The Islamic Republic of Afghanistan
Ministry of Public Health
General Directorate of Health Services
Control of Communicable Diseases
National AIDS Control Program

FINAL
POLICY ON OPIOID SUBSTITUTION THERAPY

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As Opioid Substitution Therapy (OST), is a component of a comprehensive approach to address illicit drug use issues, is endorsed as best practice by multilateral agencies such as WHO, UNAIDS, and UNODC. In 2007 UNAIDS noted that “harm reduction measures such as access to sterile injecting equipment, drug dependence treatment by Methadone and Buprenorphine, [and] community based outreach, are among the most effective and cost-effective measures for preventing HIV epidemics among injecting drug users. Adequate coverage of the full range of harm reduction measures, particularly sterile needle and syringe access and drug substitution treatment, should be promoted.” So, the Ministry of Public Health decided to develop the policy to facilitate the desired interventions.

The Ministry of Public Health acknowledges the technical support provided by the Futures’ Group International (FGI) in developing and preparing of “Opioid Substitution Therapy” (OST) policy. We also appreciate the technical input of the line Ministries including the Ministry of Counter Narcotics, Ministry of Interior, Ministry of Haj and Religious Affairs as well as MoPH implementing partners who assisted in collecting data, sharing their comments and experiences in the process of policy development.

We wish further success to all those who participated in the development of OST policy and hope to work together for its successful implementation.

Dr. Suraya Dalil
Acting Minister and
Deputy Minister for Policy and Planning
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1. BACKGROUND

1.1 Situation Analysis

This national policy on opioid substitution therapy (OST) draws together the provisions of relevant Afghan laws, strategies, policies, and operational plans, as well as medical and scientific evidence demonstrating the effectiveness of OST in reducing demand for illicit opiate drugs, and reducing the potential harm associated with illicit opiate use. The Government of Afghanistan is committed to policies and programs which reduce the supply of, and demand for illicit drugs, and which reduce the potential harm associated with illicit drug use. These programs include opioid substitution therapy (OST). The Government of Afghanistan makes this commitment in order to protect the health and safety of all Afghan people.

1.2 Drug Use in Afghanistan

Available data suggest that drug use is widespread and increasing. The rate at which drug use is increasing in Afghanistan, particularly in the cities, is estimated to be one of the highest in the world. The National Drug Survey of 2005 estimated that there were 200,000 opiate users in Afghanistan, including 50,000 heroin users, of whom around 15 percent (7,500) inject their drugs. These figures are likely to have increased since the estimates were made. There are strong indications that the number of drug users, particularly the number of women and child drug users are under-estimated, since Afghans are likely for cultural reasons to understate the level of drug use in their communities. Needle sharing has been found to be common, and drug-demand-reduction workers believe that rates of drug injecting are increasing.

There is a higher rate of drug use among returned refugees than among other members of Afghan society. A significant numbers of Afghans have spent time in Iran as refugees, yet returnees account for nearly one third of heroin users and almost the same proportion of opium users in Afghanistan. Current drug treatment services and facilities cannot meet demand. At the time of the National Drug Use Survey, there were no more than 100 beds available in residential treatment facilities in the entire country, and many areas identified as having a large number of drug users had no treatment facilities at all. Even if existing programs operated at maximum efficiency, they would able to treat less than 0.25 percent of drug users in Afghanistan each year.1

1.3 HIV Situation in Afghanistan

Social drivers of the HIV epidemic in Afghanistan include violent conflict, high numbers of displaced individuals and mobile populations, lack of access to knowledge about HIV, gender discrimination, and policy barriers. Key risk behaviors include sharing needles and syringes.2 The HIV epidemic in Afghanistan began among IDUs, with measured HIV prevalence of 3 percent among IDUs in Kabul and 3.1 percent in Herat in 20073,4. Experience throughout Asia and other regions of the world shows that increasing injection drug use and accompanying high-risk behavior can lead to explosive HIV epidemics among injecting drug users, which can subsequently spill over into the general population.5

HIV has dramatically increased the potential adverse consequences of injecting illicit drugs. For users of opiates and some other drugs, injecting is considerably more cost-effective than other routes of administration, and provides a more intense drug effect at comparable levels of drug purity. These factors raise concerns that many

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non-injectors may become injectors over time. Preventing the transition from non-injecting to injecting drug use, and encouraging cessation of injecting in favor of non-injecting practices such as substitution therapy, are therefore important measures for reducing the transmission of HIV and other blood borne pathogens.7, 8, 9, 10, 11

Prisons may prime potential sites for HIV transmission in Afghanistan, where prisoners often have limited access to services and where injecting drug use may be common. Data collected from Herat prison in 2008 found 11 percent of injecting drug users to be HIV-positive.12 A 2007 survey of injecting drug users in Kabul found that 17 percent reported having injected drugs in prison. The same study found that IDUs who injected in prison were five times more likely to be HIV-infected than those who had never injected in prison.13

1.4 Health Problems Associated with Injecting Drug Use

A well documented range of health problems result from the practice of unsafe injection of illicit drugs. The extent of potential harm provides a compelling and humane case for harm reduction interventions. The World Health Organization has noted the following health problems which commonly affect injecting drug users:

- Infection with blood-borne viruses, HIV, hepatitis B, and hepatitis C, of which the latter may lead to serious liver damage including cirrhosis and hepatocellular carcinoma (cancer of the liver);
- Injection-related bacterial infections, including septicemia, bacterial endocarditis, and osteomyelitis;
- Local soft tissue and vascular injury, including skin abscesses and thrombophlebitis;
- Tuberculosis (both pulmonary and extra-pulmonary);
- Psychiatric co-morbidity including depression;
- Overdose; and
- Poly-substance dependence, including alcohol.

People who are opiate dependent may also suffer from mental health, occupational, health, or social problems, which make their addictive disorders much more difficult to treat. Problems associated with an individuals drug addictions vary significantly.

Injecting drug use is responsible for an increasing proportion of new HIV infections in many parts of the world, including countries in Eastern Europe, South America, and east and Southeast Asia14. Globally, between 5 and 10 percent of HIV infections result from injecting drug use. In some countries in Asia and Eastern Europe, over 70 percent of HIV infections are attributed to injecting drug use, with opiates being the most commonly injected drugs in these regions. Overall, longitudinal studies suggest 2-3% of people with opiate dependence die each year, while the mortality rate for heroin users is 6-20 times higher than in the general population of the same age and gender.

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1.5 Drug Use: Stigma, Discrimination, and Social Isolation

Drug use is a prevailing source of stigma and discrimination. People who use illicit drugs face daily harassment, discrimination, and abuse—often living these experiences in isolation. When drug use is coupled with being HIV positive, drug users often face the double stigma of drug use and HIV.\(^\text{15}\) Furthermore, drug users often experience stigma and discrimination when they attend medical facilities, which can make them reluctant to access medical and related services.

When drug use is an illegal and covert activity, there is no legal protection against discrimination. Even when a legal system provides protection against and remedies for other forms of discrimination, drug users remain unprotected. Traditional approaches to drug control in many countries include punitive mandatory minimum prison sentences, physical and psychological violence by police, forced drug “rehabilitation” in quasi-prison settings whose programs lack therapeutic rationale or benefit, compulsory HIV testing, and the denial of health care services, employment, and social benefits. Fear of discrimination and arrest by police may discourage HIV-positive drug users from seeking treatment or revealing their drug use to an HIV/AIDS health care provider, leading to possible misdiagnosis or under-diagnosis of health problems, including possible undetected pharmacological interactions between HIV treatment regimens and illicit drugs.

Many drug users live on the economic and social fringes of society, and are rejected by their families. People who are most vulnerable to the impact of poverty, racial discrimination, poor health, and lack of education and employment may also be those who are most vulnerable to drug use. Social problems and discrimination faced by people who are drug dependent and/or HIV positive may in turn exacerbate drug use.\(^\text{16}\) Empathy for the drug user needs to be encouraged among both the general public and health care workers. Similarly training and capacity building is required for those involved in service provision to drug users, in order to reduce the stigma and discrimination associated with drug use, and improve access to treatment, care, and support services.

2 RATIONALE FOR IMPLEMENTING OST

International scientific evidence demonstrates that drug addiction is a treatable condition, and effective treatment interventions are available. Research also demonstrates that drug addiction treatment programs are highly effective in reducing crime and other problems associated with illicit drug dependence. The most effective treatment intervention for heroin addiction, which is the most common addiction in Afghanistan, is the use of OSTs such as methadone and buprenorphine. The use and effectiveness of these medicines has been scientifically studied in many countries and over several decades, and their success is well documented.

2.1 OST for Detoxification and for Long-term Maintenance Treatment

There is a variety of scientifically based approaches to drug dependence treatment. To increase the likelihood of success, drug addiction treatment must be voluntary\(^\text{17}\), and can include abstinence-based programs, psychosocial and behavioral interventions (such as counseling, cognitive therapy, or psychotherapy), OST such as methadone and buprenorphine, or a combination of therapeutic interventions.

Medicines prescribed for substitution treatment are used both for treatment during detoxification or withdrawal, and for medium-to-long term maintenance of abstinence from illicit drug consumption. Detoxification programs are usually linked with longer-term non-pharmacological drug treatment. They continue from periods of approximately 10 days to several months, and substitute drugs are prescribed in decreasing doses until a drug free state has been reached. Maintenance programs involve the provision of a prescribed medicine for longer periods of time, usually six months or more.

2.2 OST Is the Most Effective Treatment for Opiate Dependence

Opioid substitution therapy is the most effective treatment for opiate dependence. It is important to note that both buprenorphine and methadone were added to WHO’s list of essential medicines in 2005. In particular, methadone


has become an integral part of ongoing drug treatment interventions in many parts of the world, as an effective treatment for opiate dependence. Evidence from different drug treatment contexts and settings, has been observed and collected over more than twenty years\textsuperscript{18}. Evaluation of this evidence shows that methadone maintenance treatment is effective in addressing chronic and repeated relapsing opiate dependency. Methadone can be used in two effective therapeutic ways: maintenance therapy and substitution therapy. Both forms of treatment are suitable for drug users who are dependent on opiate derivative substances such as heroin, morphine and opium. Methadone is not designed to treat other types of drug dependency.

