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# REPUBLIC OF TAJIKISTAN

## Reassessing the sustainability of the opioid agonist therapy programme within the context of transition from donor support to domestic funding

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# Acronyms

| | |
|---|---|
| **ART** | Antiretroviral Therapy |
| **CADAP** | Central Asia Drug Action Programme |
| **CDC** | Centers for Disease Control and Prevention |
| **CEECA** | Central and Eastern Europe and Central Asia |
| **CHC** | City Health Centre |
| **CRH** | Central Regional Hospital |
| **DCA** | Drug Control Agency under the President of Tajikistan |
| **DOTs** | Directly Observed Therapy |
| **EHRA** | Eurasian Harm Reduction Association |
| **ERSMT** | Electronic Registry of Substitution Maintenance Therapy |
| **FGD** | Focus Group Discussion |
| **GDP** | Gross Domestic Product |
| **GIZ** | Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH [German Development Agency] |
| **HBV** | Hepatitis B Virus |
| **HCV** | Hepatitis C Virus |
| **ICAP** | Formerly the International Centre for AIDS Care and Treatment Programmes at Columbia University's Mailman School of Public Health |
| **LEM** | List of Essential Medicines |
| **MDECS** | Main Department for the Execution of Criminal Sentences |
| **MoHSP** | Ministry of Health and Social Protection of the Population |
| **MoIA** | Ministry of Interior Affairs |
| **MoJ** | Ministry of Justice |
| **NCC** | National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria |
| **NGO** | Non-Governmental Organisation |

| | |
|---|---|
| **OAT** | Opioid Agonist Therapy |
| **PAS** | Psychoactive Substances |
| **PEPFAR** | United States President's Emergency Plan for AIDS Relief |
| **PHC** | Primary Health Care |
| **PLHIV** | People Living with HIV |
| **RRS** | Regions of Republican Subordination |
| **SI NCCA** | State Institution 'Professor Gulyamov National Clinical Centre of Dependence' |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **UNDP** | United Nations Development Programme |
| **UNODC** | United Nations Office on Drugs and Crime |
| **USD** | United States Dollar |
| **WHO** | World Health Organization |

# EXECUTIVE SUMMARY

The Republic of Tajikistan is a country in the south of the Central Asian region that gained independence in 1991 after the collapse of the Soviet Union.

The opioid agonist therapy (OAT) programme was launched in Tajikistan in 2010. Currently, there are a total of 17 OAT sites in the country, two of which are in the penitentiary system. At the time of this assessment, 15 OAT sites[1] were housed in health facilities providing services to 622 clients. All of them receive oral methadone in the form of syrup 5mg/1.0ml. All OAT sites in Tajikistan are largely funded by international donor agencies, primarily UNDP, the Principal Recipient of Global Fund grants.

In 2020, an assessment of the sustainability of the OAT programme was conducted in Tajikistan with the technical assistance of EHRA [1].

This report presents the results of the reassessment conducted in 2022 of the sustainability of the OAT programme in Tajikistan, undertaken with the technical assistance of EHRA following its assessment guide [2].

The assessment addresses the current situation, progress made, risks, and opportunities to ensure the sustainability of the OAT programme in Tajikistan, focusing on programmatic aspects and highlighting the following three areas: policy and management; finance and resources; and services. The assessment includes an overview; analysis of progress; barriers; and opportunities in each area, as well as overall conclusions and recommendations for ministries and government agencies, national coordinating bodies, practitioners, civil society, technical partners and donors.

**Key Findings**

As a result of this reassessment, the following strengths and achievements of the OAT programme in Tajikistan were identified:

- The legislation of the Republic of Tajikistan neither restricts nor hinders the implementation of the OAT programme. Since the introduction of OAT in 2010, the programme has expanded significantly and continues to develop. Preparations are currently underway to open three additional OAT sites, including one in the pretrial detention centre.
- Regulatory and legal documents (clinical guidelines, procedures) have been approved based on the recommendations of WHO that allows the implementation of the OAT programme using such standards.

[1] No information is available on clients receiving medications at two other OAT sites in correctional facilities.

- In 2008, a set of documents was developed and approved in the country for the provision of services on an anonymous basis in agencies and facilities for HIV prevention, narcology, STI prevention and treatment, and related services [3]. The list of these services includes those provided by the OAT programme.
- Methadone and buprenorphine have been included in the List of Essential Medicines (LEM) of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan.
- Clinical guidelines for substitution maintenance treatment with buprenorphine have been developed and approved.
- During the implementation of the OAT programme, the eligibility requirements for people who inject drugs were lowered. In addition, the criteria for exclusion from the programme were significantly reduced.
- In Tajikistan, there are two OAT sites within penitentiary institutions and there is also a decree of the Ministry of Justice to open another site based on a temporary detention facility and two more sites in penitentiary institutions.
- The OAT programme has established, and is using, an Electronic Registry of Substitution Maintenance Therapy (ERSMT). It allows remote monitoring of local OAT sites and makes it easier for clients to move from one site to another when needed.
- In 2014, a system of providing integrated services for HIV, TB and OAT using the 'one-stop-shop'[2] approach was implemented in Tajikistan and showed positive results (coverage of people who inject drugs who are living with HIV and taking ART; achievement of viral suppression; regular screening for TB; initiation and completion of DOTs treatment; and chemoprophylaxis with isoniazid and cotrimoxazole). In 2020–2021, this system was expanded to four additional OAT sites.

This reassessment also identified specific barriers to the transition to domestic funding. These obstacles include the following:

- The OAT programme in Tajikistan is largely dependent on external funding, mainly through grants from the Global Fund. The government's contribution is limited to providing space, and paying for electricity and other utilities. The issues of the transition of the OAT programme to domestic funding have been repeatedly discussed at meetings of the National Coordination Committee for Countering HIV/AIDS, Tuberculosis and Malaria (NCC), but no official documents (plan, 'roadmap', etc.) have been presented.

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[2] 'One-stop-shop' is a system to provide integrated services to people who inject drugs and are living with HIV and/or TB when they receive antiretroviral therapy (ART) or DOTS along with methadone at OAT sites.

- There are gaps and inconsistencies in national legal acts in the field of drug dependence treatment that need to be completed and harmonised. For example, provisions in legal documents that reserve opioid agonist prescription and dose adjustment exclusively to a narcologist, together with the shortage of physicians in this specialty in the country, hinder the expansion of the network of OAT sites to unserved regions of the country and, therefore, the availability of OAT for people who inject drugs.
- The Health Code of the Republic of Tajikistan does not clearly indicate the possibility of providing OAT as an outpatient service, although this is indeed the case.
- A major barrier to the participation of people who inject drugs in the OAT programme is dynamic dispensary observation (registration in narcological institutions).
- Mechanisms for anonymous provision of services according to the Decree of the Ministry of Health of the Republic of Tajikistan No. 301, dated 05.06.2008, 'On approval of records of clients in the provision of anonymous medical services' are not applied in the practice of the Narcological Service. These mechanisms are used to a limited extent by non-governmental organisations (NGOs).
- There are numerous reports from OAT clients about cases of stigmatisation and discrimination against them, especially by law enforcement officials.
- Most people, including narcologists, and even members of the community of people who use drugs, tend to think of the OAT programme solely as an HIV prevention method and a harm reduction component focused on the problem of drug use.
- The formal mechanisms for providing take-home methadone doses to clients described in the clinical guidelines are not yet used in practice.
- There are no mechanisms, procedures or practices for the engagement of clients in the work of the OAT programme.
- Existing procedures for procuring medications and supplies for the OAT programme in Tajikistan are relatively expensive due to the fact that the liquid form of methadone itself is costly and requires much more transportation and storage costs than would be required for a powder or tablet form of the drug.
- Buprenorphine as an alternative to methadone in the OAT programme is not currently available.
- There is a shortage of narcologists in the country, which affects the effectiveness and quality of the OAT programme and its services.

- In Tajikistan, there is no system for training and refreshing specialists for the OAT programme (narcologists, psychologists, social workers, pharmacists, etc.). There are no mechanisms for training mentors in the system of drug treatment services.
- Providing services to OAT clients according to the 'one-stop-shop' principle, which has been practiced for five years at 9 OAT sites, has proven highly efficient in terms of treatment adherence of OAT clients living with HIV and HIV/TB. Unfortunately, this practice has not been institutionalised.
- Coverage of people who inject drugs with OAT services remains extremely low (less than 3%) compared to the estimated number of people who inject drugs in the country. Expansion of coverage is hindered by the relatively low availability of OAT in many regions of Tajikistan, the lack of adequate information about this programme and existing opportunities for participation, as well as widespread myths about methadone combined with a large amount of misinformation on Russian-language websites and social media.

Given these facts, the immediate prospect of a transition to domestic funding seems unrealistic.

Below is a summary table showing progress toward sustainability of the opioid agonist maintenance therapy programme in Tajikistan for the three issue areas examined in the 2022 assessment compared to the results of the 2020 assessment:

| Issue area | Indicators | | | | |
|---|---|---|---|---|---|
| | 2020 | 2022 | | 2020 | 2022 |
| **Policy and governance** | At moderate to high risk | At moderate to high risk | Political commitments | Moderate sustainability | Moderate sustainability |
| | | | Management of transition from donor to domestic funding | At high risk | At high risk |
| **Finance and resources** | At moderate to high risk | At moderate to high risk | Medications | Moderate sustainability | Moderate sustainability |
| | | | Financial resources | At high risk | At high risk |
| | | | Human resources | Moderate sustainability | At moderate to high risk |
| | | | Evidence and information systems | Moderate sustainability | At moderate to high risk |
| **Services** | At moderate to high risk | At moderate to high risk | Availability and coverage | At high risk | At high risk |
| | | | Accessibility | Moderate sustainability | Moderate sustainability |
| | | | Quality and integration | Moderate sustainability | Moderate sustainability |

**Recommendations**

The recommendations below can significantly improve the situation and ensure the greater sustainability and prospects for the transition of the OAT programme in Tajikistan to domestic funding.

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

- Develop a realistic plan ('roadmap') for the transition to domestic funding involving a broad range of experts from the Ministry of Health and Social Protection of the Population, the Ministry of Finance, and international donors, as well as representatives of non-governmental organisations and the community in the discussion process;
- Initiate the necessary amendments to the Health Code and other legal acts regulating the implementation of the OAT programme to harmonise them (including a provision on outpatient treatment ('take-home' OAT) in the Health Code; revision of the provisions on dynamic dispensary observation in narcology; and the elimination of discrepancies between various guidelines and other legal acts related to OAT);
- Explore the possibility of raising funds from various national foundations and other possible domestic funding sources to support the OAT programme;
- Change the existing framework related to the methadone procurement system, which makes sense for the transition to domestic funding;
- Establish mechanisms for the continuity of the OAT programme based on medical facilities, temporary detention facilities of the Ministry of Interior Affairs, and the penitentiary system (pretrial detention centres, penitentiaries), and develop appropriate regulatory documents;
- Consider the possibility of, and develop mechanisms to cover, health services for clients of the OAT programme from the budget/national funds; and,
- Hold regular meetings (working sessions, roundtables, forums, etc.) involving a broad range of stakeholders to discuss progress and prospects for transitioning the OAT programme to domestic funding. Publish and distribute final documents based on the outcomes of these meetings.

**To the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan and State Institution 'Professor Gulyamov National Clinical Centre of Dependence' (SI NCCA):**

- Ensure the enactment of mechanisms of anonymous provision of narcological services that follow the Decree of the Ministry of Health No. 301, dated 05.06.2008, 'On approval of records of clients in the provision of anonymous medical services';

- Conduct a systematic advocacy effort specifically aimed at reducing stigma and discrimination against OAT participants by law enforcement;
- Establish and maintain close cooperation between the institutions of the Ministry of Health and Social Protection of the Population that provide OAT services and local NGOs. Hold regular meetings involving management and staff of the OAT and NGO programmes to discuss issues of expanding OAT coverage and quality of OAT services, etc.;
- Revise existing clinical guidelines and protocols to include procedures for methadone tablet dispensing and/or powder form use;
- Calculate the cost of treatment per client when purchasing methadone in tablet or powder form;
- Ensure the implementation of mechanisms to enable 'take-home' medicines in accordance with the clinical guidelines for the provision of OAT in consultation with the Drug Control Agency under the President of Tajikistan (DCA) and the Ministry of Interior Affairs;
- Implement a system of informing about the OAT programme aimed at dispelling existing myths about OAT medications for employees of government agencies and NGOs that provide services to people who inject drugs;
- Institutionalise mechanisms for providing integrated services using a 'one-stop-shop' approach at OAT sites where feasible;
- Develop mechanisms for client involvement in planning and managing the work of the OAT programme at all levels;
- Review the staffing structure of OAT sites in light of the shift to domestic funding and taking into account the limited spending on health care in Tajikistan;
- Discuss the possibility of offering OAT services through pharmacy chains;
- Establish a system for training and refreshing professionals in the field of OAT in state education institutions (developing curricula, modules, etc.), and in paying special attention to the training of social workers with the appropriate profile;
- Establish a system for ongoing on-site training and mentoring;
- Develop appropriate and fair mechanisms for tangible incentives for OAT site staff, including those using the situational management tool;
- Considering that many opioid users are currently using raw opium and opioid pills, review the eligibility criteria for the OAT programme to allow this group of opioid users to also participate;

- Where feasible, consider the possibility of organising work from mobile or satellite OAT sites.

