approach applied by the Dushanbe site, whereby doses are adjusted according to individual needs, and some patients may have lower doses prescribed if it works for them (Interviews with experts and a focus group discussion, 2020). However, as noted in a recent study, an ambitious desire to reach higher performance indicators may lead to an unjustified increase in the number of OAT programme clients receiving methadone dosage of 60 mg or more at local sites.

"...I had withdrawal symptoms when I just started the programme, and I was taking 70 [mg] of methadone. It worked well for me then. Then I started to gradually decrease the dose - to 30, then from 30 to 25, then to 20. I was taking 20 [mg] — and it was fine, everything was fine! [an inspection commission came] And then they started to criticise the doctor, and we started to get +5 mg more every day. I tell them, I can't eat after I've had methadone. And I have constipation lasting for five days, I tell them. But they just say: well, you might be having a stomach problem!"

(Sharipov et al., 2017)

The national guidelines and protocols clearly state that the OAT programme aims at providing maintenance treatment, rather than short- or medium-term treatment regimens. As of the end of December, 2019, the client retention rate was at the average level. Based on the WHO calculation methodology (2015), the percentage of clients who are still in the programme at 6 months after initiating treatment is 77.6%. Of the 156 participants diagnosed with HIV, 143 (91.6%) received antiretroviral therapy.

From November 2014, a pilot project has been implemented, with the technical support of ICAP, to provide integrated HIV, TB and OAT services in a "one-stop" service modality at four OAT sites (in Dushanbe and at two cities in the Sughd Region), covering about 40% of the total number of OAT programme participants. Under this project, a number of activities were held, including training for narcology/drug dependence specialists, TB doctors, and infectious disease doctors to provide programme clients at those OAT sites with access to a range of services including HIV and TB prevention, testing, diagnostics and treatment, monitorings of immune status, drug interactions and toxicity, and treatment efficiency, as well as psychosocial counselling, and overdose prevention services (Kim, 2020; Malikov, 2020a). From November 2019, ICAP is providing financial support to AIDS Centre specialists seconded to U.S. CDC-supported OAT sites in Vakhdat, Buston, and Rudaki District in order to promote the integration of HIV and OAT services.

"At our narcology [site], they made it really awesome - it's called "one-stop". You come for methadone - and here you have ARVs first, then something for tuberculosis if you have TB, and what else do you have, and then you have your methadone, that's as far as I know."

"I always take ARVs in the morning. I have breakfast, then ARVs, and then I go to receive methadone therapy. Sometimes if I forget to take an ARV pill, I have to go back home from the site. Now, we have it like this: you bring your pills, leave them with the doctors, and you stop worrying about it - once you come to the site, you will have all [medicines] you need at one site."

(Focus group discussion, 2020)

According to the pilot project findings, the integration of HIV, TB, and OAT services through the OAT sites has resulted in reinforced efficacy of interactions between vertical healthcare services, and in an improved quality of services provided by healthcare personnel to patients. The introduction of the integrated service approach was cost-efficient and did not entail significant extra costs; the "one-stop" services continue to operate (Malikov, 2020a).

However, one of the main issues at present is how to institutionalise this service model and to scale-up its implementation across all OAT sites. Another significant issue, as pointed out by national experts, is the lack of access to viral hepatitis treatment because of the high costs of medication (Interviews with experts, 2020). There is a high demand for detoxification services for patients who, in addition to methadone, use additional substances without a doctor's prescription (Dimedrol, Somnol, etc.) or are alcohol dependent; however, since these services are provided on a fee-paying basis, they tend to be unaffordable for most clients (Sirvinskiene, 2018).

One of the most critical gaps in the provision of high-quality OAT services is an extremely limited provision of qualified psychosocial assistance to programme clients. As noted in a recent review of OAT programme sites, considerable gaps in psychosocial care is one thing they all have in common - with some sites making sporadic attempts to work on client motivation, while others providing no psychosocial support at all (except for provision of general information and counselling) (Sirvinskiene, 2018).

Many experts and programme participants involved in this assessment have noted that they did not see any significant changes in recent years. The widest range of services is provided by the programme site based at the Republican Clinical Centre of Narcology in Dushanbe. With a higher professional capacity of its team, this site can involve more highly-qualified professionals and patients themselves to provide better services. However, respondents pointed out that the case of the Dushanbe-based site is in no way representative of the situation at all other sites of the programme. Some of those psychologists who are involved in the provision of psychosocial support at the OAT site at the Republican Clinical Centre of Narcology in Dushanbe, are seconded from NGOs, with such personnel paid through international financial assistance. There is no established practice of using the social contracting mechanism to ensure a wider involvement of NGO personnel in the provision of OAT programme services. Therefore, in this case, "we are nowhere near the level of institutionalisation and sustainability" (Interviews with experts, 2020; see also Abdullaev et al., 2016).

"Other OAT sites either have no psychologists at all, or have workers who may not have professional knowledge and expertise. In educational institutions that provide psychology training, they only give theoretical knowledge, graduates have no practical skills. Even at those OAT sites that reportedly have a psychologist, they actually do not do much as psychologists, despite reports. If they sometimes conduct any consultation sessions, it could be even worse for clients. Well, sometimes the less the better, it might be better if they just got paid without providing "services" in the way they sometimes do it. Because if you have not been trained to do it - well, okay, it's not even about training, training is half the trouble... If you give false information to your clients, if you form wrong attitudes, if you stigmatise them, if you try to make them think within inappropriate frameworks, if you try to impose something with your highly-directive approaches — well, there maybe be only harm from such consultations."