Randomized control trials, studies, reports and peer-reviewed publications have all shown that OST results in:

- Reduced consumption of illicit drugs;
- Reduction in chronic drug dependency;
- Reduction in most of the drug related crimes to which people resort to pay for illicit drugs;
- Reduction in risk taking behaviors such as sharing of needles/syringes;
- Reduction in the risk of transmission of HIV and other blood borne infections such as hepatitis B and C;
- Increased retention in treatment programs for opiate dependency;
- Improved overall health of patients in treatment;
- Improvement in social relations with family and community; and
- Improved ability to engage in economic activity.

In addition, patients in substitution treatment-based programs are more likely to stay in treatment than those in detoxification or drug-free programs. Clinics administering substitution treatment have better outcomes than those that promote only abstinence. Increased retention rates (i.e. long periods) in substitution treatment programs are associated with better outcomes\textsuperscript{19}.

Relapse following detoxification alone is extremely common, and therefore detoxification rarely constitutes an adequate treatment of drug dependence on its own. Simple detoxification or stopping opiate use is often insufficient: a therapeutic process is required. Both detoxification with subsequent abstinence-oriented treatment and OST are essential components of an effective treatment system for people with opiate dependence.

2.3 Cost-effectiveness of OST

A review of three studies of opioid substitution treatment in 1998 concluded that it is cost-effective because of the substantial reductions in crime and drug use that occur.\textsuperscript{20} The cost of treatment is more than offset by savings due to reduction in some of the drug related criminal activity and subsequent criminal justice interventions. Methadone is also a cost effective therapeutic agent. The annual cost of methadone treatment is approximately one ninth of the annual cost of treating a patient for AIDS–related conditions.

2.4 Evidence for Health Impact of OST

There is a large body of evidence on the effectiveness of OST in preventing HIV transmission, as well as mitigating the impact of HIV infection and other harm associated with injecting drug use. Numerous studies have yielded consistent and strong evidence that OST is associated with reductions in illicit opiate use, criminal


activity, deaths from drug overdose, and risky behavior related to HIV transmission\textsuperscript{21, 22}. There is evidence that methadone maintenance treatment improves the overall health status of drug users infected with HIV.

3 Goal And Objectives

3.1 Goal of Policy
The overall objective of OST is to reduce morbidity and mortality due to opiate substance use, reduce risk of spread of HIV, Hepatitis B&C, other blood borne diseases and other harm associated with injecting drug use.

3.2 Objective #1
To enable MoPH with a comprehensive and legal document to act together with other partners to implement effectively OST as an integral component of a harm reduction program in open and closed communities

3.3 Objective #2
To maximize the response of, and financial support from the MoPH, donors, and other implementing partners for OST in the light of regional and international best practices regarding treatment of opiate substance abuse and reduction of associated harm, including reduction of HIV prevalence among IDU's

3.4 Objective #3
To support identification and development of implementation and monitoring and evaluation strategies and programs

4 PRINCIPLES ON WHICH THIS POLICY IS BASED

a) OST is a medical response to a public health issue;

b) OST will be implemented in accordance with Afghan law and established policy goals;

c) OST programs will be evidence-based and consistent with international best practice;

d) OST programs will be consistent with religious and cultural values of the Islamic Republic of Afghanistan;

e) Entrance into OST and other drug treatment programs will be for equitable, and non-discriminatory, and based on need;

f) OST will be made available in both community and closed (prison) settings;

g) Continuity of OST will be ensured for those who transition between community and closed settings.

5 POLICY STATEMENT

5.1 Initial Implementation through “Vertical” Programs
While the longer-term goal of the Government of Afghanistan is to integrate OST programs into general health services, it is recognized that this is not currently practical. The need to ensure the professional capacity of those involved in administering OST programs, security issues associated with the importation and dispensing of OST medications, and the stigma and discrimination currently faced by drug users, all require that OST be introduced through specialized “vertical” programs. As programs are established and scaled up, and as capacity to


implement OST programs in Afghanistan increases, the Government of Afghanistan will review this policy with a view to integration of OST into general health services.

5.2 Scale-up of OST
The current scale of illicit opiate use in Afghanistan, and the wide-ranging harm which can result, require that OST programs be implemented promptly and scaled up as soon as human and financial resources permit. This approach is supported by the results of recent research carried out in the region.

A regional project of the UNODC Regional Office for South Asia, “Prevention of Transmission of HIV among Drug Users in SAARC Countries”, is undertaking a multi-site study of OST using buprenorphine in two institutional (prison) settings and three community settings. The project supports an emergency response in Nepal, where methadone is being used in OST through an institutional model with social support for 100 clients over 12 months. Key findings following nine months of project implementation in India include: high treatment retention rates; and significant reductions in drug use (injecting and non-injecting) and high-risk sexual behaviors; and an improvement in WHO Quality of Life and Addiction Severity Index scores. The project has also concluded that OST is an essential component of a comprehensive package of services for prevention of HIV transmission among IDUs. In lieu of these findings and in partnership with other stakeholders, UNODC has advocated for the scaling up of OST in the SAARC region.

5.3 Quality Assurance
Each agency licensed to provide OST shall comply with the requirements of the Counter Narcotics Law, this policy, and the Afghanistan Opioid Substitution Therapy Protocol. Detailed patient records shall be maintained. After ensuring that patient confidentiality is protected by removing any information by which a person receiving treatment could be identified, these records shall be made available for inspection by the Ministry of Public Health and the Ministry of Counter Narcotics as required.. Patient records shall be sufficiently detailed to establish whether the agency has satisfied its obligations under Afghan law and policy. Monthly reports on all OST treatment and related activities, including supply of substitution medication, shall be submitted by each agency to the National AIDS Control Program of the Ministry of Public Health, and to the Ministry of Counter Narcotics. The Ministry of Public Health and the Ministry of Counter Narcotics have the right to conduct inspection visits every three months to ensure compliance with the provisions of the protocol, the Counter Narcotics Law, and this policy.

5.4 Procurement of Substitution Medication
Procurement processes shall ensure that medications used in the provision of OST comply with quality standards as determined by the World Health Organization and are procured at the lowest possible price and taken into consideration as well the highest quality standards, thus enhancing the sustainability of OST programs. Procurement and storage protocols should be designed to eliminate possible interruptions of supply, which would result in the discontinuation of treatment to clients or necessitate sudden reductions in their dosage. Information regarding medication prices and procurement processes shall be made publicly available to promote the transparency, accountability, and sustainability of OST programs.

5.5 OST to Be Provided Free of Charge
As a result of the economic and social disadvantages faced by users of illicit drugs, costs imposed on clients may constitute a significant barrier to access to drug treatment programs. For this reason, OST will be provided free of charge to those persons who are eligible for treatment.

5.6 Sustainability of OST Programs
At the time of development of this policy, several donors had committed funds for the implementation of OST programs in Afghanistan. With the funding currently available delays in program implementation should be avoided. The issue of sustainability is not unique to OST and must be addressed in the broader context of

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reconstruction and nation building. The Government of Afghanistan is committed to making effective use of those resources currently available for OST for the good of the nation, and in the longer term to identifying and allocating its own resources to ensure the sustainability of OST programs. Lessons learned from the proposed donor-funded programs will provide important evidence for scaling up of OST services as additional resources become available.

The issue of sustainability may also be addressed through the use of tincture of opium (TOP), which costs substantially less than either methadone or buprenorphine. There is currently some evidence of the efficacy of TOP as a medicine for substitution therapy, and further evidence may be gathered from monitoring and evaluation of OST programs using TOP.

5.7 Available in Both Community and Closed Settings

The Government of Afghanistan is committed to the implementation of OST programs in both closed (prison) settings and in the community. In establishing OST programs, the Government of Afghanistan will take into consideration the need to ensure continuity of care when people on OST move between closed and community settings. The location of OST programs will also take into account the known prevalence of opiate dependency in the different locations in Afghanistan, and the feasibility of satisfying logistical requirements of program implementation.

The Ministries of Public Health and Justice will undertake to assess all prisons to establish their need for and capacity to implement OST programs, including factors likely to pose challenges to, or to facilitate implementation. The experiences of other countries, including countries in south and central Asia, provide useful guidance on factors affecting the efficacy of OST programs in prisons. Further evidence will become available as countries conducting trials of prison OST programs evaluate these trials and identify lessons learned for future programs. Ministry representatives will hold regular meetings to ensure effective integration of new evidence, as well as communication and coordination in all aspects of prison OST programs.

Other geographic factors to be considered to determine where to begin prison OST programs include; for example:
- Proximity to a national border, where high levels of mobility among the population contribute to higher risk and transmission of HIV
- Proximity to a location where opiate drugs are produced, leading to higher rates of opiate dependence among the local population
- Location in an area of high population density, where a broad range of social problems is likely

5.8 Access Criteria Consistent with International Standards

The Government of Afghanistan is committed to compliance with international best practice standards in the implementation of OST programs. Under this policy, and in conjunction with the provisions of the Afghanistan Opioid Substitution Therapy Protocol, the following principles shall govern access to OST programs, and the terms and conditions on which OST is made available:

(a) Both injecting and non-injecting opiate dependent people shall be eligible for access to OST programs;
(b) Access to OST shall not be determined or limited by prior unsuccessful attempts at cessation of opiate use;
(c) Access to OST shall not be limited by the HIV status of the person seeking access;
(d) Initial assessment of a person’s eligibility for OST shall be done in a way which minimizes any delays in access for eligible persons;
(e) Age shall not disqualify a person who is otherwise eligible for access to OST under this policy and the Afghanistan Opioid Substitution Therapy Protocol; (Where appropriate, information, education, and support services shall be provided to the families of young people in need of or entering OST treatment)
(f) OST eligibility and treatment protocols shall address the special needs of returnees, who may re-enter Afghanistan with opiate dependency or the need for continuation of opioid substitution therapy, which was begun in another country;

25 The Afghanistan Opioid Substitution Therapy Protocol provides for a lower age limit of 18 years for access to OST.
(g) OST eligibility and treatment protocols shall address the particular political, social, and cultural barriers which women face in accessing treatment, and the need to integrate OST with other health and social support services for women;

(h) For opiate dependent people with a psychiatric illness or other mental health condition, access to OST treatment shall be determined by joint assessment with mental health care professionals, and shall follow the provisions of the Afghanistan Opioid Substitution Therapy Protocol, with the aim to coordinate provision of OST with other health and social services, thereby providing a holistic approach to multiple health and social support needs;

(i) Assessment of eligibility for OST and the monitoring of treatment shall take into account possible or observed side-effects and interactions with other medications such as ARVs used in treatments for HIV infection;

(j) Pregnant women shall not be denied OST on the grounds of their pregnancy, and specific dosing guidelines shall be developed for pregnant women;

(k) Urine testing shall be limited to use as a therapeutic tool to assist in determining the appropriate dose of substitution medication, and shall never be used to determine whether a person’s substitution therapy should be terminated, nor the results provided to law enforcement officials as possible evidence of illicit drug use;

(l) Operational procedures of organizations providing OST shall promote accessibility through the provision of services at appropriate times and locations, and the provision of “take home” medication in appropriate circumstances;

(m) Operational procedures of organizations providing OST shall include provisions for transport and storage of medication by clients, and shall comply with the requirements of the Counter Narcotics Law.