**To international donor organisations** (**the Global Fund, UNODC, UNAIDS, CDC/PEPFAR and others**):

- Take note of the need to continue funding the OAT programme in Tajikistan, taking into account that the country is not ready to transition to domestic funding in the near future;
- Support the development of a realistic plan for the transition to domestic funding with the involvement of international consultants and experts;
- Pay attention to the following aspects when planning financial support for the OAT programme:

  (i) training and refresher training for staff at OAT sites and conducting training for staff of organisations that provide services to people who inject drugs to develop an adequate understanding of the concept, purpose and goals of the OAT programme;

  (ii) supporting an adequate and fair motivation system for OAT programme staff and in improving the quality of services;

  (iii) the needs of OAT programme clients for services to diagnose and treat coexisting conditions;

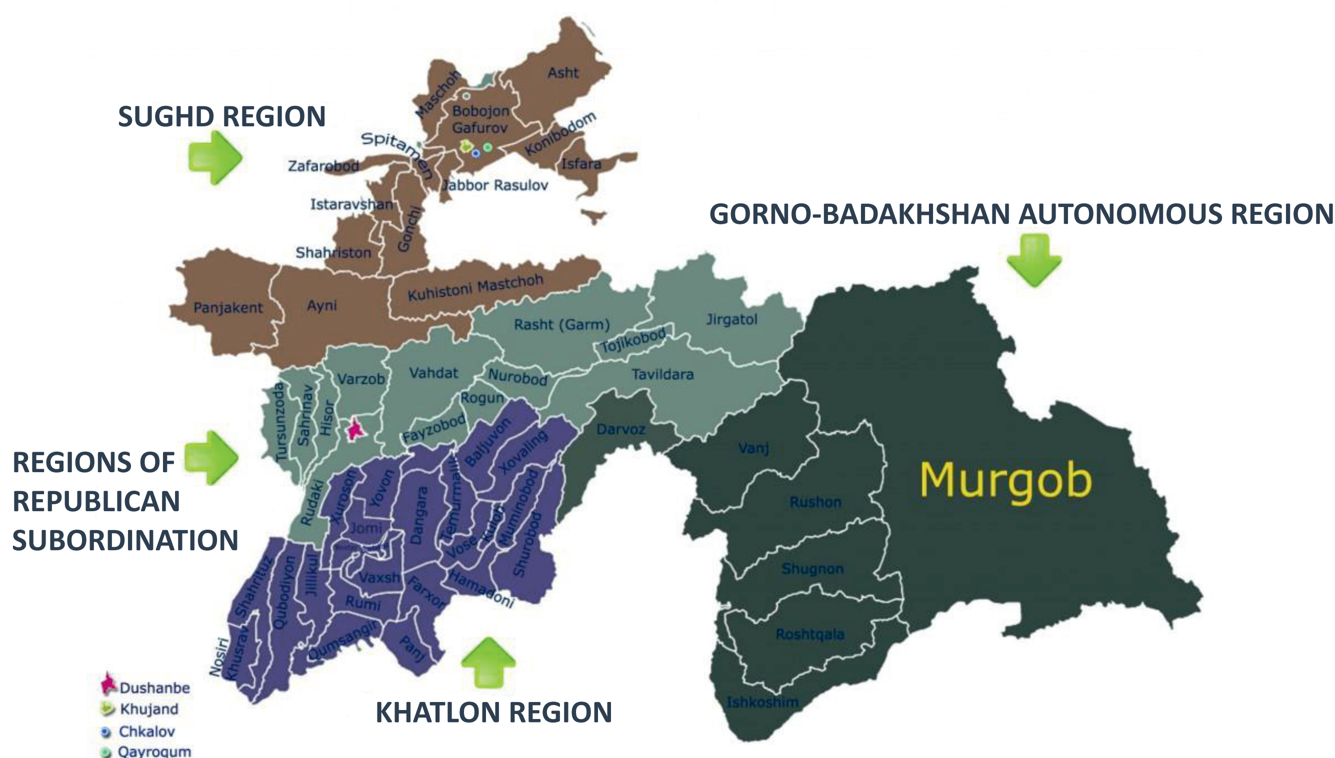
  (iv) procurement and provision of buprenorphine as an alternative to methadone; and,

  (v) supporting the establishment of OAT mobile or satellite sites where feasible;
- Support the holding of regular NCC-based partner meetings on issues related to the transition of the OAT programme to domestic funding; and,
- Continue to work with the Ministry of Justice to further improve the accessibility of OAT services in the penitentiary system, especially for women who inject drugs.

# 1. CONTEXT

The Republic of Tajikistan is a landlocked mountainous country in Central Asia with an area of 143,000km's$^2$ and an estimated population of over 10 million[3] (Figure 1).

**Figure 1. Map of the Republic of Tajikistan[4]**




The Republic of Tajikistan borders Afghanistan[5], 1,356km's in the south; the People's Republic of China, 519km's in the east; the Kyrgyz Republic, 630km's in the northeast; and the Republic of Uzbekistan, 910km's in the north and west. The long border with Afghanistan – the country that has been a leading producer of illicit drugs of the opiate and cannabis group for many years – has had and continues to have a significant impact on the drug scene in Tajikistan.

More than two-thirds of the country's population (72.9%) live in rural areas and are engaged in agricultural production. Tajikistan is classified as a lower-middle-income country[6]. Children under the age of 15 (33.9%) make up more than one-third of the country's population[7].

[3] Countrymeters Project. https://countrymeters.info/en/Tajikistan (accessed 12/23/2022).

[4] Ansor Project, 2022. http://life.ansor.info/karta-tajikistana/ (accessed 12/23/2022).

[5] Ministry of Foreign Affairs of the Republic of Tajikistan. https://mfa.tj/en/main/view/110/territorial-and-border-issues (accessed 12/23/2022).

[6] World Health Organization. Supporting national implementation of International Health Regulations. Geneva; WHO, 2020. https:// www.who.int/activities/supporting-national-implementation-of-international-health-regulations (accessed 12/23/2022).

[7] Countrymeters Project. https://countrymeters.info/ru/Tajikistan (accessed 12/23/2022).

In 2020, health spending per capita was 8% of Gross Domestic Product (GDP) or USD70 per capita. Total health care spending was 6,865,000,000 somoni, of which 1,806,000,000 somoni, or 26.3%, was financed from the state budget[8]. In Tajikistan, government spending on health care is among the lowest in the Central Asian region [4].

As of 2022, Tajikistan remained eligible for funding of HIV-related programmes under Global Fund criteria[9].

The health system in Tajikistan includes bodies that determine the country's health policy and are responsible for developing legal and sectoral mechanisms and resource planning, including human resources. These are primarily the Ministry of Health and Social Protection of the Population and other ministries (Finance, Economic Development and Trade, Education and Science, Labour, Migration, and Employment). Local executive government bodies are responsible for service delivery and funding. Currently, the public health sector dominates in Tajikistan. According to the Health Code, drug dependence treatment (narcological assistance) is the responsibility of the State Health System. As reported by the Chief Narcologist of the Ministry of Health and Social Protection of the Population, the Narcological Service operates on the territorial principle. The leading institution of the Narcological Service network in the country is the State Institution, 'Professor Gulyamov National Clinical Centre for Dependence' (SI NCCA). Narcological centres are located in the central cities of the regions (Khorog, Khujand, Kulob and Bokhtar). There are also 45 narcological offices throughout the country under the Central Regional Hospital [5]. The country's only centre for medical and social rehabilitation of people experiencing drug dependence is located in the village of Tangai, 30km's from the capital, Dushanbe. The inpatient narcological departments provide services for detoxification and the treatment of mental disorders due to the use of psychoactive substances (psychoses and others). The funding of Narcological Services comes partly from national and local budgets and partly through the introduction of fee-based services [6]. According to the Strategy for the Protection of Public Health of the Republic of Tajikistan until 2030, "significant regional and district inequalities in the distribution of funds for health care are primarily due to the fragmentation of public funding sources." The mentioned strategy includes the development of instructions to unify public finances from different sources under a single administration and envisages the creation of a unified system of state health insurance and a health insurance fund in the future.

The Republic of Tajikistan has built its drug policy on the three UN Conventions of 1961, 1971 and 1988. According to legislation, the State controls the circulation of substances included in the National List of Narcotic Drugs, Psychotropic Substances, and Precursors. Government officials

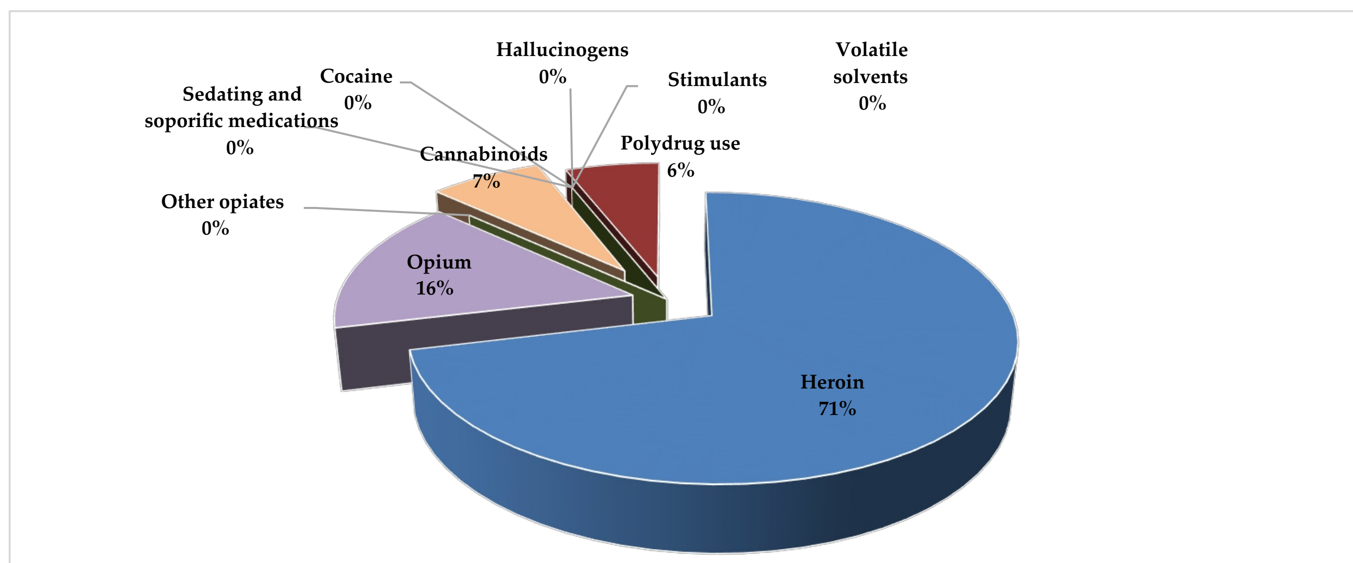
[8] World Health Organization. Global health expenditure database. Geneva; WHO. https://apps.who.int/nha/database/ViewData/Indicators/en (accessed 12/17/2022).

[9] The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Eligibility List 2022. Geneva; GFATM. https://www.theglobalfund.org/media/11712/core_eligiblecountries2022_list_en.pdf (accessed 12/17/2022).

regularly address the problems of combating drug trafficking and preventing drug use in their speeches. At the same time, dependence treatment issues remain the responsibility of the Narcological Service and are not comprehensively addressed. The strategy of reducing drug supply remains a priority in drug policy.

For a long time, drugs of plant origin (such as opium, heroin and marijuana) dominated the drug scene in Tajikistan. Recently, the use of natural opiates has tended to decline, which people who use drugs explain by the reduced availability of these substances. At the same time, the consumption of pharmaceutical opioids (Tramal) and other prescribed drugs (Tropicamide, Pregabalin, and others) is increasing[10]. In addition, according to SI NCCA, there has been an increase in requests for consultations and advice related to the use of psychostimulants from the amphetamine and methamphetamine group. However, if alcohol abuse is disregarded, the use of opiates remains the most frequent reason for registration in the narcological reporting system (Figure 2).

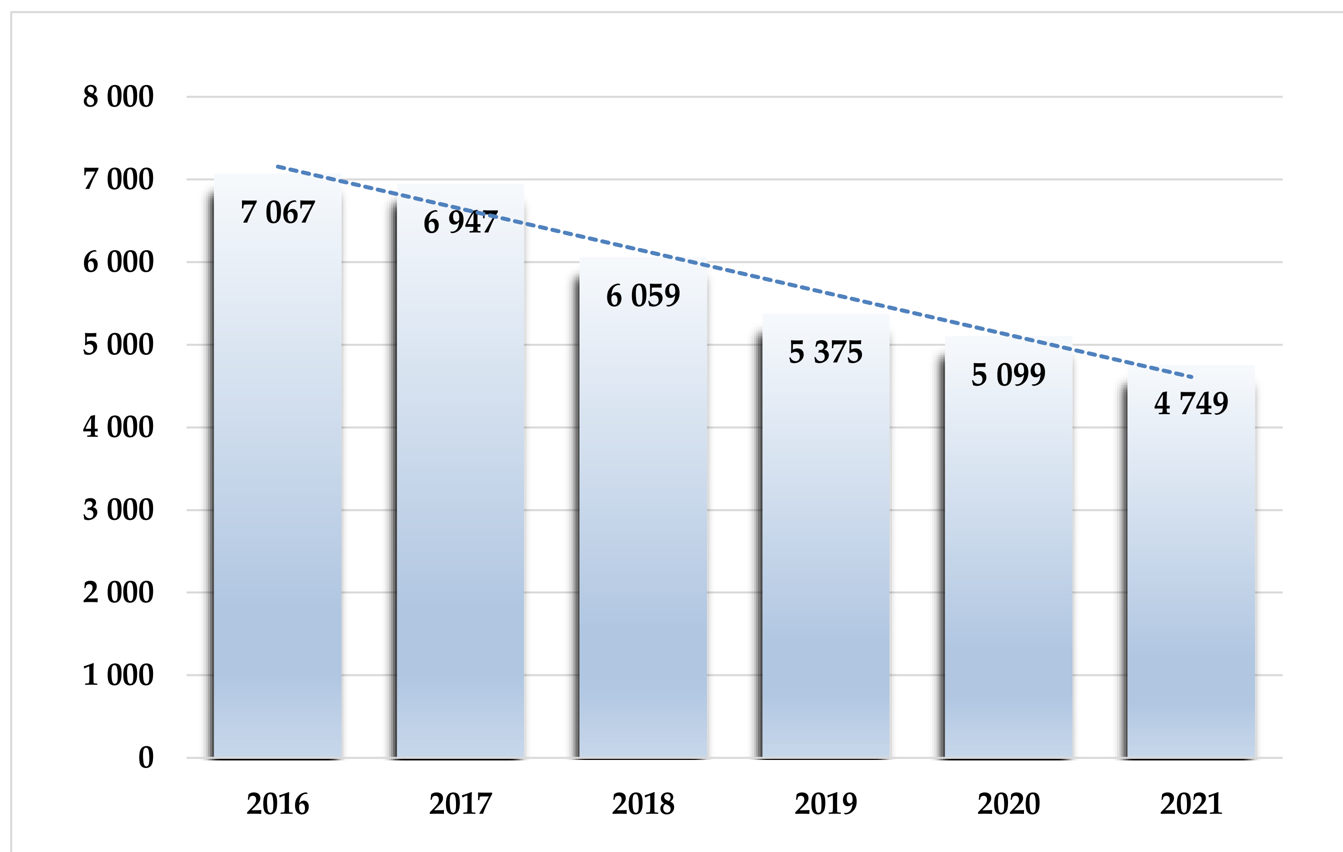
**Figure 2. Distribution of people experiencing drug dependence according to substances consumed in Tajikistan, 2021** [7]




As of 1 January 2022, there were 4,749 people experiencing drug dependence under dynamic observation in drug treatment facilities in Tajikistan. This is 32% less than in 2016, so the reduction in the official number of people registered as experiencing drug dependence may indicate an overall reduction in drug dependence in the country. In the last five years, the number of people experiencing drug dependence and under dynamic observation has decreased by 45% from 4,486 in 2016 to 2,470 in 2021 (Figure 3) [7].