(Interviews with experts, 2020)

To address existing issues (such as low quality of psychological and psychotherapeutic care for OAT clients; shortage of psychologists and psychotherapists working with PWID, and/or lack of such specialists at OAT programme sites), the ICAP project is currently developing and implementing an interactive, web-based training application for OAT clients (Malikov, 2020b). However, it is absolutely clear that a range of other measures and additional efforts will have to be taken to improve the quality of the OAT programme throughout the country.

Finally, alongside all of the above-mentioned barriers, many respondents pointed out that most programme participants urgently need help in gaining employment.

"What else can be improved in the programme? Would be great if they could help with employment. It could be an employment service with a special focus on job placement for OAT programme clients. Many people here have HIV, and you know — with this disease they won't find a job. You're not going to find a job."

"Wherever you go, for any job, employers now require a "no-record" certificate from the narcology service. How can we get such a certificate?! That's why we can never find a job. Fobbing us off. Help in employment, in job placement would be a great help to us."

(Focus group discussion, 2020)

6 Conclusions and recommendations

Based on the conducted assessment of the sustainability of the opioid agonist therapy (OAT) programme in the context of the transition from donor support to domestic funding, the **strengths and accomplishments** of the programme in the Republic of Tajikistan can be summarised as follows:

1. There are no legal barriers to the implementation of OAT in Tajikistan.

2. Since its introduction as a pilot project 10 years ago, the OAT programme has been significantly expanded with regard to both its coverage of people with opioid dependence and its geographical coverage and availability throughout the country.

3. There are authorised bodies in place that are responsible for the implementation, supervision, and coordination of the further development of the OAT programme in the country.

4. The country has adopted clinical protocols, guidelines, algorithms, and other regulations and operational documents which are necessary to foster an enabling environment for the implementation of the programme in accordance with the established criteria, rules, and regulations.

5. Methadone and buprenorphine are on the List of Essential Medicines of the Republic of Tajikistan.

6. Since the programme was first introduced, its admission criteria have been simplified and services have been made available in prisons following the introduction of the programme within the penitentiary system.

7. Through the support of, and cooperation with, projects providing technical assistance for the implementation of the OAT programme, the data collection and assessment framework has been significantly improved and the OAT Electronic Registry was established to enable informed decision-making on further OAT programme development.

8. Since November 2014, the country has been successfully implementing a pilot project to provide integrated HIV, tuberculosis (TB), and OAT care in a one-stop service modality. Under this project, four OAT pilot sites, which cover about 40% of the total number of OAT programme participants, provide access to a range of services including HIV and TB prevention, testing, diagnostics and treatment, monitorings of immune status, drug interactions and toxicity, and treatment efficiency, as well as psychosocial counselling, and overdose prevention services.

9. A significant number of OAT personnel received training, which has contributed to strengthening the overall health care system, including improved interaction and cooperation between vertical services (such as HIV, TB, and drug dependence treatment). As the OAT programme is funded from external sources as part of the HIV response, cross-programme coordination between these services is maintained at appropriate levels.

The above achievements serve as evidence indicating that the OAT programme receives political support from the government.

Meanwhile, the assessment reveals **moderate-level risks for the sustainability of the OAT programme in the context of its transition from donor support to domestic funding across all surveyed issue areas** (including policy and governance; finance and resources; and services). Indicators of particular concern involve the following: (i) management of transition from donor to domestic funding; (ii) financial resources; (iii) availability and coverage. These three indicators were assigned a high level of risk.

Major challenges and barriers to achieving greater sustainability of the OAT programme have been identified, as follows:

1. The national health care system faces significant structural challenges, particularly with regard to its financing and human resources.

2. The government's share of OAT programme funding is very limited and scarcely ever goes beyond covering utility costs; the government also provides premises for OAT sites, with renovation costs paid through external funding.

3. The OAT programme has been established in the country as part of the national response to HIV among people who inject drugs. This is the context in which the OAT programme has been considered up until now, rather than within the framework of building efficient drug policy based on a well-balanced approach to reducing the supply of, and demand for, illicit drugs.

4. The plan for the transition from donor support to domestic funding, which was developed in 2018, has not yet been approved by the government and implementation costs have not been calculated. Also, stakeholders have not yet agreed as to which domestic funding sources should be used for the OAT programme during the process of transition and after transition has been completed.

5. There is an insufficient involvement of the OAT client community in advocacy, education, and awareness programmes and activities aimed at overcoming myths about the OAT programme and in promoting dialogue on public investment in the programme.

6. The anticipated initiation of implementation of the Law "On Health Insurance" in the Republic of Tajikistan in 2022 may create additional financial barriers for OAT programme participants in the event that they do not have all of the required identity documents for health insurance, and particularly if they cannot afford to pay insurance fees.

7. Although OAT programme enrolment is free-of-charge for programme clients, services for diagnostics and treatment of psychoactive substance dependence, which are provided by specialised narcological facilities in outpatient and inpatient settings, are available on a fee-paying basis. This becomes a financial barrier to entry to the programme for potential low-income clients.

8. From a financial perspective, it will be difficult to keep the existing staffing structure (which is currently funded through Global Fund grants) within the context of the OAT programme transition to domestic funding due to limited healthcare spending in Tajikistan.

9. Although it has been quite a while since the National HIV/AIDS Response Fund was established by the government in 2014, it is not yet being fully utilised. How this Fund can be used to support any of the OAT programme components is still an open question.

10. There is no established practice of using the social contracting mechanism to ensure a wider involvement of NGO personnel in the provision of OAT programme services. The social contracting mechanism generally remains significantly underused in the country.