6 POLICY IMPLEMENTATION COMPONENTS

6.1 Medications Used in OST

The two main substances used for opioid substitution therapy are methadone and buprenorphine. Tincture of opium has also been successfully used in substitution therapy programs for opiate-dependent people, although it is less widely used. Tincture of opium has the advantage of being more affordable than either methadone or buprenorphine. This section presents information on each of these medications as currently used in opioid substitution therapy.

6.1.1 Methadone

Methadone is a long acting synthetic opiate, and is the most commonly used medication worldwide in substitution therapy for opiate dependence. The number of people globally with opiate dependence receiving prescribed methadone is estimated to be over half a million, and is increasing in almost all regions of the world. In the European Union, all 25 countries have over time introduced opioid substitution programs using methadone and/or buprenorphine, and all programs have continued successfully. Methadone programs have also been introduced, and in many cases scaled up, in India, Iran, China, and a number of other countries in Asia.

The primary objective of methadone maintenance treatment for opiate dependence is to achieve adequate suppression of withdrawal, without causing unacceptable side-effects. The failure to suppress withdrawal between dosing can lead to ongoing illicit drug use and treatment drop-out. The aim of OST is to reach the point where the patient feels comfortable having ceased illicit opiate use, and is able to function.

The clinically appropriate dose of methadone will vary among patients, because the way methadone is metabolized varies from individual to individual and can be influenced by many factors, including overall general health, mental state, pregnancy, menopause, consumption of other prescribed drugs or non-prescribed drugs, as well as consumption of alcohol and tobacco. Treatment for each patient will, therefore, be individually assessed and administered accordingly. Since methadone takes a few days to accumulate in the system, patients might use other drugs during initial treatment. The service administering OST must make it possible for the patient to

26 See paragraph 29. Severe psychiatric illness and some other medical conditions may exclude some opiate dependent persons from access to OST.

discuss this issue without fear of condemnation, or cessation of treatment. The specific situation of opiate use in Afghanistan, including the strength and purity of opiates used illicitly, and the means of administration, must be taken into account in determining the appropriate dosage for individuals commencing methadone substitution therapy.

6.1.2 Buprenorphine
Empirical evidence collected over 20 years has provided strong support for buprenorphine as an effective treatment for opiate dependence. Globally, an estimated 200,000 opiate dependent persons are receiving prescribed buprenorphine, and this figure is increasing.

Buprenorphine is typically therapeutically equivalent to methadone, except in certain patients requiring higher doses of methadone. The effective maintenance dose (which enables people to avoid the illicit use of opiate drugs) ranges between 12-34 milligrams, with an average daily dose of 16 milligrams. Buprenorphine is less likely than methadone to cause overdose. In addition, it seems to offer a slightly less difficult experience of withdrawal during detoxification. Buprenorphine is a sublingual preparation (administered by tablet absorbed through the tissue under the tongue). To date, treatment guidelines for buprenorphine use in OST in Afghanistan have not been developed.

6.1.3 Tincture of Opium
Although methadone is the principal pharmacotherapy utilized in the treatment of opiate dependence, in some parts of the world its cost is a barrier to its widespread use. A less expensive alternative is tincture of opium (TOP), which is used in some Asian countries for the management of opiate withdrawal and, less commonly, as a maintenance treatment. TOP is also commonly used in the treatment of neonatal opiate withdrawal (neonatal abstinence syndrome), and there have been recent reports of its relative efficacy and side-effect profile as a viable alternative to methadone and buprenorphine. TOP is regarded as a traditional medicine in some countries, and so is culturally acceptable.

TOP is a preparation of opium in alcohol and water that in pharmaceutical preparation is standardized to contain 1% morphine. Oral TOP could prove to be a cost-effective and sustainable treatment in Afghanistan.

6.2 OST for Drug Users with HIV
The long-standing experience with OST provides evidence of its benefits for the HIV-infected patient, in addition to reduction of illicit opiate use. Among other benefits, the stability provided by reduction in illicit substance abuse improves access to HIV medical care, including prophylaxis against opportunistic infections, preventive vaccinations, and treatment of hepatitis C and HIV infection, including improved outcomes in terms of CD4 counts, survival, and adherence to anti-retroviral therapy. (A lack of access to OST, however, should never preclude active drug users from accessing anti-retroviral therapy)

A review of research has identified a range of benefits from OST for people living with HIV. Key considerations include:
- OST should be provided in a supportive therapeutic environment in order to maximize the stability of the person’s lifestyle;
- There should be regular contact between staff in substance dependence services and drug users, whether or not OST is being administered;
- OST should be accessible (geographically, and at suitable times).

28 Maria Patrizia Carrieri, Leslie Amass, Gregory M. Lucas, David Vlahov, Alex Wodak, and George E. Woody, Buprenorphine Use: The International Experience, Clinical Infectious Diseases 2006; 43:5197–215
6.3 Use of OST in Detoxification

Detoxification – the process of medically supervised withdrawal from opiates – is an initial component of some treatment programs, but should not be considered as a treatment for opiate dependency on its own. Being opiate dependent is a chronic relapsing condition, and detoxification alone will not be effective as a long-term treatment. The majority of patients will relapse into drug dependency if there are no subsequent interventions.33

6.4 The Best OST Programs

When used appropriately, opioid substitution medications can provide safe and less uncomfortable withdrawal from opiate use.34 A growing body of research, however, indicates that the most effective drug treatments combine behavioral and pharmacological approaches, such as methadone or buprenorphine, together with the provision of psychological and social support. The most effective treatments provide sustained involvement over an extended period of time to address the chronic, relapsing nature of drug disorders, and are designed to meet the needs of individual patients. Other best-practice features of effective drug-dependency treatment have been identified:

- Detoxification using OST must be individualized to minimize the severity of withdrawal symptoms and the seriousness of medical complications. Treatment undertaken voluntarily has been shown to be more effective than treatment which is forced on the drug user. Coercive programs such as those involving only compulsory confinement and/or abstinence have proven ineffective.
- Education programs are generally ineffective unless they include skills development, and are combined with access to medical treatment for drug addiction.
- Reductions in the dosage of OST should be negotiated with the drug user, depending on the emergence of withdrawal symptoms.
- Individuals progress through drug addiction treatment at different rates; thus there is no standard length of treatment. Research has shown that good outcomes are contingent on adequate length of treatment for the individual client.
- Access to psychological support should be available throughout detoxification.

6.5 Capacity Building of Personnel

The Ministry of Public Health will work with partner Ministries and non-government partners to develop a comprehensive program of capacity building for implementation of OST programs. Productive partnerships already exist between Ministries and non-government organizations in a range of areas, and expertise from the NGO sector is currently available to assist with OST program implementation. A range of evidence-based guides incorporating international best practices in methadone substitution, buprenorphine substitution, peer-led community outreach, and low-cost community-based care for drug users, have been developed by UNODC South Asia Regional Office35,36. These international guides will be adapted for use in the Afghan context for training of relevant personnel including:

- Health care workers
- Others involved in service delivery
- Police
- Judiciary
- Prison workers

33 WHO. 2006.
The Ministry of Public Health and the Ministry of Counter Narcotics, in collaboration with non-government partners, will also ensure that pre-service training and continuing education for physicians, pharmacists, other health care personnel, staff, and volunteers will enable them to comply with the requirements of the Counter Narcotics Law, this Policy on Opioid Substitution Therapy, and the Afghanistan Opioid Substitution Therapy Protocol. Health care personnel, including community health workers, shall be trained in directly observed treatment (DOT) protocols.

6.6 **The Role of Peer Workers**

Although there is ample evidence that HIV risk behaviors among injecting drug users (IDUs) are influenced by social factors, HIV prevention interventions have typically focused on the individual, often ignoring social determinants of HIV risk behaviors. Capitalizing on natural social influence processes may be an effective approach to HIV behavioral change among drug users, since individuals identified as leaders among IDUs may be extremely effective in promoting HIV prevention and harm reduction within their networks of drug users and other community members.

There are several advantages of this approach. First, it may be more cost-effective than traditional outreach, since it may be difficult to train or pay for a sufficient number of professionals to conduct outreach. Second, peer leaders may have a greater influence than professionals on the HIV-related behaviors of friends, relatives, and sex partners. Third, the leaders are able to enter a diversity of settings, some not readily accessible by other health professionals. For these reasons, OST service providers are encouraged to recruit and train peer workers to provide information and education on OST, as well as counseling and peer support to those considering, commencing, continuing or ceasing OST, and to their families. The Ministry of Public Health in collaboration with the Ministry of Counter Narcotics and the Ministry of Interior will ensure that law enforcement personnel receive training on the public health benefits of harm reduction programs and on appropriate policing techniques that do not impede the public health promotion activities of harm reduction (peer) workers.

6.7 **Steps in OST**

According to international guidelines, the OST protocol indicates five sequential steps:

- Selection of patients
- Motivation
- Induction
- Stabilization
- Maintenance

All the mentioned steps have been explained in OST protocol.