[10] Information provided by a key informant for this assessment.

**Figure 3. Absolute number of people experiencing drug dependence and under dynamic observation in narcological institutions in Tajikistan, 2016–2021 [7]**




The OAT programme in Tajikistan began de facto in February 2010 when the first methadone maintenance treatment site, based at the SI NCCA, became operational with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund). The implementation of the OAT programme was based on the Programme on Prevention of Drug Dependence and Improvement of Drug Treatment in the Republic of Tajikistan for 2005–2010 [8] and the Programme on Combating the HIV/AIDS Epidemic in the Republic of Tajikistan for 2007–2010 [9]. The country has adopted clinical protocols, guidelines, algorithms and other regulatory and operational documents to create an enabling environment for implementation of the OAT programme following established criteria, procedures and regulations. In compliance with the goals of the national programme to expand OAT and the demand for this service, 17 OAT sites were opened in 12 years, starting in 2010 (including two satellite sites and two more in correctional facilities). The OAT sites were established through the efforts of the SI NCCA and international donors such as UNODC, Global Fund/UNDP, and others. At the end of 2021, the OAT programme included 622 clients, excluding those in correctional facilities (according to the ERSMT, 2022), representing 2.8% of the estimated number of people who inject drugs (2018 estimate) [24].

Since the start of programme implementation to the present, the primary source of funding has been the Global Fund under grants implemented by UNDP. Other funding sources include programmes and projects implemented by UNODC, CDC, ICAP and GIZ (under the CADAP programme), respectively.

Currently, all OAT sites in Tajikistan use methadone hydrochloride 5mg / 1.0 ml in the form of syrup, which was included on the List of Essential Medicines (LEM) of the Ministry of Health and Social Protection of the Population by Decree No. 118 of February 12, 2015. Later, buprenorphine in 0.2mg tablet form was also included in the LEM (Decree of the Ministry of Health and Social Protection of the Population No. 326 of April 6, 2018). However, buprenorphine has not yet been purchased and used.

# 2. GOAL AND METHODOLOGY

This sustainability assessment of the OAT programme was conducted in the Republic of Tajikistan from September to December 2022 based on the methodology and tools developed and piloted by the Eurasian Harm Reduction Association (EHRA) in 2019–2022 [2]; the previous assessment was carried out in 2020 [1].

The main objectives of the assessment are to:

- Assess the sustainability of the OAT programme as of 2022 within the context of the transition from the Global Fund and other donors to domestic funding according to the methodology developed by EHRA;
- Compare the results of this assessment with the results of the assessment conducted in 2020 and determine what progress or regression has been made over the last two years concerning the sustainability of the OAT programme for each issue area, the corresponding indicators, and overall, and draw appropriate conclusions; and,
- Highlight the risks, identify the country's capacity to ensure the sustainability of OAT within the context of transition, and formulate recommendations that can significantly influence the improvement of sustainability of the OAT programme in Tajikistan.

**Methodology**

The analytical framework for the OAT sustainability assessment includes the areas of policy and governance, finance and resources, and services. Each area is assigned two to four indicators which, in turn, contain a set of benchmarks evaluated against their respective components.

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

<table>
<tr><th>Issue area</th><th colspan="4">Indicators</th></tr>
<tr><td>A. Policy and governance</td><td colspan="2">Political commitment</td><td colspan="2">Management of transition from donor to domestic funding</td></tr>
<tr><td>B. Finance and resources</td><td>Medications</td><td>Financial resources</td><td>Human resources</td><td>Evidence and information systems</td></tr>
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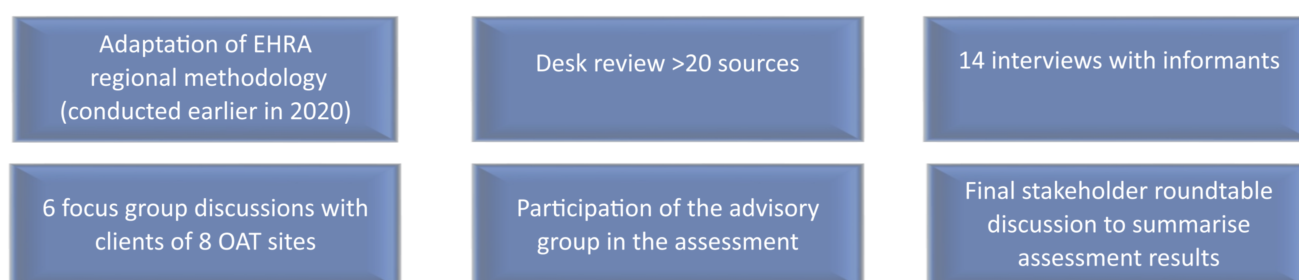
</table>

The assessment includes an overview, analysis of progress, barriers, and opportunities in each area, and overall conclusions and recommendations for ministries and government agencies, national coordinating bodies, practitioners, civil society, technical partners and donors.

Progress made toward the sustainability of the OAT programme in Tajikistan is assessed against the three issue areas. They are presented in a general summary table and individual summaries for each issue area. The following table describes the sustainability scale with the corresponding percentage values.

| *Scale for status of sustainability* | *Description* | *Approximation of the scale in percent* |
|---|---|---|
| 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 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% |

**Analysis Methodology Infographic** (**September–December 2022**)




In the original assessment, the researcher used the methodology and tools developed by EHRA and applied them during February–March 2020. This current analysis included the following main themes: changes since the last assessment (2020); sustainability of the OAT programme within the context of the transition from the Global Fund and other donors to domestic funding to-date (2022); opportunities for transition to domestic financing; and associated risks.

The assessment and its format, methodology and tools were formally agreed upon with the Ministry of Health and Social Protection of the Population (MoHSP). The approval process took

approximately one month. At the initial stage of the assessment, a list of key informants and a schedule of meetings with authorised representatives of the MoHSP were compiled and agreed upon. In parallel, the following activities were carried out: a study of the results of the previous assessment; and collection and analysis of information sources (reports, legal acts, decrees, etc.) published during the period between the two assessments.

Interviews were conducted with 14 key informants in October, 2022 (see the 'Acknowledgements' section of this report for the list of informants), and six focus groups were held with clients from eight OAT sites in the cities of Bokhtar, Vahdat, Dushanbe (SI NCCA, CHC No. 14, CHC No. 3), Kulob, Khujand, and the Rudaki region. In addition, telephone consultations were held with OAT staff in remote areas.

The preliminary findings of the assessment were discussed and agreed upon with a group of key informants that included representatives of the state, donors and public organisations.

The main limitation of this assessment was the short period for its implementation due to the long process of approval and in obtaining permission from the MoHSP.

# 3. Key Findings: Policy and Governance

| | 2020 | 2022 |
|---|---|---|
| **Policy and governance** | **At moderate to high risk** | **At moderate to high risk 37.5%** |
| Political commitment | Moderate | Moderate 53% |
| Management of transition from donor to domestic funding | At high risk | At high risk 23% |

## 3.1. Political commitment

- The Republic of Tajikistan has adopted several laws and regulations which, to a greater or lesser extent, contain provisions that can serve as the legal basis for the implementation of the OAT programme.
- Health Code of the Republic of Tajikistan (30.05.2017, No. 1413) [10]. Article 197 of the Health Code ('Duties of medical institutions providing inpatient narcological treatment') contains the clause, "Provision of alternative substitution therapy for people suffering from narcological diseases."
- National Programme to combat the epidemic of human immunodeficiency virus in the Republic of Tajikistan for 2021-2025 [11]. Under this Programme, OAT is considered a component of the harm reduction strategy. In particular, it envisages increasing the coverage and number of OAT sites and improving accessibility of the OAT programme.
- Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome' (2009) [12]. The preface to these guidelines describes OAT as "one of the most effective treatments for opioid dependence". At the same time, the stated goals of OAT include a decrease in criminal activity, a reduction in the risk of spreading blood-borne infections among people who use drugs, and a reduction in the prevalence of promiscuous sex and sex work among women who use drugs, thereby reducing the risk of spreading HIV, hepatitis B and C, and other STIs in the general population.
- Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015 [13]. In this document, compared to the operational guidelines, the threshold for entering the programme was lowered by removing the criteria of repeated unsuccessful treatment attempts in the past and the presence of somatic diseases

and/or HIV. The clinical guidelines consider OAT as a method of treating opioid use disorder. As it turned out, the clinical guidelines do not replace the previously adopted operational guidelines. Nevertheless, the rule is that if there is a conflict between normative acts, reference is usually made to a later document.

- Clinical guidelines for penitentiary medical institutions providing health services to special contingents with opioid dependence in the Republic of Tajikistan [14], MoJ, 2015, MoHSP, 2015, DCA, 2016.
- Clinical protocol on substitution therapy of opioid dependence syndrome in narcological institutions of the Republic of Tajikistan [15] (approved by Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 1040, dated December 09, 2015) also considers OAT to be a method of opioid dependence treatment.
- The Decree, 'On Improving Narcological [Drug Treatment] Care in the Republic of Tajikistan' [16] (No. 485, dated August 7, 2006) provides for the use of opioid agonists as part of detoxification and rehabilitation programmes for residents, as a stand-alone method of drug dependence treatment, and even as part of the activities of 'trust points' [centres/offices for providing harm reduction services to key populations].
- In the clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan [17] (approved by Decree of the MoHSP No. 281 on April 23, 2019), OAT is considered a method for treating opioid dependence.
- The National List of Essential Medicines of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan [18] (LEM), which includes methadone hydrochloride 5mg/1.0ml in the form of syrup (Decree No. 118 of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan, dated February 12, 2015) and buprenorphine 0.2mg in tablet form (Decree No. 326 of the Ministry of Health and Social Protection of the Republic of Tajikistan, dated April 6, 2018).
- The National List of narcotic drugs, psychotropic substances and their precursors was approved by Decree No. 121 of the Government of the Republic of Tajikistan dated February 27, 2020 [19]. In this list, methadone is classified as a narcotic substance that is "particularly dangerous and at the same time of interest for medical use". In the same list, buprenorphine is classified as a psychotropic substance, "the abuse of which is dangerous to some extent, but the substance is of interest for medical use".

The legislation of the Republic of Tajikistan neither restricts nor hinders the implementation of the OAT programmes (according to the Chief Narcologist of the MoHSP). At the same time, according to the clinical guidelines on OAT, the prescribing of opioid agonists and dose adjustment is the exclusive responsibility of a narcologist (a specialist in drug dependence and psychiatry).

In the past two years, with the support of the CDC, two round tables were organised and conducted in Dushanbe and Khujand with the participation of law enforcement representatives. The main objective of the round tables was to promote the OAT programme (according to a key informant from the MoHSP). In addition, six workshops were conducted on overcoming stigma and discrimination against people who inject drugs and advocacy for OAT (according to a key informant from UNODC).

At the beginning of OAT programme implementation, it was called a 'pilot' programme. Later, no formal regulations were issued that would have abolished its pilot status. On the other hand, subsequent documents (strategies, guidelines, protocols) do not mention that OAT is a pilot programme. The Chief Narcologist of the MoHSP also does not see this as a problem: “If the state has adopted laws and regulations and the OAT programme is already included in the state programmes - what can be a pilot...we are talking about nationwide implementation.”

The Health Code stipulates that OAT is administered only in the context of inpatient drug treatment. Although this fact does not currently prevent the operation of the OAT sites based on outpatient clinics of health care facilities, it could cause problems in the future.

The requirement for dynamic dispensary observation (mandatory registration of clients in the state narcological registration system) inherited from the Soviet drug treatment system remains one of the most influential factors hindering participation by clients in the OAT programme. FGD participants in Vahdat and Dushanbe mentioned this problem. Although Tajik legislation provides for maintaining confidentiality in the provision of health services, in practice, citizens are required to present a certificate from drug treatment centres when seeking employment or entering higher education.

According to legislation, the use of narcotic drugs and psychotropic substances is not a criminal offense. At the same time, possession of any amount of these substances without a doctor's prescription, even for personal use, is punishable. For example, possession of up to 0.5g of heroin is punishable by an administrative penalty, while possession of more than this amount is subject to criminal prosecution.

FGD participants at all OAT sites reported the practice of unlawful and/or unwarranted detention of OAT clients due to incidents related to thefts or other crimes that occurred near the OAT site.

According to one of the OAT site managers in Dushanbe, about 5% of people who inject drugs trying to enter the OAT programme do not have identification documents (such as a passport), which is a barrier to access since having such documents is a prerequisite for starting OAT, according to the 2009 operational guidelines. However, the later clinical guidelines do not mention such a requirement. This practice is because OAT site managers want to avoid potential problems

with law enforcement and regulatory authorities, as methadone is on the National List of Narcotic Drugs, Psychotropic Substances, and Precursors, and its turnover is subject to strict monitoring and reporting.

Almost all key informants agree to some degree with the thesis that if donor agencies immediately stop funding OAT, the programme cannot function. The country is currently unable to cover all the OAT programme costs. A key informant from the Sughd region suggested that in the future it would be possible to finance OAT from the state budget, but probably not in the way it is now. They believe that costs can be minimised, primarily by changing methadone suppliers and forms of dosage. Currently, the Global Fund project purchases methadone in the form of ready-to-use syrup manufactured by 'Molteni' (Italy). This drug is relatively expensive and, in addition, the logistic costs of transportation, storage and other matters are higher than for methadone in powder or tablet form.

The newly adopted Decree No. 145 of the President of the Republic of Tajikistan of March 20, 2021, 'National Drug Control Strategy of the Republic of Tajikistan for 2021-2030' [20] also, like the previous one, does not mention the OAT programme.