11. Currently, only methadone is used in the OAT programme. Methadone is used in liquid form which is much more expensive than methadone in powdered form. Methadone for the OAT programme is purchased through an international concurrent supply system which operates alongside the national procurement and supply system.

12. There is no comprehensive OAT continuity framework to ensure therapy integrity for transferred patients. If OAT programme clients are arrested or placed in pre-trial detention facilities, they have to discontinue treatment.

13. Both medical staff and OAT programme participants have pointed out that OAT clients may face harassment and abuse when dealing with police; some law enforcement personnel may create barriers for programme clients, discouraging them from programme participation.

14. Coverage of the OAT programme amounts to about 2.9% of the estimated number of people who inject drugs in the country, which is nowhere near the levels recommended by the World Health Organization (WHO) and other international organisations.

15. There is no take-home policy to dispense medication to stable programme customers for self-administered therapy, which has been (and still is) one of the major programming barriers to reaching adequate coverage and sustainability of the OAT programme. Moreover, in the context of the COVID-19 pandemic, a failure to implement the take-home medication policy is at odds with social distancing and other prevention and control measures recommended by the WHO to prevent the further transmission of coronavirus, which calls for urgent action to remove this barrier.

16. Many clients in need of OAT are discouraged from accessing the programme by its linkage to the official narcological registration system which significantly affects the fundamental rights of people who use drugs and is associated with a breach of confidentiality of individual health-related data.

17. According to existing guidelines and protocols, people under the age of 18 are not eligible to access the OAT programme, which is not in line with WHO guidelines.

18. All OAT sites dispense medication only within limited opening hours (from 7am to 12pm), which seriously impedes access to services for many programme clients, particularly those who are employed.

19. There is still a monopoly of specialist narcological care institutions over OAT services in the country. General practitioners/family doctors and other physicians are not explicitly and unequivocally authorised to provide these services under existing laws and regulations. This is the main barrier hindering the decentralised provision of OAT services through primary health care facilities.

20. There is a shortage of motivated and properly qualified health care personnel. Medical education and training of psychiatrists and psychoactive substance dependence specialists (narcologists) is an acute problem. OAT-related issues are not incorporated within the study curricula of medical schools/universities in the required detail and depth.

21. One of the most critical gaps in the provision of high-quality OAT services is an extremely low supply of qualified psychosocial support to programme clients. Most programme participants urgently need assistance with employment and/or capacity building to learn skills that are in demand in the labour market. However, such assistance is not provided within the current OAT programme.

22. Even though the national OAT programme has been successfully implemented for some 10 years, it still has a pilot project status as the completion of its “pilot” or “trial” phase has not been formally confirmed by any of the OAT programme-related regulations enactments.

Based on the conducted assessment, ***the following recommendations can be drawn to ensure greater sustainability*** of the OAT programme in the context of its transition from donor-support to domestic funding:

1. To the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria and the Coordination Council on the Prevention of Drug Abuse in Tajikistan:

1.1. Consider convening an ad-hoc joint meeting to address the sustainability of the OAT programme in Tajikistan in the context of coordination and harmonisation of the HIV/AIDS response and prevention and treatment of psychoactive substance dependence. This joint meeting should be held involving all stakeholders, including OAT service providers as well as OAT programme participants. In the future, such joint meetings should be held regularly.

1.2. Adopt a joint document outlining the position towards OAT as the primary method for opioid dependence management and emphasising commitment to support and promote further development of the OAT programme, particularly through a phased transition to domestic funding. Building upon the successful (as confirmed by country assessments) implementation of the national OAT programme over the past ten years, it is necessary to review the use of outdated wording such as "pilot" and "trial" and to recognise OAT as an evidence-based programme which has proved to be highly effective in the country. This position should be taken into account and used to inform the development of the forthcoming National HIV Response Programme in Tajikistan, as well as the forthcoming National Strategy to Combat Drug Trafficking.

1.3. Request the Ministry of Health and Social Protection of the Population to develop a roadmap to foster the development of the OAT programme in the country.

1.4. To review and approve the plan for the transition from donor-supported to domestic funding of the HIV response in Tajikistan, including its budget and the monitoring and evaluation (M&E) plan.

1.5. Analyse potential opportunities to support the OAT programme with funding from the National HIV/AIDS Response Fund and develop concrete steps to ensure implementation.

1.6. Ensure support for the OAT programme from police and law enforcement agencies. Initiate the development and introduction of special guidelines for law enforcement personnel on harm reduction, covering both general aspects and OAT in particular. Ensure that appropriate measures are taken to operationalise these guidelines, including disciplinary actions and other control measures and penalties for non-compliance.

1.7. Initiate the development and implementation of mechanisms to foster cooperation between law enforcement agencies, the penitentiary service, and health care organisations to ensure that OAT clients can continue receiving medication in case of their arrest and when being placed in pre-trial detention facilities.

1.8. Establish a special working group to review, update, and implement recommendations drawn from the assessment of the Republic of Tajikistan's legislation and policies conducted by UNODC and the Canadian HIV/AIDS Legal Network. These recommendations are presented in the report entitled, "Accessibility of HIV Prevention, Treatment and Care Services for People who Use Drugs and Incarcerated People in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan: Legislative and Policy Analysis and Recommendations for Reform."

2. To the Ministry of Health and Social Protection of the Population (MoHSP):

2.1. Ensure the immediate introduction and implementation of the take-home policy/procedure to dispense medication to stable OAT programme clients for self-administered therapy as authorized by various existing documents.

2.2. In the context of the COVID-19 coronavirus pandemic, develop measures to enable a take-home medication procedure applicable to all OAT programme participants with a stable maintenance dose in the case of social distancing, self-isolation and other prevention and control measures being introduced in the country.