6.8 **Data Collection**

Improved data on opiate dependency, HIV prevalence, and other drug-related harm, will assist in the planning of harm reduction services, including OST, in Afghanistan. The Ministry of Public Health is committed to working with provincial, national, and international stakeholders to increase the frequency and quality of surveillance activities and the quality and accessibility of health services.

7 **Reporting, Monitoring and Evaluation**

The implementing agencies will maintain a confidential, coded name-based record of clients. A summary project progress report will be provided each month to the NACP, and a complete report on methadone supply will be provided at the beginning of every month to the MoPH and the MoCN.

A quarterly visit from the MoPH and MoCN to the IPs will be organized to assess their progress and achievements based on project objectives and indicators. These visits will also ensure that achievements are based on project standards and that the project is being implemented according to the policy and guidelines.

The following illustrative indicators should be considered for project monitoring that are both monitoring and impact in nature:
Monitoring:

- Number of IDUs and DUs enrolled in the OST program
- Number of DIC implementing OST
- Number of individuals screened for illicit drug use under strict confidentiality

Impact:

- Percent of OST patient records, which are maintained and documented according to guidelines. (The patient record should have assessment results, treatment plan, daily dosages, side-effect of prescribed medicines, medical care, psychosocial and social care, laboratory findings, etc.)
- Percentage of enrolled DUs and IDUs that had an overdose episode (e.g. last month)
- Percent of HIV positive drug users under OST, who adhere to ARV treatment as prescribed

NOTE: OST projects in closed and open communities will be evaluated at mid-term or at the end by a committee composed of MOPH/NACP, donor and IP representatives. Each OST program will be evaluated in accordance with the indicators established in the program’s design.

8 Role of NACP

The primary implementing agency of the OST will be the National AIDS Control Program (NACP) at the Ministry of Public Health (MoPH). A number of line ministries will be involved. The NACP will be responsible for the overall management, coordination and M&E of the OST program and capacity building of implementers and services providers. The NACP will ensure coordination among program staff, the MoPH, and other agencies; coordinate the activities of different donors in order to ensure the efficient use of resources; maintain program records and prepare regular implementation reports.
ANNEXES

ANNEX 1

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>ANDS</td>
<td>Afghanistan National Development Strategy</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly observed treatment</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>MOCN</td>
<td>Ministry of Counter Narcotics</td>
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<tr>
<td>IDU</td>
<td>Injecting drug user</td>
</tr>
<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>NGO</td>
<td>Non-government organization</td>
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<tr>
<td>OST</td>
<td>Opioid substitution therapy</td>
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<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TOP</td>
<td>Tincture of opium</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ANNEX #2:

THE NATURE OF OPIATE ADDICTION

1. The American Psychiatric Association (APA; 2000) and World Health Organization (WHO; 1999) define substance addiction as a chronic, tenacious pattern of substance use and related problems: a complex health condition that often requires long-term treatment and care.

2. Opiate addiction is a medical diagnosis characterized by an individual's inability to stop using opiates even when objectively in his or her best interest to do so. Key elements of opiate dependency include: a strong desire or sense of compulsion to take opiates; difficulties in controlling drug-taking behavior; a physiological withdrawal state when drug use is stopped or reduced; evidence of tolerance (increased doses are required to achieve same effect); progressive neglect of alternative interests because of drug use; persisting with drug use despite clear evidence of overtly harmful consequences, such as harm to the liver, depressive mood states or impairment of cognitive functioning.

3. When associated with needle sharing, opiate addiction is often associated with explosive outbreaks of HIV and other blood-borne infections such as viral hepatitis among IDUs.

4. Opiate addiction is defined as a chronic relapsing condition by the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. DSM is used around the world, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies and policy makers.

5. Opiate addiction is a health condition that has social, psychological, and biological determinants and consequences. It does not indicate a weakness of character or will.

6. Opiate addiction is rarely cured by detoxification alone. While detoxification is an important prelude to drug treatment, it does not itself constitute treatment since it merely addresses the physical adaptation to a drug when dependence develops.

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ANNEX 3: WOMEN, DRUG USE, AND DRUG-RELATED HARM

It is likely that the number of female drug users in Afghanistan is underestimated, and that the number of female drug users is increasing and will continue to increase. While the United Nations Office on Drugs and Crime estimates that about 80 percent of Afghan drug users are male, underreporting of the number of female drug users may result from the additional stigma placed on women who use drugs illicitly. Though there are no comprehensive survey data measuring injecting drug use among women, staff of drug treatment centers working with IDUs report that injecting drug use among women does occur.

International experience suggests that women are generally under-represented as users of drug-related services. Those who do access services benefit from a very narrow range of services which are not at all gender specific and do not recognize the particular needs of women. Women IDUs are more likely than men IDUs to have a sexual partner who is also an injecting drug user. Specific patterns of women’s drug use with their sexual partners increase women IDUs’ risk for acquiring HIV, both from sexual intercourse and from unsafe injecting practices. Women IDUs are more likely than men IDUs to exchange sex for drugs and money. Sex workers who inject drugs are more exposed to HIV transmission than sex workers who do not inject drugs. Inadequate access to harm reduction services and health facilities, along with stigmatization, make female drug users less visible than their male counterparts. As a result, women IDUs appear to be at greater risk for acquiring HIV both from commercial and non-commercial sexual partners. They also have a range of legal, health, and social needs that are presently unaddressed. Women’s responsibilities as parents are not accommodated by most services for drug users. Steps must be taken to ensure that women drug users have a full access to health care, social and other supports including opioid substitution therapy where appropriate, in order to protect them and their sexual partners from acquiring HIV, and in order to meet their other health and social support needs.

Globally, women drug users are likely to have a male sexual partner who injects drugs. Women tend to be introduced to drugs by a husband, boyfriend or male member of their family. Their access to drugs usually occurs through a male sexual partner. Women are more likely to share needles and to be injected by someone else. Women experience difficulty in avoiding drug use/abstaining/accessing drug treatment if the male partner is an active drug user.

Women encounter significant systemic, structural, social, cultural, and personal barriers to accessing substance abuse treatments. In Afghanistan as in most countries women are underrepresented in positions of power that influence awareness of gender differences, policy development, and resource allocation. At the structural level, the most significant obstacles include punitive attitudes towards parenting and pregnant women, which makes them fear losing custody of their children, and prevents them from seeking treatment early enough. Often women do not have money to pay for transportation or treatment. Treatment programs may be located far from where women live and may have inflexible admission requirements and schedules.

40 UNODC (2004). Substance abuse and treatment care for women, cases studied and lessons learned.
Much more is now known about strategies that help overcome the significant hurdles that women encounter in accessing and remaining in treatment. What has proved particularly successful in societies with strong cultural taboos and sometimes few resources is informing and educating communities about the issue and training community members, particularly women in the community, in prevention-and-treatment support activities. Training other helping professionals, particularly primary care providers, and networking and linking with health and social service providers, can help in the identification and referral process of women with substance abuse problems.

As noted, there is extensive evidence of the effectiveness of opioid substitution treatment, particularly methadone maintenance, in reducing the use of illicit substances and associated problems. Where available, it is the chosen treatment of opioid dependent pregnant women. Appropriate interventions for pregnant and parenting women can reduce substance use, and improve health and social outcomes for pregnant women. OST should not be provided as a stand-alone intervention, but should be complemented by other services that address women’s needs.46

In order to provide a comprehensive response to the problem of illicit drug use in Afghanistan, demand and harm reduction programs must address the needs of women drug users, including pregnant women who are opiate dependent. As noted above, the Constitution of Afghanistan prohibits any kind of discrimination or privilege between the citizens of Afghanistan, and this prohibition applies in the context of access to OST as it does in other contexts. Dosing levels of OST medications, psychological and social needs, and accessibility of services must all be tailored to the specific needs of women. The involvement of women as health care workers, peer outreach workers, educators, and providers of social support is essential if OST programs are to be accessible to women. Building capacity to implement opioid substitution therapy in Afghanistan must include building the capacity of women to contribute to these programs.

The Legal and Policy Environment for Implementing OST in Afghanistan

The Government of Afghanistan adopts this policy on opioid substitution therapy as one component of the legal and policy framework for economic and social development in the Islamic Republic of Afghanistan. The key elements of that framework as they relate to development, counter narcotics measures, health promotion, access to medical services, and disease prevention, are set out below.

The Constitution of Afghanistan Year 1382 (2003)\(^\text{47}\)

The Constitution of Afghanistan provides that the state is obliged to create various conditions for its citizens including a prosperous and progressive society based on social justice, protection of human dignity, and the protection of human rights\(^\text{48}\). The state must also abide by the Charter of the United Nations, international treaties and conventions that Afghanistan has signed, and the Universal Declaration of Human Rights\(^\text{49}\). Article 52 of the Constitution obliques the state to provide the means of preventive health care and medical treatment, and proper health facilities to all citizens of Afghanistan. The Constitution prohibits the making of any law which is contrary to the sacred religion of Islam and the values of the Constitution\(^\text{50}\).

Afghanistan National Development Strategy

The Afghanistan National Development Strategy\(^\text{51}\) represents the combined efforts of the Afghan people and the Afghan Government, with the support of the international community, to address the major challenges affecting the country. Oversight for the development of the strategy came from Ministries across government, with participation of the Senior Economic Advisor to the President, the First Vice-President, the Ministers of Foreign Affairs, Finance, Justice, Commerce and Industry, Economy, Education, the National Security Advisor, and the Director, ANDS and Joint Coordination and Monitoring Board Secretariat. The ANDS lays out the strategic priorities and the policies, programs, and projects for achieving the Government’s development objectives. These are organized under three pillars: (i) Security; (ii) Governance, Rule of Law and Human Rights; and (iii) Economic and Social Development. Health issues are dealt with by the ANDS under the third pillar – Economic and Social Development.

Under the second pillar, Governance, Rule of Law and Human Rights, the Government’s priorities include to support efforts by religious organizations to help alleviate poverty and protect vulnerable groups. This is an important priority in the achievement of results under this pillar, particularly: reforms implemented in line with Islamic values (result (i)); greater participation of Islamic scholars in raising awareness of the importance of implementing key reforms (result (iii)); and (iv) a greatly strengthened role of the religious institutions in programs for poverty reduction.