Although OAT is clearly defined as an effective method of treating opioid dependence in clinical guidelines and other documents adopted in recent years, some key informants, including a representative of a Dushanbe-based public organisation, tend to view OAT only as a method of HIV prevention and a harm reduction component. In their opinion, 'real' treatment should aim at complete abstinence from any drugs.

All FGD participants agreed that methadone myths are a major factor negatively affecting the popularity of the OAT programme among people who inject drugs. Specifically, common myths say that methadone is 'more dangerous than heroin', 'methadone kills', and 'methadone is only for junkies'. Unfortunately, these myths are sometimes even voiced by state officials and representatives of community organisations that provide services to people who use drugs.

Despite the fact that civil society representatives, including community representatives, participate in the NCC, OAT clients in Tajikistan are rarely involved in the planning and management of these services. There are no clear mechanisms and procedures for obtaining feedback from cltients. This was also highlighted by participants in all FGDs.

## 3.2. Management of transition from donor to domestic funding

Since the 2020 evaluation, there have been no positive or negative developments in the transition of the OAT programme to domestic funding.

Funding for the OAT programme continues to come primarily from international donors. The Global Fund is the largest contributor. Other international donors include CDC (equipment and facilities at OAT sites and staff salaries at five OAT sites), UNODC (technical assistance and training of specialists, procurement of equipment, and renovation of premises at several sites), and the ICAP project (technical assistance, consumables, and financial support for staff at OAT sites).

Government support is limited to providing premises, paying for electricity and other utilities (according to the Chief Narcologist of the MoHSP). The issue of transition to domestic funding has been raised repeatedly in NCC meetings. However, no formal documents (plan, 'roadmap', etc.) have been developed (according to the UNDP/Global Fund project representative in Tajikistan). According to key informants, no documents have been signed or approved in this regard.

*"NCC should advocate for these issues. There is a draft HIV programme transition plan, but it needs to be further developed and updated."* (a key informant from the Global Fund project in Tajikistan).

Now the OAT programme is not a government priority:

*"So far, the transition from donor support cannot ensure the sustainability of the OAT programme and the stability of its funding. The Ministry of Health cannot independently regulate funding issues at the government level because the funds are provided by the Ministry of Finance. If the State is interested, it directs the Ministry of Finance to provide sufficient funding to the Ministry of Health. If the State has sufficient funds, it will allocate them for the procurement of TB medicines and vaccines. This area is a priority. The State is not ready to support OAT."* (MoHSP)

*"In my opinion, given the current situation, the OAT programme transition to domestic funding can take place in five years at the earliest, probably even later."* (interview with key informant V. Magkoev, 2022).

*"When external funding stops, everything will stop."* (FGD, NGO SPIN Plus)

*"The state has neither the will nor the capacity to support methadone-based treatment."* (FGD, Vahdat)

During the FGD with clients of the OAT programme, they were asked if it was possible to introduce paid OAT services. Almost all FGD participants responded that this was not realistic.

*"Some people can afford to pay, maybe 2–4 people."* (FGD, SI NCCA)

*"Most people experiencing drug dependence have no way to pay for methadone."* (FGD, Vahdat)

*"If methadone were a paid service, it will kill us. We are all broke."* (FGD, Bokhtar)

*"We do not have money for testing and treating sores and diseases, and you are talking about buying methadone."*

*"If methadone were a paid service, I would rather shoot heroin. At least then I can get high."* (FGD, Kulob)

# 4. Key findings: Finance and resources

| | 2020 | 2022 |
|---|---|---|
| Finance and resources | At moderate to high risk | At moderate to high risk 42% |
| Medications | Moderate | Moderate 50% |
| Financial resources | At high risk | At high risk 22% |
| Human resources | Moderate | At moderate to high risk 42% |
| Evidence and information systems | Moderate | At moderate to high risk 49% |

## 4.1. Medications

Methadone (Decree No. 118 of the MoHSP, dated February 12, 2015) and buprenorphine (Decree No. 326 of the MoHSP, dated March 3, 2018) are included in the List of Essential Medicines [18]. Both drugs are also on the National List of Narcotic Drugs, Psychotropic Substances, and Precursors and are included in the list of medically approved and compulsorily controlled substances.

The situation with methadone has not changed since the last assessment of the OAT programme in 2020. The OAT programme continues to use only methadone in liquid form.

Procurement is conducted under a parallel international system that provides an alternative to the Procurement Centre of the MoHSP. The HIV and TB project, led by UNDP and supported by the Global Fund, continues to carry out all processes related to tendering, contracting, procurement, transport and storage of methadone. MoHSP involvement in these processes is limited to determining the need for methadone. Forecasts, calculations and preparation of applications and requests within the framework of the needs assessment are carried out by staff of the SI NCCA. Purchases are made in advance and with a buffer stock so that during the reporting period there were almost no interruptions[11] in the availability of both the drug and related consumables and supplies (rapid tests for psychoactive substances (PAS), HIV, RW, HCV and HBV, blood test tubes for viral load testing, etc.) at the OAT sites. After the drug is delivered to Tajikistan, the methadone is stored centrally in a warehouse rented by UNDP. Distribution of methadone to OAT sites proceeds as follows: local OAT sites submit quarterly requests (OAT sites in hard-to-reach areas of the country submit semi-annual requests); the SI NCCA consolidates the requests and, based on this information, a general request is submitted to UNDP; UNDP then delivers methadone to the OAT sites across the country.

[11] In 2020, there were concerns that the supply of methadone might be inadequate because a shipment of methadone was detained at Vnukovo Airport in Russia. Fortunately, these fears did not materialise.

The country buys relatively expensive methadone in the form of ready-to-use syrup produced by 'Molteni' (Italy). Such a dosage form has a significantly larger volume and mass than a tablet or powder. Accordingly, the logistical costs (transportation, storage, etc.) are also considerably higher. As shown in the report by Latypov (2020) [1], the estimated annual cost of methadone per client in the OAT programme is USD50 when using the tablet form and USD143 when using the liquid. Thus, the average cost of treatment per client can be reduced by switching providers and dosage forms. Key informants in both the previous and current assessments expressed this view. At the same time, there were no official calculations of treatment costs if purchasing methadone in tablet or powder form. Another possible way to reduce medication cost, mentioned by some key informants, could be the establishment of mechanisms for the OAT service provision by pharmacy networks. Reducing the average cost of treatment per client is an essential factor that may contribute to greater sustainability of the OAT programme after the transition to domestic funding.

## 4.2. Financial resources

It is impossible to obtain information from the MoHSP budget or the budgets of local health facilities about the separate costs of a particular programme implemented under a specific service. This also applies to the OAT programme.

According to key informants (MoHSP, directors of regional narcological [drug treatment] centres and OAT site managers), the government's contribution generally covers the cost of utilities, electricity, and premises for the OAT sites. At the same time, the facilities often require renovation, which is funded by donors.

In the past two years, the OAT programme in Tajikistan has been financed mainly by the Global Fund grant implemented by UNDP (Tables 1 and 2). Other donors contributing significantly to the OAT programme include CDC (staff salaries at 5 OAT sites) and UNODC (renovation costs and equipment at 3 OAT sites). Currently, with the support of these donors, 17 OAT sites are open and operating, including two sites in the penitentiary system and two satellite sites (OAT sites where methadone is dispensed daily and a narcologist visits the site from time-to-time). In addition, three more OAT sites are about to open. All costs for repairs, equipment and supplies, provision of medications, and staff salaries continue to be covered by international donors.

**Table 1. Data on UNDP funding of the OAT programme under the Global Fund grant for 2020–2023 (key UNDP informant in Tajikistan, amounts are in national currency, Somoni)**

| Activities | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| Procurement of methadone | 678 387,08 (~62 162,1 USD) | 86 393,11 (~7 916,4 USD) | 2 895 557,08 (~265 326,13 USD) | 0,00 |
| Procurement of buprenorphine | - | - | - | - |
| Expansion of the OAT site network, establishing new OAT sites and equipping all OAT sites | - | - | - | - |
| Support of integrated services for people who inject drugs living with HIV (ART, OAT, TB, concurrent diseases, etc.), specialised services (infectious diseases, TB, psychologists) | 23 903,07 | 69 686,31 | 153 576,02 | 165 862,07 |
| Quality monitoring and training of OAT programme staff | 52 334,06 | 25 671,69 | 31 449,57 | 33 965,57 |
| Training of MDECS and NGO staff (HIV prevention, social support, STIs, harm reduction programme and OAT) | 140 465,13 | 265 741,21 | 467 216,88 | 538 921,24 |
| Maintaining and expanding OAT coverage at MDECS institutions | - | - | - | - |
| Implementation of 'one-stop-shop' approach in the OAT programme | - | - | - | - |
| Support of staff (salaries) at OAT sites | 1 048 185,66 | 1 074 060,48 | 1 823 279,64 | 2 260 232,52 |
| Other costs (please, list) | - | - | - | - |

**Table 2. Activities related to the OAT programme from the Implementation Plan of the National Programme to Combat the HIV/AIDS Epidemic in Tajikistan, 2021–2025 (document is in Tajik only; amounts are in the national currency, Somoni)**

| Activities | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|
| Procurement of methadone and naloxone | 3 325 100 | 3 340 345 | 3 365 780 | 3 374 770 | 3 387 090 |
| Expansion of the OAT site network, establishing new OAT sites and equipping all OAT sites | 850 000 | 900 000 | 950 000 | 950 000 | 970 200 |
| Support of OAT sites that provide integrated services for people who inject drugs living with HIV (ART, OAT, TB, concurrent diseases, etc.) | 500 000 | 550 000 | 600 000 | 600 000 | 600 000 |
| Quality monitoring and training of OAT site staff | 200 500 | 222 500 | 230 500 | 240 000 | 242 000 |
| Training of MDECS and NGO staff (HIV prevention, social support, STIs, harm reduction programme and OAT, etc.) | 165 000 | 170 000 | 175 000 | 170 000 | 170 000 |
| Maintaining and expanding OAT coverage at MDECS institutions | 60 000 | 70 000 | 80 000 | 90 000 | 100 000 |
| Implementation of unified services for PLHIV based on HIV, TB and OAT centres, maternity clinics and PHC | 500 000 | 550 000 | 600 000 | 650 000 | 700 000 |

Based on the information in the above tables, it is difficult to understand the specifications of the planned expenditures; for example, which part of it is spent on training and which on honoraria. The MoHSP is responsible for the implementation of all activities included in the Programme Implementation Plan. At the same time, the sources of funding are the Global Fund, partners and budgetary funds. It is unclear which units of the MoHSP are responsible for a particular activity and how the costs are allocated by funding source (Global Fund, partners and state budget). There are no data specifying the group of 'partners' funding the activities.

## 4.3. Human Resources

The provision of drug misuse treatment services is the prerogative of the Narcological Service of the Republic of Tajikistan. At the same time, the strategy for protecting the health of the population for the period up to 2030 [22] states that, “Tajikistan faces the problem of the insufficient number of doctors in some specific specialties.” The list of such specialties includes psychiatrists-narcologists. Both key informants representing the drug treatment system and FGD participants at most of the OAT sites have mentioned the negative consequences of this situation. The professionals who perform the duties of a narcologist at OAT sites perform other tasks at the same time. Some of them are forced to travel from one place of work to another, and the distances can be considerable. Therefore, the presence of a narcologist at an OAT site may be limited in time. This has a negative impact on the quality of services provided. For example, 6 of the 15 OAT sites are located in PHC facilities that do not have narcologists on staff. Due to this situation, there are narcologists at these sites whose primary workplace is another drug treatment facility.

According to key informants (MoHSP, SI NCCA), a 'bonus system'[12] for staff remuneration was introduced in 2019 at Global Fund-supported OAT sites. It means that payments are calculated according to quantitative performance, with a reduction in the basic salary. The purpose of introducing this system was to increase the coverage of people who inject drugs. However, this led to side effects in the form of 'chasing' new clients and increased staff turnover. Staff layoffs (social workers, nurses, security guards, pharmacists, narcologists) were observed at OAT sites with a small number of clients. Since July 2022, the bonus system has been revised to increase the basic monthly payment to 600 Somoni and to pay the bonus portion individually based on the results achieved by the OAT site. Despite this change, the outflow of employees from the OAT programme continues.

[12] The 'bonus system' was introduced at the request of the Global Fund, which has not paid salaries to public sector employees since 2018.

Staff turnover was also influenced by the fact that ICAP support for OAT staff was reduced in the last two years due to funding cuts (seconded infectious disease physicians from AIDS centres, TB physicians from a TB centre, peer counselors (navigators) from local NGOs, and psychologists) who provided integrated services using the 'one-stop-shop' approach.

Staff turnover has impacted not only local OAT sites but also the OAT programme components that are implemented at national level. In particular, there is currently no mentoring specialist at the national level.

According to the programme's staffing structure, the following positions exist at OAT sites:

- OAT site manager;
- Narcologist;
- Psychologist (only at the SI NCCA);
- Social worker;
- Pharmacist;
- Medical laboratory technician (only at the SI NCCA and Khujand);
- Nursing assistant;
- Nurse;
- Security guard; and,
- Driver (only at the SI NCCA).

There are also paid managerial positions at the national level. In OAT sites located in PHC facilities, a manager is the director of the PHC facility, who is responsible only for organising and managing the activities of the OAT site.

As mentioned by Latypov [1] in the 2020 report, the workload varies at different sites. At the same time, employees working in similar positions at different facilities receive the same base salary and the difference in bonuses is negligible.

Moreover, it should be noted that the salaries of staff of the five sites (including two satellite sites) supported by CDC is twice that of staff at the 12 OAT sites supported by the Global Fund project implemented by UNDP. This situation leads to unhealthy competition between the staff of OAT sites.

According to key informant V. Magkoev, the system of formal education, training and retraining of specialists on OAT issues has not been established. This situation negatively affects the quality of services, especially in view of existing staff turnover. Previously trained specialists change jobs or even leave the country. At the same time, there is no institutional basis for training new professionals.

Previously, with the support of the ICAP project, there was a mechanism for continuous training of OAT programme staff in the workplace (mentoring visits). This process was discontinued as the financial support was over. This fact has influenced the decrease in the indicator of the degree of sustainability in the human resources component.