2.3. Ensure that a decree is adopted to enable the provision of OAT and related services on a free-of-charge basis. List 2 in Annex 1 to the "Regulation On Co-payment for Health Services, Provided to the Citizens of Tajikistan by Public Health Care Facilities," passed by a joint Decree of the MoHSP and the Ministry of Finance of Tajikistan No. 938-135 as of November 5, 2014, should be amended by adding people with opioid dependence enrolled in the OAT programme. The amended Regulation should state that people living with HIV/AIDS are entitled to free medical care which is not limited to their underlying disease only.

2.4. Provide opportunities to import methadone in a powdered form into the country to use it for liquid preparations domestically, which would significantly reduce the cost of OAT medication. Reducing the cost of OAT medication (particularly through the use of it in tablet form) is a viable option to enhance the sustainability of the OAT programme and to optimise such costs in the course of transition to domestic funding.

2.5. Prioritise the replacement of personalised data records within the narcological registration system with a case registration system based on unique identification codes. Develop practical guidelines to facilitate the application of this system and to set out procedures to identify a person's drug dependence status, if required and justified in terms of the observation of human rights, but without relying on the narcological registration system.

2.6. Adopt a decree to enable OAT service provision by General Practitioners/family doctors and other health care specialists provided that they have been appropriately trained and certified by duly accredited educational institutions.

2.7. Put in place measures to increase the coverage of people who use opiates through the decentralised provision of OAT services at primary health care facilities and the opening more OAT sites in primary health care settings.

2.8. Institutionalise the delivery of integrated HIV, TB, and OAT services in a "One-Stop Shop" service modality, followed by the widespread introduction of this model at all OAT sites.

2.9. If the implementation of the Law "On Health Insurance in the Republic of Tajikistan" starts in 2022, take steps to minimise financial barriers for OAT programme participants. Taking into account that a number of European Union countries have OAT services covered by their national health insurance plans, their (as well as other countries') experiences should be studied to adapt and implement the best international practices in Tajikistan.

2.10. Jointly with the Ministry of Education and Science of the Republic of Tajikistan and heads of graduate and postgraduate medical education institutions and universities, take measures to improve professional training of doctors and nurses in the fields of substance dependence and psychiatry, and to include detailed OAT topics in relevant curricula and study programmes/syllabi.

2.11. Intensify efforts to apply the social contracting mechanism and involve NGO personnel to the delivery of OAT programme services. Ensure that all necessary conditions to enable this are in place, including the revision/adoption of appropriate regulatory framework, as necessary.

3. To OAT service providers, including managers of the OAT programme and the Republican Clinical Centre of Narcology named after Professor M. G. Gulyamov that provides operational and methodological support for the OAT programme:

3.1. Ensure that OAT sites establish a more convenient time to dispense medications to patients. One of the possible options is to establish pick-up and take-in hours both in the morning (07:00–12:00) and the afternoon (15:00–18:00).

3.2. Initiate a review of existing OAT clinical protocols to further improve them and to make them fully compliant with WHO guidelines and recommendations, particularly regarding eligibility criteria for OAT programme enrolment, and eliminating age restrictions.

3.3. Make the provision of qualified psychosocial support to clients as a key priority for the OAT programme. Jointly, with technical assistance of partners and donors, develop and implement a range of measures to address this high-priority task.

3.4. To improve the quality of the OAT programme and to ensure higher retention rates within the programme, consider developing an employment counselling and assistance programme to support clients who need such help.

3.5. Examine the financial feasibility of the existing staff structure at OAT sites. Analyse whether, and how, it can be rationalised to adapt to the workload of each particular site, and how it can be optimised given the available domestic funding in a limited-resource setting.

4. To civil society members, and communities of OAT clients and people who use drugs :

4.1. Draft a formal appeal letter addressed to all stakeholders, including the Ministry of Health and Social Protection of the Population; the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria; the Coordination Council on the Prevention of Drug Abuse; service providers, senior management of the OAT programme, as well as technical partners and donors, whereby the following issues should be raised: (i) expression of concern with existing risks which can undermine the sustainability of an OAT programme in the context of transition from donor support to domestic funding; (ii) stressing the serious gaps in the management of the transition; (iii) demanding urgent actions to address the identified challenges and barriers; (iv) calling on the government, technical partners and donors to provide financial, technical and methodological support to civil society members to ensure their meaningful involvement in all processes related to the implementation and sustainability of the OAT programme.

4.2. Together with the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria, the Ministry of Health and Social Protection of the Population, and senior management of the OAT programme, initiate the practice of conducting annual partnership forums to specifically review progress towards OAT programme sustainability in the context of the transition from donor support to domestic funding.

5. To technical partners and donors (including WHO, UNODC, UNAIDS, Global Fund, CDC, PEPFAR, etc.):

5.1. Taking into account the current economic situation in Tajikistan, continue providing funding to the national OAT programme.

5.2. Review the outcomes of the assessment of the sustainability of the OAT programme in the context of the transition from donor support to domestic funding in Tajikistan. In coordination and close cooperation with each other, agree on concrete actions to provide technical and financial assistance to implement the proposed recommendations to enhance OAT programme sustainability in the country.

5.3. Prioritise the provision of financial, technical and methodological support to civil society organizations, including communities of OAT clients and people who use drugs, in order to (i) foster the enabling environment to ensure their more meaningful involvement in the processes of on-going monitoring and improvement of the OAT programme; (ii) support community mobilisation efforts; (iii) strengthen communication and advocacy capacities; and, (iv) support a dialogue between civil society members and government agencies to discuss both investment and allocation of national financial resources for the implementation of the OAT programme and options for cost optimisation.