Sector strategies have been developed to promote reforms under the third pillar, Economic and Social Development. Under the Health and Nutrition Sector Strategy the Government is committed to developing relevant legal and regulatory mechanisms that govern health related work in the public and private sectors. The Ministry of Public Health will review, develop, and enforce relevant legal and regulatory instruments that govern health and health related work to safeguard the public and ensure service quality.\(^\text{52}\)

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\(^{47}\) Unofficial English translation, Loya Jirga and President of the Transitional Islamic State of Afghanistan. Please refer to official Pashtu and Dari texts for accuracy.

\(^{48}\) See Chapter 1, Article 6.

\(^{49}\) See Chapter 1, Article 7.

\(^{50}\) See Chapter 1, Article 3.


\(^{52}\) ANDS, at p.9.
Chapter 7 of the ANDS addresses in detail the priorities and expected outcomes under the *Health and Nutrition Sector Strategy* for the period 1387-1391 (2008-2012). They include to have halted and begun to reverse the spread of HIV/AIDS by 2020\(^53\). Challenges identified include inadequate financing for many key programs and reliance on external sources of funding, inadequately trained health care workers, and low levels of utilization for certain health services, especially preventive services. The Ministry of Public Health (MoPH) will provide leadership at all levels in policy formulation and translating policies into concrete actions, and coordination in priority policy and program areas, including coordinating the contributions of all national and international agencies involved in the Health and Nutrition Sector\(^54\). Under the Disease Control and Nutrition Program of the Health and Nutrition Strategy, the Ministry of Public Health is committed to implement actions needed to better control communicable diseases through strengthened management of integrated, cost-effective interventions for prevention, control, and treatment. A key action will be the development and institutionalization of a Comprehensive Health Preparedness Plan at the national and provincial levels. This plan will set out the programs needed to address key emerging public health problems including illicit drug use and HIV/AIDS\(^55\). Expected outcomes include “Establishing centers for treatment and rehabilitation of Drugs users”\(^56\).

**Harm Reduction Strategy for Injecting Drug Use and HIV/AIDS Prevention in Afghanistan**

The *Harm Reduction Strategy*\(^57\), developed by the Ministries of Public Health and Counter Narcotics in 2005, found that there is likely to be a rise in the use of opiates such as opium and heroin among all age groups in Afghanistan, but particularly among high-risk groups such as returning refugees, ex-combatants, the unemployed and women. The Strategy also envisaged a possible increase in drug injecting, which in turn would increase the risk of transmission of blood borne diseases such as HIV/AIDS and hepatitis C. The Strategy states:

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“Any proposed drug treatment protocol for Afghanistan should consider drug substitution therapy... Currently, many heroin addicts in Afghanistan develop a very crude self-administered substitution programme by using a wide range of drugs easily available over-the-counter from pharmacies and other retail outlets if heroin is not available.”
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The Strategy states that while there may be some security risks involved in introducing methadone into Afghanistan:

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“methadone maintenance therapy is considered to be one of the most effective substitution therapies. Work must be done in developing a reliable system to administer methadone therapy for drug users.”
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**National Drug Control Strategy 2006**

The *National Drug Control Strategy*\(^59\) characterizes Afghanistan’s “opium economy” as the single greatest challenge to the long-term security of development, and effective governance of Afghanistan. The overarching policy goal of the Strategy is “to secure a sustainable decrease in cultivation, production, trafficking and consumption of illicit drugs with a view to complete and sustainable elimination. The four key priorities of the Strategy are to: (1) Disrupt the drug trade by targeting traffickers and their backers; (2) Strengthen and diversify legal rural livelihoods; (3) Reduce the demand for illicit drugs and provide treatment for drug users; and (4) Develop state institutions at the central and provincial level vital to the delivery of the counter narcotics strategy\(^60\). Both His Excellency, the President of Afghanistan, and the Minister for Counter Narcotics refer specifically to the need to reduce the production and trafficking of illicit drugs, as well as their consumption.

\(^{53}\) ANDS, at p.108.
\(^{54}\) ANDS, at p. 109.
\(^{55}\) ANDS, at p. 111.
\(^{56}\) ANDS, at p. 223.
\(^{57}\) HIV/AIDS Unit, Ministry of Public Health, and Demand Reduction Section, Ministry of Counter Narcotics, May 2005.
\(^{58}\) At p. 11.
\(^{60}\) See pp. 18-21.
Improving the treatment facilities available for drug users is one of the strategies that can help reduce the demand for and use of illicit drugs.\textsuperscript{61} The Strategy notes that:

“Drug use still carries a stigma, and can lead to social exclusion, in particular the arrest and punishment of drug users needs to be reduced and those dependent on drugs diverted into treatment and harm reduction programmes.

“Currently there are only limited services available and in the next three years these need to be rapidly scaled up through mainstreaming of demand reduction in healthcare, education and law enforcement sectors. Drug awareness and prevention campaigns need to be targeted at high-risk groups in order to stop people from starting to use drugs. Community-based and residential treatment services need to be established for those dependent on drugs. For injecting drug users, harm reduction measures must be introduced as a public health measure to prevent the transmission of blood-borne diseases like HIV and hepatitis C.”\textsuperscript{62}

\textbf{Afghanistan National Strategic Framework for HIV/AIDS (2006-2010)}\textsuperscript{63}

The guiding principles of the \textit{National Strategic Framework for HIV/AIDS} include the following:

- All persons have the right to protection from HIV infection and other sexually transmitted infections. Information, education, and communication (IEC) and counseling and health care shall be sensitive to the culture, language, and social circumstances of all people at all times.
- All interventions shall be subject to critical evaluation and assessment. Continued efforts should constantly be made to improve HIV programmes, taking into account lessons learned at national, regional, and/or global level.
- All efforts to combat HIV should be considered and be sensitive to the socio-economic and cultural context of Afghanistan.
- In line with international experience a harm reduction approach will underpin the HIV strategy.\textsuperscript{64}

In relation to IDUs, the \textit{National Strategic Framework} states that “A comprehensive harm reduction service needs to be established, including needle and syringe access and disposal programmes and advice on safer injecting. Access to drug treatment services is also important in reducing HIV risk amongst injecting drug users.”\textsuperscript{65} The \textit{National Strategic Framework} endorses the \textit{Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS in Afghanistan} and the \textit{National Drug Control Strategy}. Key strategies for the \textit{National Strategic Framework for HIV/AIDS} include:

- Ensure all drug users have access to drug treatment including drug substitution therapies.
- Ensure IDUs have access to harm reduction services, including needle and syringe access and disposal programmes.
- Ensure comprehensive provision of information regarding HIV for drug users who are not currently IDU. This should include harm reduction strategies.
- Ensure all drug users have access to drug treatment including drug substitution therapy.

\textbf{Program Operational Plan for the National HIV/AIDS Strategic Plan}

The \textit{Program Operational Plan} has been designed as a roadmap for the National HIV/AIDS Control Program (NACP) to implement the \textit{National HIV/AIDS Strategic Framework}. Activities proposed within the \textit{Program Operational Plan} aim to provide a comprehensive framework from which to address HIV and AIDS. The \textit{Program Operational Plan} envisages that HIV and AIDS interventions will be developed and implemented with key stakeholders and with the financial support of various donors. There is a need to scale up a range of HIV and AIDS interventions.

\textsuperscript{61} See pp. 5-6.
\textsuperscript{62} See p. 20.
\textsuperscript{63} Ministry of Public Health, Director General of Preventive Medicine and PHC, National AIDS and STI Control Program.
\textsuperscript{64} At p. 6.
\textsuperscript{65} At p. 25.
AIDS interventions, including by building a comprehensive harm reduction program for injecting drug users. In line with the cross-cutting nature of many HIV and AIDS interventions, particularly those for injecting drug users, the Program Operational Plan envisages that a range of Ministries will be involved in program implementation, including Defense, Women’s Affairs, Social and Labor Affairs, Returnees and Refugees, Education, Higher Education, Finance, and Information, Culture and Youth Affairs.

Advocacy and policy development are key components of the implementation of the Program Operational Plan. Activities are to be supported which contribute to the development of an enabling policy framework for HIV and AIDS interventions in Afghanistan.

Also supported by the Program Operational Plan is the targeting of vulnerable populations and people living with HIV and AIDS through the development of customized packages of services. For injecting drug users, these include a range of harm reduction services including opioid substitution therapy implemented by local and international NGOs and CBOs with extensive experience working with IDUs.66

Counter Narcotics Law
Afghanistan’s Counter Narcotics Law 200567 aims to prevent the illicit use of narcotic drugs and psychotropic substances, and also to regulate their use for licit purposes including medical treatment and scientific research in accordance with the provisions of the law68. Methadone, buprenorphine, and tincture of opium, together with other controlled substances and pharmaceutical preparations, may be authorized for use through the issue of licenses by the Drug Regulation Committee established by the law69. Further information regarding these procedures is included in the section below on procedures for implementation of OST programs in Afghanistan.

National Essential Drugs List
Afghanistan’s National Essential Drugs List70 includes buprenorphine, methadone, and tincture of opium for dependency substitution therapy. This is consistent with World Health Organization’s Model List of Essential Medicines, which includes methadone and buprenorphine in its model list of essential medicines.71 In Afghanistan, availability of these drugs for therapeutic purposes is subject to written approval of the Ministry of Public Health National Substance Dependency Program72. Their use in OST programs is also subject to the licensing requirements under the Counter Narcotics Law which are discussed in more detail below.