## 4.4. Evidence and information systems

Following the 2020 OAT programme assessment, a study was conducted to assess the outcomes of implementing HIV and TB services at OAT sites using the 'one-stop-shop' principle [25]. Local experts participated in data collection for the report. The study showed positive results of implementing an integrated approach to service delivery at the OAT sites. At all OAT sites, people who inject drugs and living with HIV adhered to ART and had viral suppression, and people who inject drugs and had TB completed the DOTS course with 'cured' and 'treatment completed' outcomes. It should be noted that a retrospective analysis of outpatient documentation of clients in the OAT programme prior to the implementation of integrated services revealed a high mortality rate among clients with TB.

UNODC is currently conducting a survey (mapping) of health facilities that provide services to people with substance use disorders in Central Asian countries. The results of this survey will be published in 2023.

In January 2023, UNDP plans to conduct a study of the drug scene in Tajikistan under the Global Fund project which will examine actual injecting and non-injecting drug use in the country, as well as non-medical drug use. The study results will provide data to develop recommendations for expanding coverage of people who inject drugs with the OAT programme.

During July–August 2022, with the technical support of the CDC, another Integrated Biobehavioral Study was conducted in Tajikistan [24]. One of the study objectives was to determine the estimated number of people who inject drugs in the country. The results of this study will be available in 2023.

By March 2022, the Electronic Registry of Substitution Maintenance Therapy (ERSMT), developed under the ICAP project, was functioning in the country and was implemented at all OAT sites [23] in the civil sector. ERSMT is a medical information system for collecting, storing and processing data on all clients of the OAT programme. This system allows OAT clients to receive services at different locations if they move. To do so, they only need to provide a certificate from the former OAT location if it is not in the same city. The physician at the former OAT location must transfer the electronic data of the client in the system to the new location.

The ERSMT system allows physicians to obtain not only information about the dosage of the drug, but also all the necessary information about the client. The ERSMT system is a full-fledged tool for monitoring the activities of the OAT programme. It allows remote control of the quality of service delivery and to evaluate the effectiveness of OAT at different levels. All OAT participant data in the system are stored confidentially: staff at one site cannot view the clients data at another in the electronic system, with the exception of the OAT site at the SI NCCA as the administrative centre. The electronic database is adequately protected, and there have been no instances of confidentiality breaches or unauthorised access throughout the operation of the ERSMT system.

However, between March and November 2022, the electronic registry did not function because the technical capabilities of the server were unable to cope with the large amount of OAT client data. This may have contributed to a drop in the sustainability score for the 'evidence base and information systems' component.

# 5. Key findings: Services

| | 2020 | 2022 |
|---|---|---|
| Services | At moderate to high risk | At moderate to high risk 41% |
| Availability and coverage | At high risk | At high risk 17% |
| Accessibility | Moderate | Moderate 57% |
| Quality and integration | Moderate | Moderate 50% |

## 5.1. Availability and coverage

The following institutions provide drug treatment in Tajikistan (MoHSP):

- State Institution 'Professor Gulyamov National Clinical Centre for Dependence' (the SI NCCA);
- Narcological centres in the cities of Khorog, Khujand, Kulob and Bokhtar;
- 45 narcological offices under the Central Regional Hospital; and,
- The Tangai Medical and social rehabilitation centre for people experiencing dependence (the only one in the country).

No new OAT sites have been opened in Tajikistan since the last assessment. Preparations are underway for the opening of three new sites in the country's penitentiary institutions, including one in the remand prison in Dushanbe and penitentiary institutions in the city of Vahdat and in Sughd region. The relevant document has already been signed by the authorities of the Ministry of Justice (Decree No. 176 of the Deputy Head of the Main Department for Execution of Criminal Sentences of the Ministry of Justice, dated 18.09.2021). Currently, OAT clients cannot continue methadone therapy after arrest or incarceration. In addition, OAT services are only available to men in prison. The new sites opening in pretrial detention centres and correctional facilities for women will ensure continuity of the OAT programme between health care facilities and the penitentiary system and will make services available to women in custody or serving a sentence. There are currently 17 OAT sites in the country: 13 in the health care system (two of which have satellite sites) and two in the penitentiary system (no data available). As of 1 December 2022, 614 clients received OAT services in civil sector health facilities (Figure 4). According to legislation, OAT services cannot be provided by NGOs and in private clinics. This factor limits the development of the programme.

**Figure 4. Number of participants in the OAT programme in Tajikistan as of 01.12.2022 (ERSMT)**

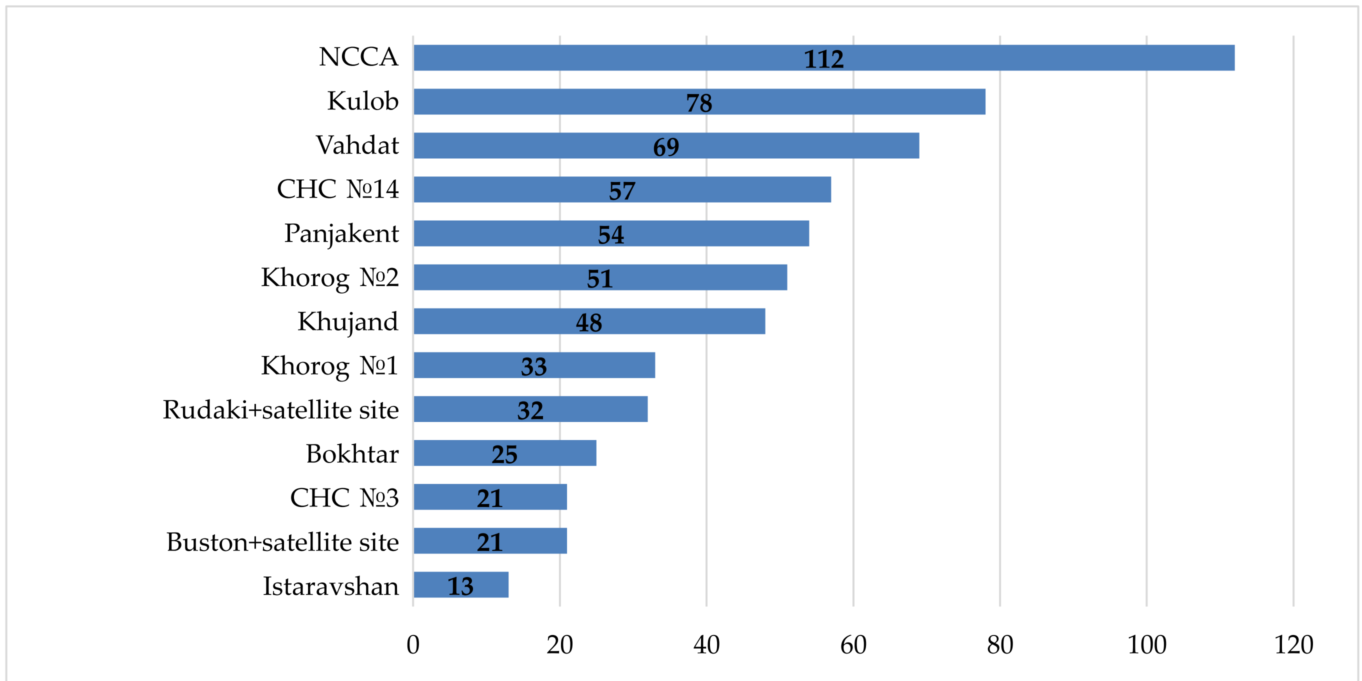
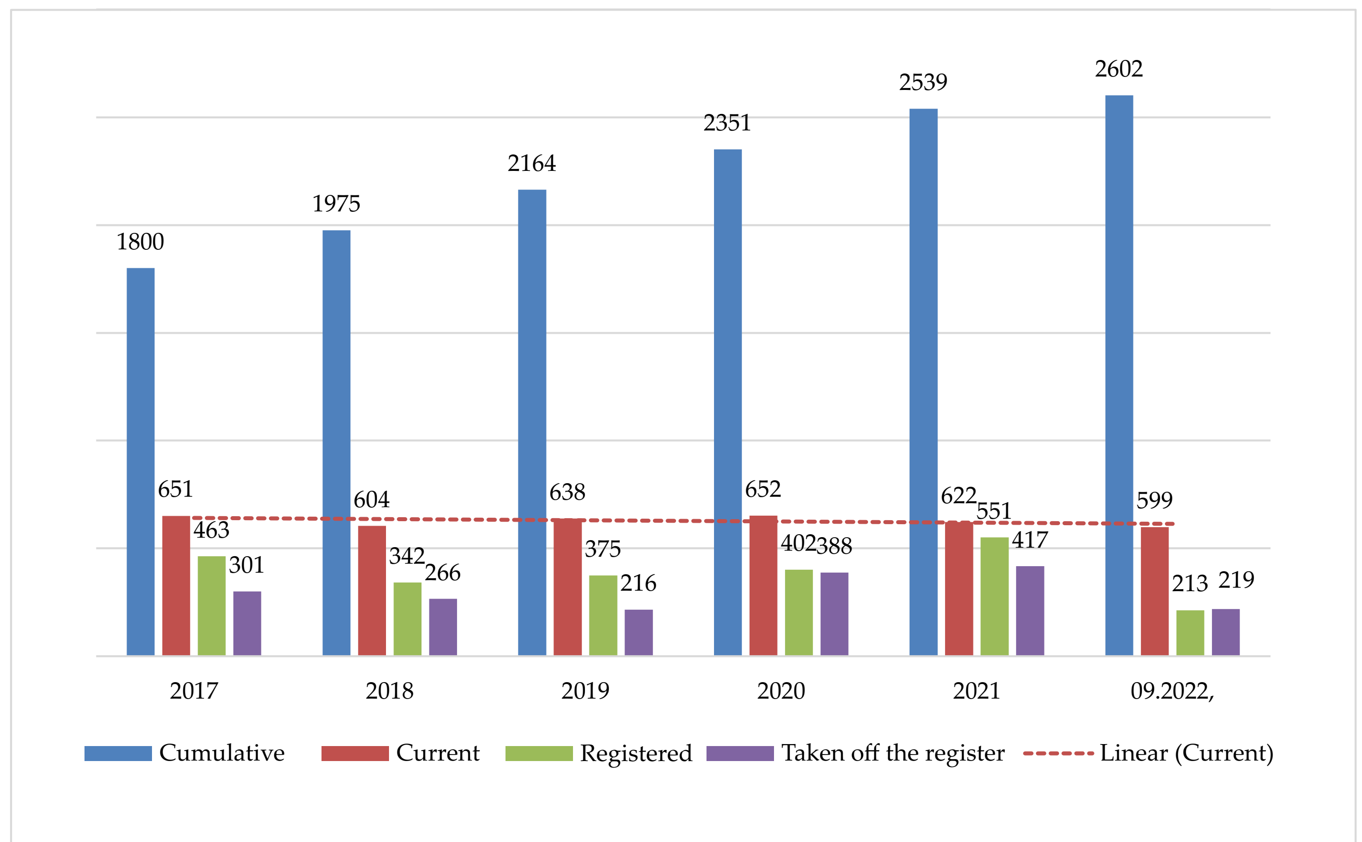



**Figure 5. Dynamics of OAT programme clients in Tajikistan (excluding those in the penitentiary system) from 2017 to 30.09.2022 (unpublished report of the ERSMT coordinator)**



As can be seen from the data above, the coverage of people who inject drugs by the OAT programme has not changed significantly since the last assessment and remains at a low level (about 3%). According to key informants (MoHSP), the number of people who inject drugs in the country has decreased due to the reduced availability of heroin and does not match the estimated number. This is also indirectly evidenced by a significant decrease in visits by people who inject drugs to narcological facilities and cases of opioid overdose.

OAT in Tajikistan currently functions as an outpatient service. Methadone is not used for detoxification in a hospital setting. There are mechanisms for dispensing methadone to clients undergoing inpatient treatment for certain diseases. Some of the OAT sites are located within PHC facilities. There is no dispensing of take-home medication, although this is provided for in legislation.

According to FGD participants at the OAT sites in Kulob and Bokhtar, a significant number of new clients could be attracted to the OAT programme if it were more accessible to people who inject drugs who are living near these cities and in surrounding districts. It could be achieved by opening new/satellite OAT sites or by organising mobile teams.

FGD participants receiving OAT services at sites in Kulob and City Health Centre No. 14 in Dushanbe noted that doctors are often busy with other tasks. Hence, clients do not always receive consultations. It is also a barrier for new clients to receive services. According to key informants, this happens because OAT physicians simultaneously perform their duties at other health care facilities / departments. Sometimes, the OAT site location is on the other side of the city/town from the primary workplace of a narcologist.

Another barrier to the expansion of OAT coverage is the lack of 'take-home' methadone for clients. Although clinical guidelines and protocols clearly outline the mechanisms and procedures for dispensing 'take-home' methadone to stabilised clients, these procedures are not used. Narcological service authorities explain this by the absense of a normative act (coordinated with law enforcement) that would give programme clients the right to possess methadone. It is necessary to form a working group that includes representatives of the MoHSP, DCA and the Ministry of Interior Affairs to develop such a document.

## 5.2. Accessibility

The OAT programme is currently implemented mainly in cities (Figure 6).

Dushanbe:

1) SI NCCA, CHC № 3 and CHC № 14,

Regions of Republican Subordination (RRS):

2) Rudaki district and satellite site of Rudaki district in Juybadam jamoat.
3) Vahdat

Khatlon region:

4) Bokhtar
5) Kulob

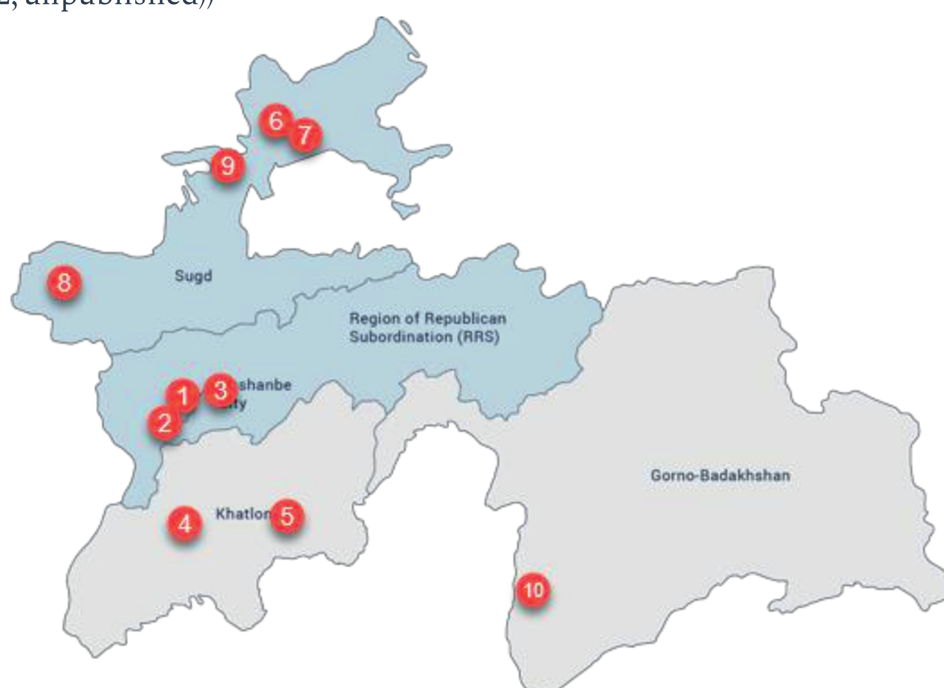
Sughd Region:

6) Khujand
7) Buston
8) Panjakent
9) Istaravshan

Gorno-Badakhshan Autonomous Region:

10) Khorog, site № 1 and site № 2.