5.4. Support the development and operation of various multi-sectoral platforms to facilitate sustainability planning for the OAT programme, to improve awareness on programme development issues among stakeholders, to strengthen policy, and to secure wider support to the OAT programme both at the governmental level and in the society. Encourage more active involvement of the academic sector in such multi-sectoral platforms.

5.5. When conceptualising any future technical and financial assistance, discuss with national partners and develop concrete steps and activities to ensure the continued sustainability of the proposed programmatic interventions.

5.6. Prioritise continued dialogue with the Government of Tajikistan to adopt a Plan for Transition from Donor Support to Domestic Funding with a corresponding budget, as well as to identify domestic funding sources for the OAT programme in transition. Continue to provide necessary technical assistance to cost the Plan.

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ISSUE AREAS	INDICATORS AND BENCHMARKS			
A. POLICY AND GOVERNANCE	*Indicator A1:* **Political commitment** • OAT is included in national drug control, HIV and/or hepatitis strategies and action plans, with a commitment to WHO-recommended targets • Legislation explicitly supports the provision of OAT • OAT is a core part of national policy for opioid dependence management • Law enforcement and justice systems support implementation and expansion, as needed, of OAT • Effective governance and coordination oversee the development of OAT in the country • Civil society, including OAT clients, are consulted in OAT governance and coordination at country level		*Indicator A2:* **Management of transition from donor to domestic funding** • Country has adopted a plan which defines transition of OAT from donor to domestic funding, including a timeline • There is a multi-year financial plan for the OAT transition to domestic sources, with unit costs developed, co-financing level, the (future) domestic funding sources for OAT identified and agreed among country representatives • Donor transition oversight in the country effectively supports implementation of the OAT transition to domestic funding • There is good progress in the implementation of the OAT-component in the transition plan	
B. FINANCE AND RESOURCES	*Indicator B1:* **Medications** • OAT medicine procurement is integrated into domestic PSM system and benefits from good capacity without interruptions • Both methadone and buprenorphine are registered and their quality assurance system is operational • Methadone and buprenorphine are secured at affordable prices	*Indicator B2:* **Financial resources** • MMethadone and buprenorphine are included in the state reimbursed medicine lists and are funded from public sources • OAT services are included in universal health coverage or state guaranteed package of healthcare, including for people without health insurance • OAT services are paid through sustainable public funding sources which secure adequate funds to cover comprehensive services • In countries with active HIV grants, OAT services are co-financed by the Government in accordance with the Global Fund Sustainability, Transition and Co-Financing Policy	*Indicator B3:* **Human resources** • OAT is included in the job description of main health staff and core functions of the state system for drug dependencies with relevant capacities to prescribe and dispense OAT to a required scale • Capacity building system is adequate for OAT implementation in a sustainable way	*Indicator B4:* **Evidence and information systems** • OAT monitoring system is in place and is used for managing the OAT programme, including programme need, coverage and quality assurance • Evidence-base for OAT effectiveness and efficiency is regularly generated and inform policy and programme planning • OAT client data is stored in a database; it is confidential, protected and not shared outside of the health system without a client's consent

ISSUE AREAS	INDICATORS AND BENCHMARKS		
C. SERVICES	*Indicator C1:* **Availability and coverage** • OAT is available in hospitals and primary care; take-home doses are allowed • Coverage of estimated number of opioid dependent people with OAT is high (in line with WHO guidance: 40% or above) • OAT is available in closed settings (including for initiation onto OAT), during pre-trial detention and for females • OAT is possible and available in the private and/or NGO sectors in addition to the state sector	*Indicator C2:* **Accessibility** • There are no people on a waiting list for entering the service • Opening hours and days accommodate key needs • Geographic coverage is adequate • There are no user fees and barriers for people without insurance • OAT is available and, in general, accessible for populations with special needs (pregnant and other women, sex workers, underage users, ethnic groups) • Illicit drug consumption is tolerated (after dose induction phase) • Individual plans are produced and offered with involvement of the service user • OAT inclusion criteria are supportive of groups with special needs and are not restrictive, i.e. failure in other treatment programmes is not required prior to enroling into the OAT programme	*Indicator C3:* **Quality and integration** • Adequate dosage of methadone/ buprenorphine is foreseen in national guidelines and practice in line with WHO guidance • OAT programmes are based on the maintenance approach and have a high retention of users • A high proportion of OAT maintenance sites are integrated and/or cooperate with other services and support continuity of care for HIV, TB and drug dependence (in line with WHO guidance: 80% or more of the sites) • A high proportion of OAT clients receive psycho- and social support (in line with WHO guidance: 80% or more of the sites)

ANNEX 2. List of respondents who contributed to the assessment

Below is a full list of national experts who provided information and critical feedback, opinions, and recommendations, which made a significant contribution to, and were at the core of, the assessment of OAT programme sustainability in Tajikistan.