Afghanistan Opioid Substitution Therapy Protocol73
This protocol was developed by the Ministry of Public Health with inputs from international organizations experienced in the administration of opioid substitution therapy programs. The protocol is the primary source of guidance for operational issues associated with implementation of OST, and will be reviewed regularly by Government Ministries in consultation with non-government stakeholders. The protocol provides detailed guidance on:

• Properties and use of methadone, buprenorphine, and tincture of opium in OST;
• Combination OST and antiretroviral therapy for HIV-positive opioid dependent people;

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66 See pp. 35-36.
67 English translation from Official Dari by Dr Abdul Jabbar Sabit, Legal Advisor to Ministry of Interior dated 17 December, 2005.
68 See Article 2(2).
69 See “Classification and Regulation of Narcotic Drugs” (Article 4), and “Duties of Committee” (Chapters II and III).
70 Ministry of Public Health, General Directorate of Pharmacy, Avicenna Pharmaceutical Institute, Essential Drugs Department, 2007.
72 See “National Dependency Substitution Program List, National Essential Drugs List, at p. 38.
• Dosing regimens for detoxification;
• Elements of a comprehensive and multidisciplinary approach to OST treatment and care;
• The importance of making OST available within closed settings (prisons);
• Continuity of care on transfer between closed and community settings;
• Logistics and supply of OST as regulated by the Ministry of Counter Narcotics and the Ministry of Public Health;
• Prescription and delivery of OST medication;
• Reducing the risks of diversion (unauthorized use) of OST medicines through the mechanism of directly observed treatment;
• Steps for selection, induction, stabilization, and maintenance of patients;
• Monitoring and evaluation procedures.

These issues are considered in more detail below in the section “OST Policy Commitments by the Government of Afghanistan”.

**Afghanistan’s International Commitments**

Pursuant to the provisions of the *Constitution of Afghanistan*, the state must abide by the UN Charter, the *Universal Declaration of Human Rights*, and international treaties and conventions to which Afghanistan is a signatory. This obligation encompasses a number of provisions which are relevant to the provision of opioid substitution therapy. The *Universal Declaration of Human Rights* provides that everyone has the right to an adequate standard of food, clothing, housing and medical care, and social services, and to share in scientific advancement and its benefits. Afghanistan is a signatory to the *International Covenant on Economic, Social, and Cultural Rights*, Article 12 of which stipulates that “everyone has the right to the enjoyment of the highest attainable standard of physical and mental health” and that “steps to be taken ... to achieve the full realization of this right shall include those necessary for...The prevention, treatment and control of epidemic, endemic, occupational and other diseases”. UN human rights monitors have identified access to harm reduction as necessary for States to be compliant with their legal obligations under Article 12.

Afghanistan is a signatory to all the major UN Conventions against illicit traffic of narcotic drugs and psychotropic substances, and as such is committed to suppressing the illicit trafficking of these substances. The obligations which arise under these Conventions are consistent with the implementation of harm reduction programs, such as opioid substitution therapy, as noted by the United Nations. The official Commentary on the 1988 Convention states:

“The 1971 Convention and the 1961 Convention as amended by the 1972 Protocol include a provision (identical in the two texts) to the effect that when drug abusers have committed offences under the Convention, the parties may provide, either as an alternative to conviction or punishment or in addition to a conviction or punishment, that such abusers undergo measures of treatment, education, aftercare rehabilitation or social reintegration.”

Thus the official Commentary makes clear that support is found in all three earlier Conventions for drug treatment, instead of, or in addition to, penal sanctions for drug offences. The official Commentary also clarifies that treatment may include prescription of pharmacological treatment such as methadone maintenance.

**The Role of Religious Leaders**

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74 United Nations General Assembly, 10 December 1948.
75 See Article 25(1).
76 See Article 27(1).
79 See paragraph 3.109.
Religious leaders play a prominent role in relation to social issues in Afghanistan, and the Government of Afghanistan recognizes the need to provide information and education to religious leaders in order to promote their support for OST programs. While the teachings of the Koran prohibit the ingestion of psychoactive substances, this does not apply in the context of medical treatment. Psychoactive substances such as pain medication, anesthetics used in surgical procedures, and medications for the treatment of psychiatric illness, are just some examples of the accepted use of psychoactive substances in medical treatment. OST treatment can be implemented in Islamic republics because it is medical treatment for a chronic medical condition – opiate addiction. Furthermore, the Koran teaches that Islam protects property, personal wealth, and health, and this includes the health of those people who are dependent on opiates, and hence does not prohibit or impede the implementation of OST programs.

NGOs operating in Afghanistan have undertaken productive work with religious leaders, providing education, information, and support for community initiatives by Mullahs including teaching on various aspects of HIV in mosques. In one pilot project, 10 Mawlawies contacted through the Ministry of Hajj and Religious Affairs were provided with two weeks training on public health by an international NGO, and each Mawlawie then provided training on public health to 20 Mullahs. The Mullahs then provided training at Juma prayers, thus reaching large numbers of people. The opening and closing speaker as the head of a local Sharia faculty, and topics covered by training modules were:

- HIV/AIDS
- STIs
- Hepatitis
- Tuberculosis
- Hygiene and sanitation
- Health and Islam
- HIV and Islam

Through monitoring and evaluation, the following lessons learned were identified from the training of religious leaders:

1. Training on HIV and STIs is acceptable to religious leaders, particularly in the context of a public health course
2. Training must be sensitive and the content of the training must be within accepted Islamic values
3. Religious leaders are a very effective way of transmitting sensitive information to communities
4. The course could be replicated in many areas of Afghanistan
5. There is a need for a nationwide plan for training religious leaders in all provinces.80

The roles which the Ministry of Public Health, the Ministry of Counter Narcotics, and the Ministry of Hajj and Religious Affairs can play in developing ongoing programs is dealt with in more detail in the section on “Inter-Ministerial Cooperation” below.

INTERNATIONAL EXPERIENCE

OST proven effective in clinical trials
As noted above, a review of international evidence in a joint publication by the World Health Organization, UNAIDS, and UNODC in 2004 concluded, “Substitution therapy is one of the most effective treatment options for opiate dependence.” More recently, UNODC has stated that “Harm reduction is often made an unnecessarily controversial issue as if there was a contradiction between prevention and treatment on one hand and reducing the adverse health and social consequences of drug use on the other. This is a false dichotomy. They are complementary.” Interventions recommended by UNODC include easily accessible “low-threshold”

pharmacological interventions (such as opioid substitution therapy) which are not directly related to drug free programs, but to immediate health protection.82

**OPIOID SUBSTITUTION THERAPY: ISLAMIC REPUBLIC OF IRAN**83

The Islamic Republic of Iran formed a National AIDS Committee in 2001, and in 2002 established a Harm Reduction Sub-Committee, involving multi-sectoral collaboration between various agencies including the Ministry of Health and Medical Education, the Drug Control Headquarters Secretariat, the Iranian Prisons Organization, law enforcement representatives, and the Iranian Red Crescent Society. The role of non-governmental organizations in providing harm reduction services for drug users is increasingly being recognized. Since its formation the Committee has initiated harm reduction interventions throughout the country. Draft protocols and guidelines for government and private sector methadone maintenance treatment clinics have been developed, as well as guidelines for establishing and operating outreach programs, drop-in centers, and shelters for drug users. The Iranian National Center for Addiction Studies at Tehran University of Medical Sciences carries out ongoing research into the effectiveness of harm interventions, and to date has focused on methadone maintenance treatment services.

**Scaling Up Methadone Maintenance**

Methadone maintenance has now been established and is expanding in many settings, including university clinics, the Iranian Prisons Organization, drug rehabilitation centers, NGOs, and the private sector. With an ongoing training program for physicians, methadone maintenance treatment was initially scheduled to be delivered to approximately 30,000 opiate-dependent people by the end of 2005. Currently the coverage of methadone treatment programs is inadequate.84 Methadone treatment is useful for all opiate-dependent people, and not just those who inject heroin. As the Islamic Republic of Iran is estimated to have a total opiate dependent population of between 1.2 million and 2 million people, the provision of treatment for opiate dependence will need to be rapidly expanded for several years. Buprenorphine has been included in the Iranian pharmacopoeia (essential drugs list), and several projects providing buprenorphine treatment have begun. It is important for opiate-dependent people living with HIV/AIDS to have the option to stabilize themselves with substitution therapy for improving adherence to HIV treatment. For people who are HIV-negative, opioid substitution therapy remains part of an effective HIV prevention strategy.

**Challenges to HIV prevention among injecting drug users in Iran**

Most NGOs are not involved in drug use and HIV activities, and, with lack of experience and expertise in the field, they may be reluctant to become involved. NGOs may be of the opinion that it is easier for them to engage in activities which the general community recognizes and approves. Training of staff at suitable organizations will enhance their capacity. NGOs seeking to run HIV prevention programs for IDUs must be capable of winning the trust of drug-using communities. To develop optimal community-based interventions, drug users must be involved in the design as well as the implementation of services. NGOs must be encouraged to engage former drug users in their teams.

**Need for Community Involvement**

Community outreach should target not only drug users and injectors, but also the families of drug users, (in particular the spouses of married drug users), and the general community. Community barriers to sometimes controversial interventions can only be overcome through efforts to win the confidence of communities in which the drug users live. Community participatory processes are recommended. Community advisory boards comprising local community and religious leaders, which can help navigate the development and implementation of interventions, are critical to the process.

82 UNODC. Reducing the adverse health and social affects of drug use: A comprehensive approach. 2008.
84 WHO, 2008 at p. 15.
Role of Police

Cooperation between police and agencies responsible for implementing harm reduction programs is important for the success of those programs. Training must be provided to police and law enforcement officials on the importance of harm reduction programs for drug users. Training can also discourage policing practices which may reduce the benefits for public health and for individuals of harm reduction programs, such as concentrating police personnel and resources in areas where harm reduction services are provided. The World Health Organization has noted that the duty of police to enforce laws, including laws against drug use, does not preclude the exercise of some discretion in the manner in which laws are enforced:

"Police may determine whether to enforce laws more or less vigorously, in which areas to focus their resources, and on what crimes they will concentrate. Evidence shows that fear of arrest by the police is often stronger than fear of acquiring HIV/AIDS..." 85

Fostering partnerships between law enforcement and public health sectors can help reduce drug-related crime and stem the supply of illegal drugs, while increasing access to effective drug treatment. While strict law enforcement may reduce the visible aspects of illicit drug use, research shows that such interventions generally result in the relocation rather than the cessation of illicit drug-using practices, and also produce negative public health outcomes. In order to serve the overall public interest, responses to illicit drug use require broad-based multi-faceted approaches, in which policing is not the only component. 86

Role of Judiciary

In early 2005, the Head of the Judiciary Organization of Iran issued an Executive Order to all courts in support of harm reduction programs for drug users. The Executive Order stated that judges at all courts and prosecutors’ offices must consider the issue of public health in the implementation of interventions by the Ministry of Health and Medical Education, such as the provision of sterile injecting equipment and methadone programs for opiate-dependent people. The Executive Order also directed judicial authorities not to impede the implementation of those much-needed and successful programs. The Executive Order said, in part:

"The interventions carried out by the Ministry of Health and Medical Education includes the provision of needles, syringes, and other material used by drug addicts and AIDS patients, as well as methadone maintenance treatment programs which help to combat HIV and hepatitis infections among drug addicts.