**Figure 6. Geographic location of OAT sites in Tajikistan** (draft report on mapping medical facilities providing services to people with substance use disorders in Central Asian countries (UNODC 2022, unpublished))



OAT sites are located in these cities because they have the highest number of officially registered people who inject drugs.

Official data do not always reflect the real situation. For example, the low number of people who inject drugs registered in the Rasht Zone could be due to the low quality of drug treatment services and the respective low number of people who inject drugs seeking help. In the Rasht Zone, physicians of other specialties work part-time as narcologists. In fact, they can only perform statistical tasks. The same applies to Khatlon region on the border with Afghanistan.

The capacity for OAT service provision is limited enough to meet demand in major cities and towns. The limitations are due to national standards that entrust the provision of these services to narcologists, of whom there are not enough. There are no waiting lists for the OAT programme in the country. However, this may be due to the lack of narcologists and OAT sites in some regions.

Participants of FGDs in Bokhtar and Kulyab noted that the geographic distance between the OAT sites and the places where people who inject drugs live is the factor that discourages new clients from starting OAT. A vivid example is a mother and her two sons from the Vakhsh district in the Khatlon region. They are forced to spend at least 60 Somonis (a little less than USD6) each day to travel to Bokhtar and back. According to them, between 50 and 100 people who inject drugs in the Vakhsh district do not have access to OAT services.

In Kulob, the situation is similar. Here, FGD participants reported a large number of people in need of OAT services and living in Vose, Kulob, Shuroobod [now Shamsiddin Shohin], Hamadoni, and Muminabad [now Mu'minobod] districts.

FGD participants mentioned the need to open new OAT sites or to establish mobile sites in these districts.

National standards envisage the provision of methadone from 07:00 in the morning and at weekends. In Tajikistan, the work schedule of all OAT sites provides for methadone dispensing at weekends and holidays. However, in practice, only some OAT sites start methadone provision at 07:0. In addition, the time for providing services at OAT sites is limited: services are provided until noon. After this, the staff work on documentation.

In Dushanbe, the only city in Tajikistan with a population of more than one million, there are three OAT sites in Firdavsi, Sino and Shokhmansur districts, as well as one site within the penitentiary system.

The national policy does not include measures to regulate the affordability of OAT as this programme is funded by international donors.

The country does not have a health insurance system. Therefore, there are no mechanisms for regulating client expenses, considering their financial situation, support mechanisms, and excluding possible hidden payments, etc. In Tajikistan, OAT clients (like other citizens) have to pay for diagnostic services themselves to start the OAT programme. The tests include general blood and urine tests, liver tests, chest X-rays, etc. Currently, the diagnostic costs are partially covered by local NGOs at the expense of international donors.

In Tajikistan, the national OAT standards take into account the interests of various population groups that may have difficulties accessing OAT services. The national OAT standards do not have contraindications for the inclusion of pregnant women who inject drugs into the programme. Clients under 18 years of age require consent from their parents or guardians to participate in the programme.

In large cities, NGOs operate programmes that provide specialised services to key populations with special needs (people who inject drugs who are living with HIV, pregnant or lactating mothers who inject drugs, etc.). However, the availability of such services is entirely dependent upon funding from international donor agencies and is not stable

In Tajikistan, there are identified key populations with special needs, and various health strategies envisage services to address those needs.

In the national standards, the use of illicit drugs is not a criterion for exclusion from the OAT programme. At the same time, there is no clear indication that people who use drugs that are not prescribed by a doctor should not be excluded from the programme.

If a person uses non-prescribed (illicit) drugs, national standards recommend reviewing and adjusting the OAT medication dosage and treatment approach in case of need.

National standard requirements are met in the majority of OAT sites in Tajikistan. FGDs conducted as a part of this study found no evidence of systematic non-compliance with the standards.

Major cities and towns with OAT facilities also have needle and syringe programmes that are available to OAT clients.

In general, national standards provide for a detailed needs assessment, consistency of treatment with those needs, and informed consent from the client. There are no contraindications for pregnant women and no age restrictions. However, for those under 18 years of age, parental or guardian consent must be obtained. There is a list of documentation to be completed for each client, including medical history, clinical examination data and tests.

For each client, there is an individual treatment plan according to the clinical protocol. This plan is reviewed every three months or sooner if needed.

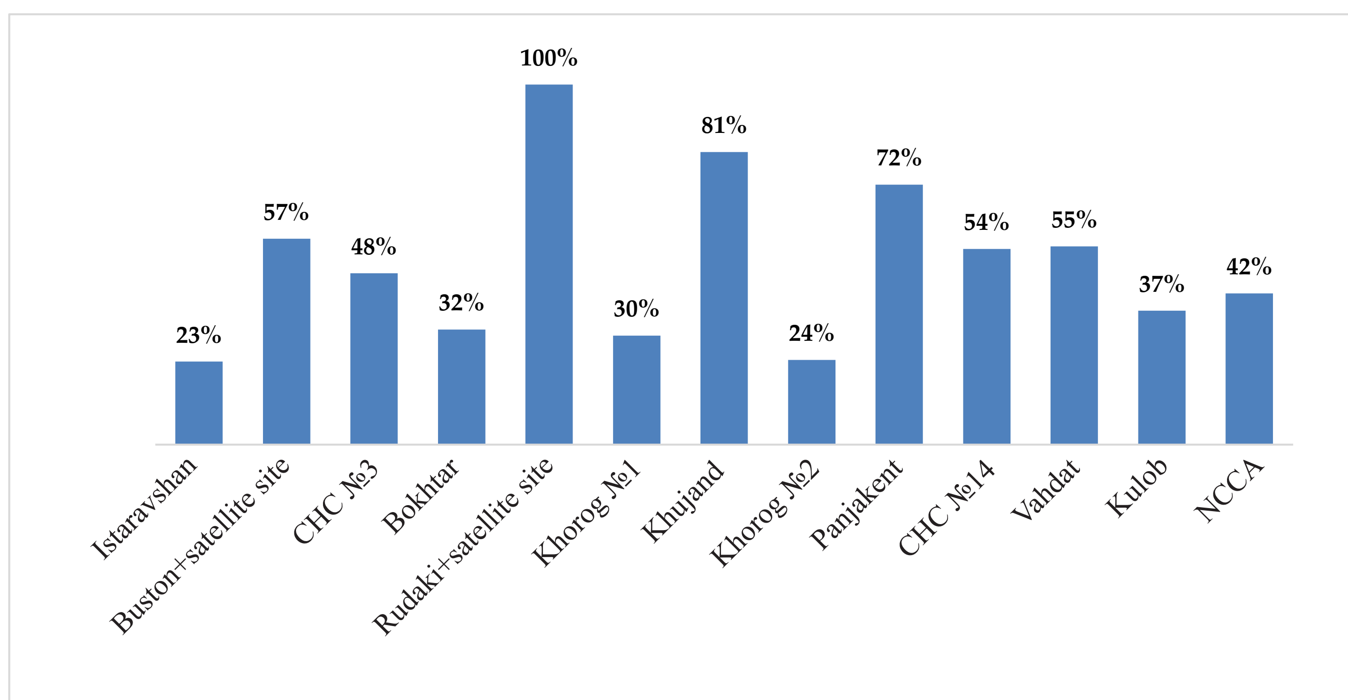
The clinical protocol does not provide barriers to starting the OAT programme for individuals who did not previously receive drug dependence treatment. In practice, people are not required to confirm previous unsuccessful treatment attempts to participate in the OAT programme.

The clinical protocol prioritises the inclusion in the OAT programme of people living with HIV, pregnant women who inject drugs, people with TB who inject drugs, and people who inject drugs and have viral hepatitis

## 5.3. Quality and integration

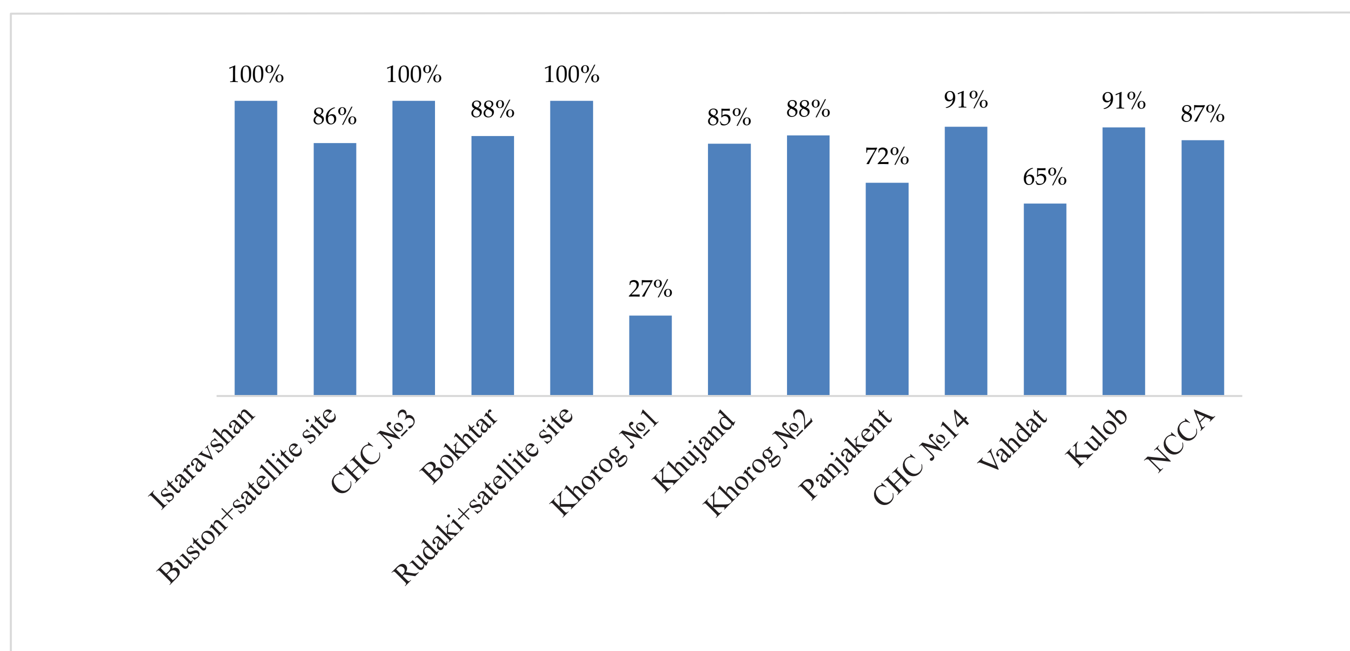
Currently, all OAT sites use methadone in syrup form. People who inject drugs have no alternative and no choice. It should be noted that the inclusion of buprenorphine in the LEM of the MoHSP in 2018, as well as the availability of approved clinical guidelines on the use of buprenorphine, opens opportunities in this regard. In OAT sites in Tajikistan, the WHO recommendations on methadone dosing are generally followed (Figure 7).

**Figure 7. Proportion of clients in the OAT programme receiving daily doses of 60mg's or more as of December 1, 2022 (ERSMT)**




The OAT programme in Tajikistan has a high client retention rate (Figure 8).

**Figure 8. Percentage of OAT clients on therapy for 6 months or longer as of 1 December 2022 (ERSMT)**




The clinical protocol specifies a minimum dose of 60mg's for methadone and 12mg's for buprenorphine. The limitation, according to the 2009 operational guidelines, is a dosage of 200mg's of methadone. There are no such restrictions in the clinical guidelines. For buprenorphine, the clinical guidelines state that, "the manufacturer's recommended maximum daily dose of buprenorphine (with or without naloxone) is 16–24mg's" [17]. Thus, there is no strict dose limit for buprenorphine in the clinical guidelines.

In six of the thirteen OAT sites, the proportion of clients receiving a maintenance dose of methadone ≥60mg's was 46% on 1 December 2022 (Figure 7).

Clinical guidelines indicate that OAT in Tajikistan is aimed at maintenance therapy (6 months or longer) and this standard is met in most cases. OAT clients confirmed this information in the course of the FGDs.

According to ERSMT data, as of 1 December 2022, in 12 of 13 sites, the proportion of clients who remained on therapy for more than six months ranged from 65% to 100% (Figure 8).

The integration of the OAT programme with the services of AIDS centres, TB services and relevant NGOs is declining.

Formally, there are social workers at every OAT site. However, the quality of psychosocial work is low because their knowledge and skills in this area are insufficient. In Tajikistan, there are no educational institutions where social workers are trained to work with people who inject drugs. Psychological services are available only on the basis of the OAT site at the SI NCCA.

Since the beginning of 2022, the quality of services was affected by the discontinuation of financial support for staff at OAT sites, including seconded specialists from TB and HIV services, as part of service delivery under the 'one-stop-shop' principle. Seconded physicians stopped visiting OAT sites due to a lack of motivation. As a result, the number of clients receiving HIV and TB services at OAT sites declined significantly. FGD participants representing all OAT sites that previously offered integrated services reported a decline in the quality and attractiveness of services.

Similarly, SI NCCA specialists worked with ICAP specialists to conduct quarterly mentoring visits to OAT sites in Dushanbe, RRS and Sughd region. They mentored staff, monitored processes, assessed the quality of data from the ERSMT system, analysed complex clinical cases, and provided on-site mini-training (coaching) to staff on key topics based on identified vulnerabilities. According to the results of each mentoring visit, a service improvement plan was developed on-site that included a description of activities, designation of responsible individuals, and deadlines. However, after funding for the ICAP project was cut, it became difficult to assess the frequency and effectiveness of these visits.