Table 3. List of national experts who contributed to the assessment of OAT programme sustainability in Tajikistan

№	FAMILY NAME, NAME	AFFILIATED ORGANISATION
1	Azizmamadov, Maram	NGO "Volunteer"
2	Boymatov, Alloudin	NGO "Apeiron"
3	Burkhanova, Mavzuna	UN Development Programme
4	Vohidova, Mutabara	UN Office on Drugs and Crime
5	Jamolov, Pulod	NGO "SPIN Plus"
6	Karimov, Sino	NGO "Dina"
7	Kim, Irina	The Republican Clinical Centre of Narcology named after Professor M. G. Gulyamov
8	Magkoev, Vladimir	The Republican Clinical Centre of Narcology named after Professor M. G. Gulyamov
9	Maksumova, Zumrad	ICAP
10	Malakhov, Mahmadrahim	The National Centre for Monitoring and Prevention of Drug Dependence under the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan
11	Malikov, Naimjon	ICAP
12	Muzafarov, Muzaffar	U.S. Centers for Disease Control and Prevention
13	Mussaeva, Zarina	USAID Eliminate Tuberculosis in Central Asia Activity
14	Orbelyan, Sona	UN Development Programme
15	Saparova, Nargiza	UN Development Programme

ANNEX 3. OAT service packages and payments in countries throughout the region

In Ukraine, the National Health Service purchases OAT services from health care providers in the framework of the implementation of the "Programme of State Guarantees of Healthcare Services". The OAT service, defined in the Programme as "Treatment of people with opioid use-related mental and behavioural disorders using substitution therapy medications" includes the following structural components:

1. OAT medication dispensing:
   a. medicines are dispensed and directly observed therapy is administered by the service provider staff at the point of service;
   b. compliance evaluation is made to determine whether the client is eligible for take-home doses for self-administered therapy; take-home doses are authorised and facilitated for eligible service clients;
   c. for clients who cannot visit service facilities daily due to health reasons, OST services are provided in a clinic-at-home mode;
   d. continued, non-interrupted OST treatment is ensured in the event of hospitalisation/transfer of the service client to other facilities;
   e. the use of OAT doses dispensed for self-administered therapy in outpatient settings is monitored and controlled to ensure compliance.
2. Developing individual patients' follow-up and treatment plans:
   a. individual client assessments are conducted to evaluate a client's health condition and needs, and to develop a treatment plan;
   b. a follow-up and treatment plan is developed;
   c. adherence to treatment is evaluated, to identify factors that may adversely affect the client's adherence to the programme and to adjust the treatment plan accordingly.
3. Treatment monitoring:
   a. monitoring of treatment plan compliance to ensure that the client visits their service provider on a timely and regular basis, in line with their individual follow-up and treatment plan;
   b. monitoring of referrals and referral outcomes, when the client is referred by the service provider to other health facilities;
   c. monitoring of treatment efficacy and adverse drug reactions related to OAT;
   d. following up on adverse drug reactions, making adjustments to ensure efficient OAT drug dosage prescriptions;
   e. monitoring of drug interactions, to manage interactions of the OAT drugs with other drugs, such as antiretrovirals, antituberculosis drugs, painkillers, and antidepressants.
4. Screening for certain mental health disorders, including the following:
   a. screening for depression, post-traumatic stress disorder, and anxiety disorders;
   b. referral of OAT clients with positive screening results to specialists for further examination and diagnosis.

5. Screening for tuberculosis, screening or referral for screening for HIV and viral hepatitis, and further referrals to specialists for diagnosis and treatment, as required.
6. Counselling and awareness raising on the prevention of HIV, viral hepatitis, sexually transmitted infections, overdose, and substance use-associated risks.
7. Re-evaluations are conducted to review the treatment plan every three months at the initial stage (within the 1st year) and later on as required, on a case-by-case basis, depending on the client's individual needs and progress.
8. Referral of OAT patients to other specialised (secondary) and highly specialised (tertiary) health care facilities, as required.

For the provision of OAT services (consisting of all above-mentioned structural components), an OAT service provider is paid a fixed (tariff-based) sum currently amounting to UAH1,635.46 for a period of 9 months from April to December 2020, or about UAH181.72 per month (which is about USD7.40 per month, according to the exchange rate set by the National Bank of Ukraine as of March 1, 2020). This OAT service cost does not include the cost of diagnostic supplies and medicines purchased by the Ministry of Health through a centralised procurement system. The service package does not include the diagnosis of mental and behavioural disorders related to opioid use, as such diagnostic service is provided within other state-reimbursed packages of health services (Cabinet of Ministers of Ukraine, 2020; National Health Service of Ukraine, 2020).

ANNEX 4. Previous assessments of the OAT programme in Tajikistan: identified weaknesses and gaps, opportunities for improvement, conclusions, and recommendations