"According to the Ministry, some judicial authorities have considered such interventions to be assisting criminal activity and subject to punitive action. This unintentionally impedes the implementation of health and treatment programs aimed at preventing and combating the transmission of dangerous contagious diseases.

"This order is to remind judges at all courts of justice and prosecutors’ offices throughout the country that, since a major element of criminal action is verifiable malicious intent, the aforementioned interventions are clearly devoid of such intent and, instead, are motivated by the will to protect society from the spread of deadly contagious diseases such as AIDS and hepatitis.

"[All judicial authorities] must consider the lack of malicious intent in the interventions of the Ministry of Health and Medical Education as well as those of other centers and organizations that are active in this field."

Making services accessible through drop-in centers

Following the successful establishment of a drop-in center for drug users in south Teheran, which includes methadone maintenance treatment in the range of services it provides, the Ministry of Health and Medical Education has encouraged medical universities in collaboration with NGOs in seven cities to establish drop-in centers. A total of 48 drop-in centers have now been established in 7 cities and 13 provinces in Iran. Most have

been operating since mid-2005, and have consulted with current and former drug users in choosing the location and opening times for drop-in centers, in order to ensure accessibility for the client base.

**OPIOID SUBSTITUTION THERAPY: REPUBLIC OF KYRGYZSTAN**

*From Soviet Narcology to Harm Reduction*

During the Soviet era, “narcolgy” was a part of the Kyrgyz security system, very close to the Ministry of Internal Affairs. The Chief Narcologist for Osh oblast states, “Patients were afraid of us. We were like the police to them. But when harm reduction programs began, when the documents changed, when the protocols changed, our approach could also change.” Kyrgyzstan’s Chief Narcologist was authorized by government officials to implement a methadone maintenance treatment program in 2001, with approval from the Ministry of Internal Affairs, the National Security Service and the State Drug Control. Pilot programs began in Osh and Bishkek in 2002, each providing services to 50 patients. With donor funding the programs have subsequently expanded and now provide treatment to a total of 200 patients.

**Control of Methadone and eligibility restrictions**

Methadone remains highly controlled, with the Chief Narcologist required to report regularly to government authorities. Some of the restrictions on access to methadone are not consistent with international evidence-based best practice. These include limited dispensing sites (only two in the country), overly restrictive eligibility criteria, a general prohibition on “take home” doses which further restricts access to those who can travel daily to one of the two dispensing sites, and the absence of an “anonymous treatment” option for drug dependent people.

**Services offered to clients**

Methadone and supportive services are offered free to those clients who satisfy eligibility criteria. Methadone is obtained from a Slovak supplier at a cost of US$0.08 per patient per day, which is the same price as a bus ticket in Bishkek. Methadone is seen as part of a continuum of care rather than an end in itself, and is linked to:

- Regular psychological counseling including peer-based group support and cognitive behavior therapy;
- Medical consultations on intake including electrocardiogram, and hepatitis and HIV tests;
- Access to medical treatment during daily clinic visits;
- Close links with harm reduction and drug-free programs, enabling methadone patients to participate in twelve-step programs or to volunteer as harm reduction peer workers. This ensures familiarity with services they would need if they returned to drug use or decided to move from methadone treatment to abstinence.

**Evaluation process and outcomes**

Both Bishkek and Osh programs conduct evaluation of patients and seek feedback from family members. Some outcomes for clients on Methadone maintenance are:

- A sharp drop in criminal activity;
- Enhanced health and a sharp drop in side-effects from treatment over time;
- Greatly reduced rates of opiate use over time;
- Increased financial stability of Methadone maintenance clients and their families;
- Only one HIV infection was reported in the first year of the program, in a patient who did not test positive for opiates at any time during his Methadone maintenance treatment.

**Lessons learned: law enforcement and legal reform**

Structural reform including legal reform may be as important to the effectiveness of harm reduction and HIV prevention in Kyrgyzstan as any individual intervention. Drug sentencing guidelines in 2005 mandated incarceration for those who possess only a single dose of heroin. Other laws increase stigma and discrimination against sex workers, drug users, and people living HIV, making it more difficult to reach them with HIV

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88 Wolfe D, *op. cit.* at p.45.
89 Wolfe D, *op. cit.* t p.47. Note these are 2005 prices.
prevention or health services, and increase their vulnerability to extortion or mistreatment by police\(^90\). Improvements to police practices are also needed. While the Ministry of Internal Affairs and high-ranking officials may be supportive of harm reduction, frequent changes in mid- and lower-level staff, and the common police practice of extorting money from the public have left drug users and harm reduction workers vulnerable to police abuses\(^91\). Government officials and NGOs alike have identified the need for greater police training on harm reduction.

\(^{90}\) Some examples are: (1) carrying a syringe in Kyrgyzstan remains grounds for detention, search, or forced drug testing; (2) regulations passed to address skyrocketing rates of sexually transmitted infections authorized “medico-legal teams” to round up groups considered to be “avoiding” medical treatment or who are considered to be a public danger and forcibly test them for HIV and STIs. These have included sex workers and drug users; (3) as of September 2002 more than 50 percent of those known to have HIV in Os oblast have been forcibly tested in temporary detention centers or through criminal investigations, with little or no pre-test counseling; (4) sex between an HIV positive and an HIV negative person, even if consensual or with a condom, can be prosecuted as a criminal act.

\(^{91}\) Some examples are: (1) projects working with sex workers and drug users report problems with law enforcement including round ups and forced HIV testing of their clients; (2) arrests from outreach sites and methadone clinics; (3) clients of harm reduction programs routinely report that police plant illicit drugs on them and the demand money to prevent incarceration or public humiliation in the media.
ANNEX 5

Memorandum of Understanding – Policing Practices and Public Health

To maximize the public health benefits of diversion from imprisonment, the Ministries of Public Health, Counter Narcotics, Interior, and Justice shall develop a Memorandum of Understanding governing policing practices concerning the following:

(a) Access by drug users to harm reduction services including needle and syringe programs and OST, ensuring that policing practices do not impede or discourage access to these services;
(b) Recognition of the important role played by peer workers in OST programs, ensuring that police practices do not result in harassment of or unwarranted intervention in the health promotion activities of peer workers;
(c) Possession of injecting equipment shall not be used as evidence of a drug-related offence;
(d) Cases of drug overdose to be dealt with as medical emergencies and not as matters requiring police intervention, beyond assistance in obtaining medical treatment for a person who has overdosed;
(e) Persons apprehended by police on suspicion solely of an offence under 27 of the Counter Narcotics Act to be referred to appropriate medical services as specified in the Memorandum of Understanding, and not charged with a criminal offence;
(f) The Ministry of Interior shall provide training for all serving police officers and new recruits on public health and policing issues including harm reduction services for drug users, with curriculum developed in collaboration with the Ministry of Public Health, the Ministry of Counter Narcotics, and non-government partners.

Inter-Ministerial Cooperation

Chapter VII of the Counter Narcotics Law outlines the responsibilities of Government Ministries concerning counter-narcotic activities.

The Ministry of Counter Narcotics is responsible for:
- Coordination of counter-narcotic activities with “other Ministries, independent bodies, and other concerned organizations”;
- Preparing a National Drug Control Strategy with other stakeholders, proposing revisions to the strategy not less than every three years, and evaluating the strategy;
- Providing staff and resources for implementation of the Counter Narcotics Law jointly with the Ministry of Interior.

The Ministry of Public Health is responsible for:
- Establishing residential and community-based detoxification, harm reduction, treatment and rehabilitation services for drug addicted-dependant persons in consultation with the Ministry of Counter Narcotics;
- Promoting campaigns against illicit drug use with the Ministries of Education and Higher Education, in collaboration with the Ministry of Counter Narcotics;

The Ministry of Education and the Ministry of Higher Education shall include information about illicit drug use in their curriculum. Prevention of the cultivation of illicit drugs is the joint responsibility of the Ministries of Interior, Public Health, Agriculture, Food Stuff and Animal Husbandry, Rural Rehabilitation and Development, within their respective activities. The Ministry of Foreign Affairs shall mobilize resources from international sources for drug prevention and treatment, and report to the United Nations annually on the implementation of international agreements on illicit drugs. Other Ministries including the Ministries of Culture and Information, and Religious Affairs (Hajj and Awqaf) are also identified as playing roles in implementing the Counter Narcotics Law.92

92 Articles 52-54.
Coordinating Ministries
Under Chapter VII of the *Counter Narcotics Law*, primary responsibility for inter-Ministerial coordination rests with the Ministries of Counter Narcotics and Public Health. These Ministers or their designated representatives shall be responsible for ensuring effective collaboration with a range of Ministries on OST, and the integration of all available expertise and experience concerning the different context and populations in which OST programs will be implemented. A multi-sectoral collaborative committee will be established with membership from Ministries of Justice, Interior, Hajj and Religious Affairs, Women’s Affairs, as well as multilateral agencies and NGOs involved in HIV, harm reduction, and OST policies and programs. This multi-sectoral committee will provide advice on the range of issues associated with effective implementation of OST programs among the various population groups, and in the various geographical locations, where they are needed. The Ministries of Public Health and Counter Narcotics will take the lead in developing terms of reference for the multi-sectoral committee. In addition to the provision of policy and program advice, the committee shall identify human and financial resources for OST programs, and ensure effective monitoring and evaluation of programs.