According to key informants (UNDP), an additional indicator for non-governmental organisations –referrals of people who inject drugs to the OAT programme – was introduced to increase coverage of people who inject drugs by OAT services. Key informants at OAT sites in Dushanbe said that the vast majority of new clients came to the OAT programme on their own or were brought by other participants. This may indicate a low level of collaboration between NGOs and the OAT programme.

OAT programme clients reported that programme staff often treated them indifferently. Services are limited to dispensing methadone.

*“They do not want to talk to us much. Come, drink, and go. They have removed the benches where we used to sit.”* (FGD at the OAT site at the SI NCCA)

“*We leave home early in the morning to get methadone. We do not even have time to eat breakfast. If only we could get Rolton (instant noodles) here or at least cook it ourselves.”* (FGD at the OAT site in Bokhtar)

# 6. Conclusions and recommendations

The Republic of Tajikistan has a legal framework enabling the implementation of the OAT programme. At the same time, there are gaps and inconsistencies in various national legal acts. These issues need to be completed and harmonised. For example, provisions in legal documents that reserve opioid agonist prescribing and dose adjustment exclusively to a narcologist, together with the shortage of physicians in this specialty in the country, hinders the expansion of the network of OAT sites to unserved regions of the country and, therefore, the availability of OAT for people who inject drugs. The Health Code of Tajikistan does not clearly indicate the possibility of providing OAT as an outpatient service.

The insufficient financial support of the OAT programme by the State and the lack of visible changes in the existing situation pose significant risks to the sustainability of the programme in the future. For almost five years, the plan for transition to domestic funding has not been adopted.

A major barrier to engaging people who inject drugs in the OAT programme is dynamic dispensary observation (registration in narcological facilities).

There are cases of stigmatisation and discrimination against clients of the OAT programme, especially by law enforcement officials.

Most people, including MoHSP officials, narcologists, and even members of the community of people who use drugs, tend to think of the OAT programme solely as an HIV prevention method and a harm reduction component focused on the problem of drug use.

The formal mechanisms for dispensing take-home methadone doses to clients are not yet used in practice.

There are no mechanisms, procedures, or practices for client engagement in the work of the OAT programme.

All key informants consider the immediate prospect of a transition to domestic funding as unrealistic.

Existing procedures for procuring medications and supplies for the OAT programme in Tajikistan are relatively expensive due to the fact that the liquid form of methadone itself is costly and requires much more transportation and storage costs than would be required for a powder or tablet form of the drug.

There is a shortage of narcologists in the country, which affects the effectiveness and quality of services provided within the OAT programme, as specialists are forced to combine work at OAT sites with their primary job.

Current staff turnover in the Narcological Service requires that new employees acquire the appropriate knowledge and skills in OAT provision on time. However, there is no system for training and retraining specialists (narcologists, psychologists, social workers, pharmacists, etc.).

Providing services to OAT clients according to the 'one-stop-shop' principle, which has been practiced for five years at 9 OAT sites, has proven to be highly efficient in terms of treatment adherence of OAT clients living with HIV and HIV/TB. Unfortunately, this practice has not been institutionalised.

Coverage of people who inject drugs with OAT services remains extremely low (less than 3%) compared to the estimated number of people who inject drugs in the country. Expansion of coverage is hindered by the relatively low availability of OAT in many regions of Tajikistan, the lack of adequate information about this programme and existing opportunities for participation, and the widespread myths about methadone combined with a large amount of misinformation on the Russian-language segment of the Internet.

Mentoring is an important factor influencing the quality of services provided by the OAT programme. In Tajikistan, specialists from the SI NCCA regularly conduct mentoring visits to OAT sites in the regions. At the same time, there are no mechanisms for training mentors and evaluating the quality of mentoring.

**Recommendations**

- Develop a realistic plan for the transition to domestic funding involving a broad range of experts from the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan, the Ministry of Finance of the Republic of Tajikistan, and international donors, as well as representatives of non-governmental organisations and the community in the discussion process.
- Hold meetings involving a broad range of stakeholders to discuss progress and prospects for transitioning the OAT programme to domestic funding. Publish and distribute information on the outcomes of these meetings.
- Introduce the necessary amendments to the Health Code (include the OAT programme in the functions of ambulatory care; revise the provisions for dynamic observation and the provision assigning the prescribing of OAT medications to narcologists only).
- Put into practice the mechanisms of anonymous provision of services in health care institutions following Decree No. 301 of the Ministry of Health dated 05.06.2008, *'On approval of records of clients in the provision of anonymous medical services'*.

- Raise funds from various national foundations and other possible domestic funding sources to support the OAT programme.
- Conduct a systematic advocacy and information effort to reduce stigma and discrimination against OAT participants by law enforcement.
- Establish and maintain close cooperation between the institutions of the Ministry of Health and Social Protection of the Population providing OAT services and local NGOs through regular meetings to discuss issues of expanding OAT coverage, the quality of OAT services, etc.
- Expand the OAT programme in the penitentiary system and implement them in temporary detention facilities under the Ministry of Interior Affairs.
- Develop and approve a joint instruction coordinated with the Ministry of the Interior Affairs and the DCA for 'take-home' medications for OAT clients.
- Introduce cheaper forms of methadone (powder, tablets) suitable for transition to domestic funding, in addition to the existing procurement system for the ready-to-use drug (methadone syrup). Revise existing clinical guidelines and protocols to include procedures for dispensing methadone tablets and/or methadone powder.
- Implement a system of informing about the OAT programme aimed at dispelling existing myths about OAT medications for employees of government agencies and non-governmental organisations that provide services to people who inject drugs.
- Develop and support mechanisms for client involvement in planning and managing the work of the OAT programme at all levels.
- Consider reducing costs of the OAT programme by changing drug procurement policies and practices and the format of the programme itself.
- Calculate the cost of treatment per client when purchasing methadone in tablet or powder form.
- Discuss the possibility of offering OAT services through pharmacy chains.
- Institutionalise mechanisms for providing integrated services using the 'one-stop-shop' approach at OAT sites where feasible.
- Review the staffing structure of OAT sites in light of the shift to domestic funding and taking into account “the limited spending on health care in Tajikistan” [1].
- The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan and the State Institution Professor Gulyamov National Clinical Centre of Dependence, together with the UNDP project, should continue their efforts on the further development of the 'bonus system' to motivate and retain the staff of the OAT sites.

- The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan and the State Institution Professor Gulyamov National Clinical Centre of Dependence should establish a system for ongoing on-site training and mentoring.
- Establish a system for training and refreshing professionals in the field of OAT in state educational institutions: develop curricula, modules, etc.
- Review, where possible, the mechanisms and procedures of the work of OAT sites to improve the accessibility of their services to clients (opening hours, the establishment of mobile teams and satellite sites, etc.).
- Revise eligibility criteria for the OAT programme to facilitate access to OAT services for people who use opioids but do not inject them.
- Continue funding the OAT programme in Tajikistan, taking into account that the country is not ready to transition to domestic funding in the near future.
- Support the development of a realistic plan for the transition to domestic funding with the involvement of international consultants and experts.
- Plan further funding of the OAT programme taking into account the need for:

  (i) training and refresher training for staff at OAT sites;
  (ii) conducting trainings for staff of organisations that provide services to people who inject drugs to develop an adequate understanding of the concept, purpose, and objectives of the OAT programme;
  (iii) support of an adequate and fair motivation system for OAT programme staff and in improving the quality of services;
  (iv) services to diagnose and treat coexisting conditions for OAT programme clients;
  (v) procurement and provision of buprenorphine as an alternative to methadone;
  (vi) supporting the establishment of OAT mobile or satellite sites where feasible.
- Support the holding of regular NCC-based partner meetings on issues related to the transition of the OAT programme to domestic funding.
- Continue to work with the Ministry of Justice to further improve the accessibility of OAT services in the penitentiary system, especially for women who inject drugs.

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[13] Маджлиси Оли Республики Таджикистан (Парламент) состоит из двух Маджлисов (палат) Маджлиси милли и Маджлиси намояндагон. Аббревиатуры: МН МОРТ – Маджлиси намояндагон Маджлиси Оли Республики Таджикистан); ММ МОРТ – Маджлиси милли Маджлиси Оли Республики Таджикистан). In Russian. The Majlis-i Oli of the Republic of Tajikistan (Parliament) is composed of two chambers (majlis-i) - the Majlis-i Milli and the Majlis-i Namoyandagon. Abbreviations: MN MORT – Majlisi namoyandagon Majlisi Oli of the Republic of Tajikistan; MM MORT – Majlisi milli Majlisi Oli of the Republic of Tajikistan.

15. Приказ МЗ и СЗН РТ «Об утверждении клинического руководства по заместительной терапии при синдроме опиоидной зависимости в учреждениях наркологической службы РТ» от 09.12.2015 г., № 1040. In Russian. Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 1040 of 09.12.2015, *'On approval of the Clinical protocol on substitution therapy of opioid dependence syndrome in narcological institutions of the Republic of Tajikistan'.*

16. Приказ Министерства здравоохранения РТ «О совершенствовании наркологической помощи в Республике Таджикистан» от 07.08.2006 г., № 485. In Russian. Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 485 of 07.08.2006, *'On Improving Narcological [Drug Treatment] Care in the Republic of Tajikistan'.*

17. Распоряжение МЗ и СЗ РТ «Об утверждении клинического руководства по заместительной терапии бупренорфином при синдроме опиоидной зависимости в учреждениях наркологической службы Республики Таджикистан» от 23.04.2019 г., № 281. In Russian. Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 281 of 23.04.2019, *'On Approval of the Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan'.*

18. МЗ и СЗН РТ. Национальный список основных лекарственных средств (СОЛС). Обновляется ежегодно. In Russian. Ministry of Health and Social Protection of the Population of the Republic of Tajikistan. *The National List of Essential Medicines* (LEM). Updated annually.

19. Постановление Правительства РТ «Об утверждении Национального списка наркотических средств, психотропных веществ и их прекурсоров» от 27 февраля 2020 года, № 121. In Russian. Decree of the Government of the Republic of Tajikistan No. 121 of 27.02.2020, *'On approval of the National List of narcotic drugs, psychotropic substances and their precursors'.*

20. Указ Президента Республики Таджикистан «Об утверждении Национальной стратегии по контролю за наркотиками в Республике Таджикистан на 2021–2030 годы» от 20 марта 2021 года, № 145. In Russian. Decree of the President of the Republic of Tajikistan No. 145 of 20.03.2021, *'National Drug Control Strategy of the Republic of Tajikistan for 2021–2030'.*

21. Постановление Правительства Республики Таджикистан «Об утверждении Плана реализации Национальной программы противодействия эпидемии ВИЧ/СПИД в РТ на 2021–2025 годы» от 27.02.2021 г., № 50. In Russian. Decree of the Government of the Republic of Tajikistan No. 50 of 27.02.2021, *'On approval of the Implementation Plan for the National Programme to combat the HIV/AIDS epidemic in the Republic of Tajikistan for 2021–2025'.*

22. Постановление Правительства Республики Таджикистан «Об утверждении Стратегии охраны здоровья населения РТ на период до 2030 года» от 30.09.2021 г. № 414. In Russian. Decree of the Government of the Republic of Tajikistan No. 414 of 30.09.2021, *'On approval of the Strategy for protecting the health of the population of the Republic of Tajikistan for the period up to 2030'.*

23. Приказ МЗ и СЗН РТ «О внедрении электронного регистра пациентов заместительной поддерживающей терапии метадоном в Республике Таджикистан» от 16.04.2015 г., № 333. In Russian. Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 333 of 16.04.2015, *'On the introduction of an electronic register of clients on substitution maintenance therapy with methadone in the Republic of Tajikistan'*.

24. МЗ и СЗН РТ, CDC. Интегрированное биоповеденческое исследование среди ЛУИН, 2018. In Russian. Ministry of Health and Social Protection of the Republic of Tajikistan, CDC. Integrated biobehavioral survey among PWID, 2018.

25. Результаты пилотного проекта по интегрированному оказанию услуг по ВИЧ и туберкулезу в пунктах поддерживающей терапии метадоном в странах Центральной Азии. Алматы, Казахстан: Проект ICAP, 2021. In Russian. Results of the pilot project on integrated provision of HIV and TB services at methadone maintenance therapy sites in Central Asian Countries. Almaty; ICAP project, 2021.