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
Opioid Substitution Therapy in Central Asia: Towards Diverse and Effective Treatment Options for Drug Dependence. Authors: A. Latypov, D. Otiashvili, O. Aizberg and A. Boltaev. Eurasian Harm Reduction Network	2010	1. Pay special attention to the creation of concomitant positive legal, programmatic and informational environment related to OST program. 2. Continue the work aimed at replacing the narcological register with a system that registers cases rather than individuals and uses unique identifier codes. Develop guidelines for implementing this system and work out a way to determine dependence status when it is both necessary and justified from the human rights point of view, and at the same time without having to rely on the narcological registration. Until the new system is introduced, ensure not to place OST program participants on the narcological register by referring to state guarantees with regard to the anonymity of drug treatment and to the right of patients to anonymous treatment. 3. Add methadone and buprenorphine to the list of essential medications. 4. Determine one agency that will be responsible for control over the licit use of drugs in the OST programs. This agency should coordinate checks with all the other agencies and keep them informed of the results. 5. Ensure that the process of procurement of methadone for use in OST programs is transparent, and initiate a mechanism for monitoring prices. 6. Allow private and NGO-run drug treatment facilities to use narcotic substances and to provide outpatient OST programs in accordance with permissions issued on the basis of the requirements of the Tajik legislation. 7. Increase financing of the drug treatment service by reallocating a certain part of funds earmarked for counternarcotics activities. 8. Continue the process of reforming the drug treatment service, and also include a module on organizing and carrying out OST programs in the training of medical and social workers.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
		9. Increase the coverage of OST programs and do not allow them to become "perpetual pilot" programs. Both government money and donor funds should be used and be allocated according to detailed plans which consider various aspects such as financial and technical sustainability, the spectrum of services provided at each individual site, accessibility, patient recruitment, personnel and training, potential challenges and risks and ways of minimizing them etc. 10. Provision of OST should not be limited to drug users who have HIV/AIDS. Ensure low-threshold access to OST, as recommended by the WHO (2009). 11. Develop a mechanism to transfer medications to other medical institutions for situations where patients on the OST program are hospitalized elsewhere. 12. Make a concerted effort to include drug dependent people and other interested communities and professional groups in the planning, evaluation and improvement of OST programs. 13. Ensure that OST is available in the penitentiary system. People with opioid dependency who were not taking part in the OST program prior to their incarceration should also be allowed to take part in the programs.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality. Authors: A. Latypov, A. Bidordinova and A. Khachatrian. International Drug Policy Consortium	2012	Opportunities for increasing access to, and improving the quality of, OST programmes: 1. National ownership of OST service provision that can be achieved through strong political commitment and national funding of OST projects. 2. Policy reform through comprehensive analysis and advocacy action to review restrictive and poorly written policies, or adopt new policies in support of OST. 3. Protection from police harassment and violation of human rights of OST clients and service providers. 4. Strengthening technical and human resource capacities and developing national standards and protocols in line with international best practices to ensure adequate quality of OST programmes. 5. Dissemination of up-to-date evidence-based information on OST programmes, which is tailored to the needs of various target audiences. 6. Engaging with, and gaining support from, policy champions, the media, OST specialists, clients and their families to effectively promote OST and address the claims and concerns of the opposing groups. 7. Investing in building local capacities for OST advocacy in the region. 8. Producing OST model legislation tailored to the legislative realities of the region. 8. Producing OST model legislation tailored to the legislative realities of the region. 9. Developing a decision model that outlines various funding options and ensuring increased national funding to OST services through transparent mechanisms. 10. Advocating for and ensuring the provision of take-home OST doses for stable clients motivated to continue their treatment. 11. Increasing coverage of OST programmes by engaging general practitioners, drug treatment specialists, AIDS centres and other healthcare facilities in offering OST.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
		12. Ensuring continuity of OST services in community and prison settings by integrating OST programmes into in-patient facilities and introducing OST programmes in both pre-trial detention centres and prisons. 13. Establishing a comprehensive system for monitoring and evaluation of OST programmes with active participation of OST clients. 14. Ensuring better quality of OST programmes through increased provision of psychosocial support and integration with other services. 15. Conducting regular regional forums on OST to stimulate interest and to recognise the efforts of countries supporting OST. 16. Establishing a formal scientific community of distinguished scholars with knowledge and expertise in OST-related issues in Eurasia, who could be mobilised to respond to possible attacks of opposing groups on OST. 17. Supporting efforts to promote harm reduction and OST scholarship in Eurasia by expanding Russian language evidence base through the publication of original research from the region and translation of peer-reviewed English language literature. 18. Developing a set of plans with specific activities designed to respond to OST crises that can potentially unfold in countries of Eurasia under different scenarios.
Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan. Authors: A. Boltaev, A. Deryabina, S. Kholov and A. Howard. ICAP	2013	1. Further expand the MAT program, improving access in remote areas of the country, where there might be a need for such therapy. Along with improving MAT accessibility in new areas, accessibility to the therapy in Dushanbe, Khorog and Khujand must also be improved by opening additional MAT sites. Special attention should be paid to the provision of MAT in detention facilities. 2. In order to further reduce the cost of MAT medications and facilitate their import into the country, include methadone and buprenorphine in the list of essential medicines of the Republic of Tajikistan in accordance with the WHO Model List of Essential Medicines. 3. Improve technical assistance to MAT sites by selecting, training and engaging specialists in addiction psychiatry from medical institutions and non-governmental organizations to work as technical advisors.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
		4. Update the MAT program admission criteria in accordance with the WHO recommendations and remove the current enrolment requirements related to number of unsuccessful treatment attempts and duration of drug injection experience. 5. Improve monitoring and evaluation procedures for MAT, ensuring the collection and analysis of data related not only to program implementation, but also to MAT impact on patients (changes in behavior and health). At the same time, it is important to ensure standardization of data collected from various sites; simplify reporting forms; and introduce an electronic MAT program monitoring system that will increase data quality and reduce paper work for employees. 6. In order to improve quality of MAT programs, develop simplified manuals with basic provisions and requirements of the Operational MAT Guidelines, separately for doctors, nurses and social workers. 7. Increase participation of community organizations and MAT patients in activities aiming to explain MAT to PWID and their families. The expertise and experience of NGOs must also be used in provision of psychosocial support to MAT patients and their families. Representatives of community organizations and patients can be extremely useful in improving the quality of MAT by creating and serving on public committees at MAT sites. Functions of such committees could be integrated into the existing committees for admission of new patients. 8. Train the MAT program staff and AIDS centers' clinicians on the fundamentals of antiretroviral therapy for patients receiving MAT in order to increase the number of patients on ART and treatment adherence. 9. Enhance interaction of MAT sites with harm reduction, HIV and tuberculosis treatment programs. Identify ways to provide comprehensive care for MAT patients with HIV and tuberculosis as a “one stop shop” model.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
		10. Strengthen comprehensive advocacy efforts aimed at the development and promotion of a positive attitude to MAT patients and MAT services amongst key medical and non-medical stakeholders, particularly law enforcement authorities at the national and local levels. 11. In order to ensure sustainability of the MAT program, develop alternative funding mechanisms including a co-payment on the part of the state budget and patients in need of MAT. Such funding mechanisms will reduce the dependence of MAT on support from foreign donors. There is also a need to optimize the staffing schedules of MAT sites to increase the potential for extending the program to remote areas of the country, including eliminating security guards positions and creating opportunities for narcologists to work part-time at several MAT sites in nearby areas.
HIV/AIDS in Tajikistan. Mid-term review of the National AIDS Programme 2011–2015. Prepared by: Ulrich Laukamm-Josten, Lali Khotenashvili, Baktygul Akkazieva, Svetlana Antonyak, Svetlana Cebotari, Lella Cosmaro, Sayohat Hasanova, Sowmya Kadandale, Iurii Kobyshcha, Jadranka Mimica, Otilia Scutelniciuc and Emilis Subata. World Health Organization	2014	Key findings (pertaining to OST): 1. OST covers approximately 1% of estimated IDU; restrictive national policies and practices including guidelines, narcological registry along with geographical remoteness of OST sites, and the absence of psychosocial assistance form major barriers preventing early access to treatment. The narcological services are not offered free of charge including detoxification from heroin thus creating additional barrier. 2. Methadone has not been registered as medication and is not included in the essential drug list of MOH. Methadone is imported at higher costs than some neighbouring countries (e.g. Kyrgyzstan).