Memorandum of Understanding: Religious Leaders, HIV, and Public Health
In order to support and encourage the important role of religious leaders in raising community awareness and understanding of HIV and public health issues including OST, the Ministries of Public Health, Counter Narcotics, and Hajj and Religious Affairs, will enter into a Memorandum of Understanding to clarify the roles and responsibilities of each Ministry concerning ongoing information and education activities by religious leaders concerning HIV, OST, and other important public health issues. The MOU will identify the human and financial resources needed to increase the number of religious leaders providing public health education in their role as community leaders and educators, the source of those resources, and a planning mechanism to guide collaborative work by these Ministries over a 3-5 year period.
ANNEX 6:

Permission to administer OST

The Government of Afghanistan recognizes the need for flexibility in the allocation of OST program tasks. In accordance with the Counter Narcotics Law, various health care practitioners including licensed pharmacists and physicians, and nurses and midwives in the conduct of their professional duties, are authorized to dispense methadone, buprenorphine, and opium. The Drug Regulation Committee may also authorize licensed pharmacists to dispense small quantities of these drugs without prescription. The Government of Afghanistan recognizes the important role that multidisciplinary teams of staff and volunteers play in the effective administration of OST programs, and supports measures to maximize flexibility in the administration of OST programs, while at the same time adhering to the requirements of the Counter Narcotics Law.

Diversion from criminal justice system

In accordance with the Counter Narcotics Law and the commitments in this policy, “drug addicted persons” as referred to in Article 27 of the Counter Narcotics Law shall be dealt with to the extent possible on the basis of their need for medical and other treatment and support, including possible eligibility for OST, rather than through the criminal justice system. Article 27 enables a court to order a person found guilty of use or possession of illicit drugs, including heroin and opium, to undergo medical treatment rather than a fine or imprisonment.

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93 Article 10(6).
Responses to Drug Use and Opiate Addiction

**International Agreements on the Suppression of Narcotic Drugs and Psychotropic Substances**

The *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*\(^{94}\) promotes a range of measures to reduce the production, trafficking, and use of illicit drugs. Article 3(1) provides that each Party to the 1988 Convention shall adopt necessary measures to create criminal offences against the intentional “production, manufacture, extraction, preparation, offering for sale, distribution, sale, delivery, transport, importation or exportation of any narcotic drug or any psychotropic substance contrary to the provisions of the 1961 Convention, the 1961 *Single Convention on Narcotic Drugs* or the 1961 Convention as amended by the 1962 Protocol, or the *Convention on Psychotropic Substances* 1972. Parties to the Convention may adopt measure for the confiscation of the proceeds derived from any offence referred to in Article 3(1).

The 1988 Convention also recognizes the need to adopt appropriate measures aimed at reducing illicit demand for narcotic drugs and psychotropic substances, with a view to eliminating human suffering and eliminating financial incentives for illicit traffic.\(^{95}\) These measures may be based on the recommendations of specialized UN agencies such as the World Health Organization.

**The Role of Harm Reduction**

A harm reduction approach, including the provision of needle and syringe programs and opioid substitution therapy, is endorsed and promoted in numerous best practice documents and guidelines from multilateral agencies such as the World Health Organization (WHO), the Joint United Nation Programme on AIDS (UNAIDS), and the United Nations Office on Drugs and Crime (UNODC). In 2007 UNAIDS noted that “harm reduction measures such as access to sterile injection equipment, drug dependence treatment such as methadone and buprenorphine, [and] community-based outreach, are among the most effective and cost-effective measures for preventing HIV epidemics among injecting drug users. Adequate coverage of the full range of harm reduction measures, particularly sterile needle and syringe access and drug substitution treatment, should be promoted.”\(^{96}\) By implementing programs which focus on reducing the harms related to drug use as well as programs that aim to reduce drug supply, harm reduction can prevent the spread of infections including HIV/AIDS and hepatitis; reduce the risk of overdose and other drug-related fatalities; and lessen the negative effects which illicit drug use may have on individuals and communities including poverty and crime. Harm reduction approaches drug use from a realistic and pragmatic public health perspective and focuses on feasible goals. Further, by preventing the spread of blood-borne infection among IDUs, harm reduction helps to prevent the spread of HIV/AIDS among the entire population.

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\(^{95}\) Article 14(4).

Compliance with Licensing and Approval Requirements of Counter Narcotics Law

The Counter Narcotics Law provides a strong regulatory framework for the importation, storage, distribution, and administration of medicines used in opioid substitution therapy. “Strictly controlled plants and substances with a medical use” including methadone and opium, and “Controlled substances and pharmaceutical preparations” including buprenorphine may be imported for medical use under license from the Drug Regulation Committee. Import licenses are not transferable. Premises for the storage or use of controlled substances are also subject to regulation. They must be identified in the license issued by the Committee, and must comply with security standards set by the Committee. Any company involved in the transport of controlled substances must abide by the Committee’s regulations regarding prevention of transport of controlled substances for illicit purposes. Trade in and distribution of pharmaceutical preparations of controlled substances is restricted to those categories of persons stipulated in Article 10. License holders are required to provide the Committee with quarterly reports, and are obliged to comply with all regulations and procedures established by the Committee. Annual inventories must be reported to the Committee, and any discrepancies in inventory records must be reported to the Committee immediately they are noted. The Counter Narcotics Law imposes penalties for a range of drug-related offences including drug trafficking, drug-related corruption and intimidation, illicit prescription of drugs, and consumption of illegal drugs.

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97 Counter Narcotics Law 2005, Article 4 and Chapter III.
98 Article 9(5).
99 Article 7(2) and (6).
100 Article 9(27).
101 Article 11.
102 Article 12.
Annex 9

OBJECTIONS TO IMPLEMENTATION OF OST

Often objections to substitution treatment are based on moral or religious views that oppose the replacement of heroin dependence, for example, with dependence on another substance. However, a drug user in substitution treatment has a better chance of rehabilitation, access to medical care and effective psychotherapy (where it is available), as well as a decreased risk of contracting or spreading HIV, Hepatitis C, and other blood-borne infections. Denying opiate dependent people access to substitution therapy cuts them off from their best chance of effective treatment and improved health, and also misses opportunities to prevent the spread of HIV and other blood-borne infections. In some cases, objections to the provision of OST may be based on concerns that the medicines used in treatment will be diverted for illicit purposes, with the potential for creating a “black market” in methadone and other OST medicines. However the Counter Narcotics Law provides detailed procedures for safeguarding the security of medicines used in OST at all stages including importation, storage, distribution, prescription, and dispensing of medicines. The Afghanistan Opioid Substitution Therapy Protocol also provides detailed operational procedures and reporting requirements for importing, handling, and dispensing medicines used in OST therapy, including the use of “directly observed treatment” (DOT) protocols to ensure the security of medicines.

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103 See Counter Narcotics Law Chapter III: Licensing, Manufacture, Cultivation, Production, Trade, Distribution, and Use of Plants, Substances, and Preparations Listed in Tables 1, 2, 3, and 4.

104 See section 2 paragraph 17: Diversion and Retention; section 3: Logistics and Supply of OST Medicines (methadone); and section 5: Monitoring and Evaluation.
Annex 10

GLOSSARY

**Buprenorphine**: a prescription medication for people dependent on heroin or other opiates that acts by relieving the symptoms of opiate withdrawal.

**Cirrhosis**: a complication of liver diseases characterized by abnormal structure and function of the liver. Infections such as hepatitis C that can lead to cirrhosis do so because they cause injury to and death of liver cells, and the inflammation and repair that is associated with the dying liver cells causes scar tissue to form.

**Drug demand reduction**: policies or programs directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions. The distribution of these narcotic drugs and psychotropic substances is forbidden by law or limited to medical and pharmaceutical channels.

**Dependency**: physiological need for and use of a habit-forming substance characterized by the development of tolerance, and of well-defined physiological symptoms of withdrawal on cessation of use.

**Detoxification**: to rid the body of an intoxicating or addictive substance.

**Harm reduction**: Harm reduction aims to prevent or reduce negative health consequences associated certain behaviors through the application of good public health principles to relevant laws, policies, and programs. In relation to drug use, a harm reduction approach recognizes that for some drug users, total abstinence is not feasible in the short term, and that interventions apart from detoxification followed by abstinence may be required. Harm reduction interventions include provision of sterile injecting equipment, access to opioid substitution therapy using prescribed medications such as methadone or buprenorphine, and provision of health information, education, and referral to appropriate services.

**Methadone**: a long-acting synthetic opiate medication used in treatment programs for persons dependent on opiates such as heroin. It is administered in either liquid or tablet form to block the effects of illicit opiate use, and to decrease opiate craving. Methadone is an agonist medication.

**Opiate**: a substance, either a medication or an illicit drug, derived from the opium poppy. Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. Long-term use of opiates can cause addiction, and over-use can cause overdose and possibly death.

**Opioid**: a synthetic narcotic that resembles naturally occurring opiates. Opioids bind to or otherwise affect opiate receptor cells in the body.

**Substitution therapy**: the medically supervised treatment of individuals with drug dependency involving administration of a prescribed medicine with similar action to the drug of dependence. Nicotine replacement therapy for tobacco smokers is the most widely used substitution therapy. Substitution programs for illicit drug users primarily target opiate dependant persons. Medicines most commonly prescribed for opiate dependency are opiate agonists such as methadone and buprenorphine. Medicines for opiate substitution therapy are prescribed to treat both detoxification and withdrawal, as well as for longer-term maintenance of abstinence from opiate use, and relapse prevention.

**Tincture of opium (TOP)**: a preparation of opium in alcohol and water that in pharmaceutical preparation is standardized to contain 1 percent morphine. TOP is regarded as a traditional medicine in some countries. It has been used successfully in substitution therapy programs for opiate-dependent people, although it is less widely used than methadone or buprenorphine. Its low cost compared to methadone and buprenorphine is an added advantage.
Laws and policies: Afghanistan


Reports, articles, presentations

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• Political Declaration: Guiding Principles of Drug Demand Reduction and Measures to Enhance International Cooperation to Counter the World Drug Problem. Special Session of the United Nations General Assembly Devoted to Countering the World Drug Problem Together, 8-10 June 1998
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