# Annex 1. An analytical framework of OAT programme sustainability

<table>
<tr><th>ISSUE AREAS</th><th colspan="4">INDICATORS AND BENCHMARKS</th></tr>
<tr><td>A. POLICY AND GOVERNANCE</td><td colspan="2">Indicator A1:<br>Political commitment<br><br>• OAT is included in national strategies and action plans for drug control, HIV, and/or hepatitis, with a commitment to achieve the WHO-recommended targets<br>• Legislation explicitly supports the provision of OAT services<br>• OAT is an integral part of national policy for the treatment of opioid dependence<br>• Law enforcement and justice systems support OAT implementation and expansion, as needed<br>• The country ensures effective governance and necessary coordination of the OAT programme<br>• Civil society, including OAT clients, is consulted in OAT governance and coordination at the country level</td><td colspan="2">Indicator A2:<br>Management of transition from donor to domestic funding<br><br>• The country has adopted a plan that specifies the transition of OAT from donor to domestic funding, including a timeline<br>• There is a multi-year financial plan for the OAT transition to domestic funding sources, with defined unit costs and co-financing levels, and with (future) domestic funding sources for OAT identified and agreed upon among representatives of the state<br>• As part of the oversight of the transition process in the country, the integration of OAT into national systems is effectively supported<br>• Significant progress has been made in implementing the OAT sustainability component in the transition plan</td></tr>
<tr><td>B. FINANCE AND RESOURCES</td><td>Indicator B1:<br>Medications<br><br>• OAT medicine procurement is integrated into high-potential domestic PSM system and functions without interruptions<br>• Both methadone and buprenorphine are registered and their quality assurance system is operational<br>• Methadone and buprenorphine are secured at affordable prices</td><td>Indicator B2:<br>Financial resources<br><br>• Methadone and buprenorphine are included in the lists of state-reimbursed drugs and are financed from public funds<br>• OAT services are included in the universal health care programme or in the government-guaranteed health care package, which is also available to people without health insurance<br>• OAT services costs are covered by sustainable public funding sources that ensure adequate resources for a comprehensive package of services<br>• 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</td><td>Indicator B3:<br>Human resources<br><br>• The provision of OAT services is one of the primary responsibilities of the State Narcological Service and part of the job description of the core medical staff of this institution, who are authorized to prescribe and dispense OAT in the required dosage/quantity<br>• The employee training system ensures the sustainable implementation of the OAT programme</td><td>Indicator B4:<br>Evidence and information systems<br><br>• The OAT monitoring system is in place and is used to manage the OAT programme, including determining programme needs, ensuring coverage, and quality control<br>• An evidence base on the effectiveness and efficiency of OAT is generated regularly and informs the development of regulatory documents and programme components planning<br>• OAT client data is stored in a database; this information is confidential, protected and may not be disclosed outside the health system without the client's consent</td></tr>
</table>

| C. SERVICES | Indicator C1:<br>**Availability and coverage** | Indicator C2:<br>**Accessibility** | Indicator C3:<br>**Quality and integration** |
|---|---|---|---|
| | • OAT is available in hospitals and primary care facilities; 'take-home' doses are permitted<br>• Coverage of the estimated number of opioid-dependent people with OAT is high (in line with WHO guidance: 40% or more)<br>• OAT is available in penitentiary settings (including for entry into the OAT programme), during pretrial detention, and for women<br>• In addition to the state sector, OAT is also available in the private and/or NGO sector | • There are no waiting lists for participation in the OAT programme<br>• OAT sites opening hours and days meet the needs of most clients<br>• Geographic coverage is adequate<br>• There are no fees for using OAT services and no barriers for people with low incomes or without health insurance<br>• OAT is available and generally accessible to populations with special needs (pregnant and other women, sex workers, minors who use drugs, representatives of ethnic groups, etc.)<br>• Use of illicit drugs is tolerated (after the dose adjustment phase)<br>• Individual plans for participation in the OAT programme are developed with the involvement of clients and offered to them<br>• Inclusion criteria for OAT support special needs groups and are not restrictive, i.e., confirmation of failure in other treatment programmes is not required before entering the OAT programme | • Methadone/buprenorphine dosages specified in national standards/guidelines, as well as dosages prescribed in practice, are derived from and consistent with recommendations of the WHO<br>• OAT programmes are based on the maintenance approach and have a high retention of clients<br>• A high proportion of OAT maintenance sites are integrated and/or collaborate with other health services and provide continuity of care for HIV, TB, and drug dependence (in line with WHO guidance: 80% or more of the sites)<br>• A high proportion of OAT clients receive psychological and social support (in line with WHO guidance: 80% or more of sites) |

# Annex 2. Summary table of scores for all indicators and benchmarks in the framework of the reassessment

| ISSUE AREA/INDICATOR/BENCHMARK | SCORE | SOURCES |
|---|---|---|
| **POLICY AND GOVERNANCE** | **37.5%**<br>**At moderate to high risk** | |
| **Political commitments** | **53%**<br>**Moderate sustainability** | |
| Benchmark A1.1:<br>OAT is included in national strategies and action plans for drug control, HIV, and/or hepatitis, with a commitment to achieve the WHO-recommended targets | 50%<br>Moderate sustainability | • National Programme to combat the epidemic of human immunodeficiency virus in the Republic of Tajikistan for 2021–2025. Approved by the Decree of the Government of the Republic of Tajikistan No. 50 of 27.02.2021 |
| Benchmark A1.2:<br>Legislation explicitly supports the provision of OAT services | 75%<br>Substantial sustainability | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413). |
| Benchmark A1.3:<br>OAT is an integral part of national policy for the treatment of opioid dependence | 70%<br>Substantial sustainability | • Operational guidelines, Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 1040 of 09.12.2015<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• The National List of Essential Medicines of MoHSP RT (LEM) |
| Benchmark A1.4:<br>Law enforcement and justice systems support OAT implementation and expansion, as needed | 25%<br>At high to moderate risk | • Clinical guidelines for penitentiary medical institutions providing health services to special contingents with opioid addiction in the Republic of Tajikistan, approved by the MoJ RT (03.03.2015), agreed with the MoHSP RT (23.11.2015) and the DCA (29.01.2016) |
| Benchmark A1.5:<br>The country ensures effective governance and necessary coordination of the OAT programme | 50%<br>Moderate sustainability | • Decree of the Government of the Republic of Tajikistan No. 127 of 28.02.2015, 'On the National Coordination Committee for combating acquired immunodeficiency syndrome, tuberculosis and malaria in the Republic of Tajikistan'<br>• Results of the pilot project on integrated provision of HIV and TB services at methadone maintenance therapy sites in Central Asian Countries. Almaty, Kazakhstan: ICAP project, 2021 |

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| Benchmark A1.6:<br>Civil society, including OAT clients, is consulted in OAT governance and coordination at the country level | 50%<br>Moderate sustainability | • Regulations on the NCC for combating acquired immunodeficiency syndrome, tuberculosis and malaria in the Republic of Tajikistan<br>• Minutes of NCC meetings with participation of civil society representatives |
| **Management of transition from donor to domestic funding** | **23%<br>At high risk** | |
| Benchmark A2.1:<br>The country has adopted a plan that specifies the transition of OAT from donor to domestic funding, including a timeline | 13%<br>At high risk | • Draft of the Transition Plan for HIV prevention programmes |
| Benchmark A2.2:<br>There is a multi-year financial plan for the OAT transition to domestic funding sources, with defined unit costs and co-financing levels, and with (future) domestic funding sources for OAT identified and agreed upon among representatives of the state | 0%<br>At high risk | • Interviews with key informants |
| Benchmark A2.3:<br>As part of the oversight of the transition process in the country, the integration of OAT into national systems is effectively supported | 63%<br>Moderate sustainability | • Regulations on the NCC for combating acquired immunodeficiency syndrome, tuberculosis and malaria in the Republic of Tajikistan<br>• Minutes of NCC meetings with participation of civil society representatives |
| Benchmark A2.4:<br>Significant progress has been made in implementing the OAT sustainability component in the transition plan | 17% At high risk | • Disbursement plan (UNDP) for HIV prevention programs, including activities on OAT |
| **FINANCE AND RESOURCES** | **42%<br>At moderate to high risk** | |
| **Medications** | **50%<br>Moderate sustainability** | |
| Benchmark B1.1:<br>OAT medicine procurement is integrated into high -potential domestic PSM system and functions without interruptions | 50%<br>Moderate sustainability | • Interviews with key informants: International Narcotics Control Board (INCB) quotas cover methadone needs<br>• Interviews with key informants and FGD: there have been no interruptions in the supply of medicines in any region of the country in the last 12 months |

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| Benchmark B1.2:<br>Both methadone and buprenorphine are registered and their quality assurance system is operational | 75%<br>Substantial sustainability | • The National List of Essential Medicines of MoHSP RT (LEM)<br>• Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikista n, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants and FGD with OAT clients |
| Benchmark B1.3:<br>Methadone and buprenorphine are secured at affordable prices | 25%<br>At high to moderate risk | • Interviews with key informants |
| **Financial resources** | **22%**<br>**At high risk** | |
| Benchmark B2.1:<br>Methadone and buprenorphine are included in the lists of state-reimbursed drugs and are financed from public funds | 0%<br>At high risk | • Interviews with key informants |
| Benchmark B2.2:<br>OAT services are included in the universal health care programme or in the government-guaranteed health care package, which is also available to people without health insurance | 25%<br>At high to moderate risk | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413)<br>• Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 4 85 of 07.08.2006, 'On Improving Narcological [Drug Treatment] Care in the Republic of Tajikistan '<br>• Interviews with key informants |
| Benchmark B2.3:<br>OAT services costs are covered by sustainable public funding sources that ensure adequate resources for a comprehensive package of services | 13%<br>At high risk | • National Programme to combat the epidemic of human immunodeficiency virus in the Republic of Tajikistan for 2021–2025. Approved by the Decree of the Government of the Republic of Tajikistan No. 50 of 27.02.2 021<br>• Interviews with key informants |
| Benchmark B2.4:<br>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 | 50 %<br>Moderate sustainability | • Agreement between the Government of the Republic of Tajikistan and UNDP (May 2021) |
| **Human resources** | **42%**<br>**At moderate to high risk** | |

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| Benchmark B3.1:<br>The provision of OAT services is one of the primary responsibilities of the State Narcological Service and part of the job description of the core medical staff of this institution, who are authorized to prescribe and dispense OAT in the required dosage/quantity | 33%<br>At high to moderate risk | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413)<br>• Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants and FGD with OAT clients |
| Benchmark B3.2:<br>The employee training system ensures the sustainable implementation of the OAT programme | 50%<br>Moderate sustainability | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413)<br>• Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019 |
| **Evidence and information systems** | **49%<br>At moderate to high risk** | |
| Benchmark B4.1:<br>The OAT monitoring system is in place and is used to manage the OAT programme, including determining programme needs, ensuring coverage, and quality control | 38%<br>At moderate to high risk | • Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 333 of 16.04.2015, 'On the introduction of an electronic register of patients on substitution maintenance therapy with methadone in the Republic of Tajikistan'<br>• Interviews with key informants |
| Benchmark B4.2:<br>An evidence base on the effectiveness and efficiency of OAT is generated regularly and informs the development of regulatory documents and programme components planning | 33%<br>At high to moderate risk | • Report by A. Latypov, 2020<br>• Interviews with key informants and FGD with OAT clients |
| Benchmark B4.3:<br>OAT client data is stored in a database; this information is confidential, protected and may not be disclosed outside the health system without the client's consent | 75%<br>Substantial sustainability | • Decree of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 333 of 16.04.2015, 'On the introduction of an electronic register of patients on substitution maintenance therapy with methadone in the Republic of Tajikistan'<br>• Interviews with key informants |

| **SERVICES** | **41%<br>At moderate to high risk** | |
|---|---|---|
| **Availability and coverage** | **17%<br>At high risk** | |
| Benchmark C1.1:<br>OAT is available in hospitals and primary care facilities; take-home doses are permitted | 33%<br>At high to moderate risk | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413)<br>• Interviews with key informants and FGD with OAT clients |
| Benchmark C1.2:<br>Coverage of the estimated number of opioid-dependent people with OAT is high | 0%<br>At high risk | • Report by A. Latypov, 2020<br>• Interviews with key informants |
| Benchmark C1.3:<br>OAT is available in penitentiary settings (including for entry into the OAT programme ), during pretrial detention, and for women | 33%<br>At high to moderate risk | • Clinical guidelines for penitentiary medical institutions providing health services to special contingents with opioid addiction in the Republic of Tajikistan, approved by the MoJ RT (03.03.2015), agreed with the MoHSP RT (23.11.2015) and the DCA (29.01.2016)<br>• Decree of the Deputy Head of the Main Department for Execution of Criminal Sentences of the Ministry of Justice of the Republic of Tajikistan No. 176 of 18.09.2021 |
| Benchmark C1.4:<br>In addition to the state sector, OAT is also available in the private and/or NGO sector | 0%<br>At high risk | • Health Code of the Republic of Tajikistan (30.05.2017, No. 1413)<br>• Interviews with key informants |
| **Accessibility** | **57%<br>Moderate sustainability** | |
| Benchmark C2.1:<br>There are no waiting lists for participation in the OAT programme | 50%<br>Moderate sustainability | • Interviews with key informants and FGD with OAT clients |
| Benchmark C2.2:<br>OAT sites opening hours and days meet the needs of most clients | 50%<br>Moderate sustainability | • Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019 |

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| Benchmark C2.3:<br>Geographic coverage is adequate | 50%<br>Moderate sustainability | • Decree of the MoH RT No. 500 of 24.07.2009, 'On the introduction of substitution therapy'<br>• Decree of the Government of the Republic of Tajikistan No. 50 of 27.02.2021 , 'On approval of the Implementation Plan for the National Programme to combat the HIV/AIDS epidemic in the Republic of Tajikistan for 2021 –2025' |
| Benchmark C2.4:<br>There are no fees for using OAT services and no barriers for people with low incomes or without health insurance | 0%<br>At high risk | • Interviews with key informants and FGD with OAT clients |
| Benchmark C2.5:<br>OAT is available and generally accessible to populations with special needs (pregnant and other women, sex workers, minors who use drugs, representatives of ethnic groups, etc.) | 63%<br>Moderate sustainability | • Operational guidelines, 'Methadone substitution maintenance therapy for opioid dependence syndrome', 2009<br>• Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019 |
| Benchmark C2.6:<br>Use of illicit drugs is tolerated (after the dose adjustment phase) | 75%<br>Substantial sustainability | • Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019 |
| Benchmark C2.7:<br>Individual plans for participation in the OAT programme are developed with the involvement of clients and offered to them | 67%<br>Moderate sustainability | • Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants and FGD with OAT clients |
| Benchmark C2.8:<br>Inclusion criteria for OAT support special needs groups and are not restrictive, i.e., confirmation of failure in other treatment programmes is not required before entering the OAT programme | 100%<br>High sustainability | • Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants and FGD with OAT clients |
| **Quality and integration** | **50%**<br>**Moderate sustainability** | |

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|---|---|---|
| Benchmark C3.1:<br>Methadone/buprenorphine dosages specified in national standards/guidelines, as well as dosages prescribed in practice, are derived from and consistent with recommendations of WHO | 50%<br>Moderate sustainability | • Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants |
| Benchmark C3.2:<br>OAT programmes are based on the maintenance approach and have a high retention of clients | 100%<br>High sustainability | • Clinical guidelines on substitution therapy for opioid use disorder in drug treatment facilities of the Republic of Tajikistan, 2015<br>• Clinical guidelines for buprenorphine substitution therapy for opioid dependence syndrome in drug treatment facilities of the Republic of Tajikistan. Approved by the Decree of MoHSP No. 281 of 23.04.2019<br>• Interviews with key informants and FGD with OAT clients<br>• Reports of SI NCCA |
| Benchmark C3.3:<br>A high proportion of OAT maintenance sites are integrated and/or collaborate with other health services and provide continuity of care for HIV, TB, and drug dependence | 50%<br>Moderate sustainability | • Results of the pilot project on integrated provision of HIV and TB services at methadone maintenance therapy sites in Central Asian Countries. Almaty, Kazakhstan: ICAP project, 2021<br>• Interviews with key informants |
| Benchmark C3.4:<br>A high proportion of OAT clients receive psycholo gical and social support | 0%<br>At high risk | • Interviews with key informants and FGD with OAT clients |