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
		3. There is no established OST capacity building system for medical staff. Most of the nurses have never been trained. Key recommendations (pertaining to OST): 1. Further optimise integration of ART and OST services. 2. Revise National OST Guidelines in accordance with WHO and other internationally agreed standards. 3. Establish positions of social workers and psychologists at existing OST sites to provide comprehensive psychosocial assessment and support. 4. Develop mechanisms of mixed (government/donor) funding of NSP/OST. 5. Replace "narcological dispensary registry" with national case-based statistical database (unique identifier code). 6. With cooperation of donors, open new OST sites in narcological centres/cabinets; decentralize existing OST where possible to make OST geographically close to IDU. Promote integration of HIV/TB/OST services. 7. Use existing narcological infrastructure and existing staff at primary and secondary level to provide more OST programmes. 8. Consider introducing OST issues into curricula of narcologists, nurses and psychiatrists at medical schools, medical colleges and institutions of post-graduate training. 9. Open OST in prisons (including remand prisons) so that OST patients could continue OST and inmates could initiate OST in prisons and continue in civil sector.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
Factors influencing the adherence to the opioid substitution therapy programme in Khujand, Tajikistan. Study report. Authors: A. Sharipov, I. Nematov and A. Abdugaffarov. NGO "Khujand"	2017	Recommendations: To the Ministry of Health and Social Care, the Narcological Service, international donor agencies that provide funding to the OST programme, NGOs, country and regional coordinating committees: 1. Revise and amend existing policy regulations to enable the implementation of the take-home doses procedure for methadone. 2. Consider options for anonymous programme enrolment (based on using unique identification codes instead of identity documents). 3. Revise the state narcological service regulations and update them to ensure more support to programme clients in employment issues. For example, revise restrictive narcological registration procedures which make it impossible for patients registered as drug dependent to find a job. Once registered, they have to wait for 3–5 years to be deregistered. 4. Consider/introduce a procedure to dispense methadone to programme clients through the local pharmacy chains or the primary health system facilities to expand the geographic coverage of the programme. To NGOs working in the harm reduction field, and to OST site management in the city of Khujand: 1. Establish and promote the development of OST patient communities, mutual help and self-help groups, patient councils/boards based at OST sites, which will facilitate valuable feedback about the programme from programme users and promote their involvement in decision-making processes regarding both the overall programme design and their own treatment plans. 2. In consultation with clients, develop a plan to improve psychosocial support in the framework of the OST programme. 3. Consider expanding the range of services at the OST site, including the introduction of social, household and domestic services, vocational education courses, or recreational activities. 4. Consider including a full-time position of peer counsellor (an OST client) to provide primary counselling and support clients in the treatment process. 5. Community organisations can help identify potential clients and link them to the programme, provide primary counselling, conduct motivation sessions as well as support groups for OST clients. It is possible to involve NGO personnel to provide case management services to help programme clients to address social, legal, and other issues.

Title, author(s), affiliated organisation(s)	Year published	Identified gaps/opportunities for improvement/conclusion(s)/recommendation(s)
The analysis of activity of opioid substitution therapy sites in Tajikistan. Author: A. Sirvinskiene. UNODC	2018	Weaknesses (generally applies to all OST sites): 1. There is no psychosocial support (only general information and counselling is provided). 2. No individual treatment/care plans are developed to address the client's psychosocial status. 3. Treatment plans are built in a rather formalistic way, not tailored to the individual client's situation. 4. Take-home doses of methadone for stable clients are not authorised. 5. No attention to individual behaviour changes in the client and no care plans are built to address behaviour changes accordingly. 6. There are only sporadic attempts at doing motivational work at some programme sites. 7. Individual withdrawal strategies for programme discontinuation are not discussed, psychological help is not provided. 8. The range of services to be provided free-of-charge is rather small (e.g. detoxification services are on a fee-paying basis, no Minnesota programme). 9. No tools/scales (such as the Camberwell assessment scale) are used to assess and measure changes in health, as well as in social, work-related, and psychological areas that could be instrumental to inform the development and adjustment of treatment plans. 10. No evaluation is made to assess changes (in the psychosocial domain) of an individual patient (while assessing minor achievements).