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Commentary

Decolonizing addiction treatment in Eastern Europe and Central Asia: Confronting Russian narcology and Western retreat

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ABSTRACT

Eastern Europe and Central Asia (EECA) face a dual crisis in addiction treatment. On one side, Russian imperial legacies persist through punitive "narcology," now weaponized amid ongoing aggression. On the other, Western retrenchment, marked by abrupt aid suspensions and dwindling harm-reduction budgets, has weakened the evidence-based counterweight that once challenged authoritarian approaches. The result is a convergence of punitive logics that marginalizes people who use drugs, whether through active repression, such as the closure of methadone programs in Crimea, or sudden neglect, such as the withdrawal of donor funding for opioid agonist therapy in Tajikistan. We call for a decolonial, community-driven response grounded in non-reformist reform and transformative discomfort—one that reduces harm while dismantling punitive systems and embraces the tensions of shared authority and care. Drawing on the case of self-run addiction treatment in Kyrgyz prisons, we call for resourcing user-led infrastructures as models for decolonial directions in global health amid a splintering global health world order.

Introduction

Eastern Europe and Central Asia (EECA) are experiencing a dual crisis in addiction treatment. On one side, Russian anti-drug measures rooted in Soviet-style "narcology" have expanded and intensified. On the other, Western disengagement, through shrinking harm-reduction budgets and sudden aid suspensions, has eroded the evidence-based counterweight that once tempered authoritarian drug policies. The combined result is a convergence of punitive logics that undermines harm reduction and addiction treatment alike.

Yet, existing scholarship has not integrated the colonial genealogy of narcology with contemporary donor withdrawal. We address this gap, arguing that a decolonial, community-driven approach is urgently needed to meet this crisis. We trace the historical legacy of Soviet narcology, examine its present convergence of authoritarian expansion and Western retreat, and propose alternative models of addiction treatment grounded in *non-reformist reform* and an ethics of *transformative discomfort*. Our aim is pragmatic as well as theoretical: to highlight community-driven practices that offer survival and dignity, and to urge policymakers and researchers to support them.

Historical legacy: from Soviet narcology to Russian imperialism

The present landscape of addiction treatment in EECA cannot be understood without its Soviet inheritance and Russian imperialism in particular (Piacentini & Slade, 2024). Emerging in the mid-20th century as a Soviet subspecialty of psychiatry, narcology was institutionalized as the official approach to addiction treatment and functioned as a tool of social control. It framed addiction not as a health but as a moral and political problem. People who use drugs were pathologized as "degenerates" and subjected to compulsory treatment, registration, and punishment (Elovich & Drucker, 2008; Raikhel, 2016). This system often targeted marginalized groups and was tightly interwoven with the machinery of state repression, reflecting a colonial mentality that "knew best" how to manage local populations (Elovich & Drucker, 2008).

Colonial hierarchies of knowledge reinforced this punitive system, extending narcology's logic of control from the Soviet metropole into its colonial peripheries. In Central Asia, indigenous practices such as

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Islamic *tibb* were denigrated as unscientific, while the Soviet state imposed "modern" substitutes, famously attempting to replace opium dens with "red teahouses" in Tajikistan (Latypov, 2023). The positioning of Soviet medicine as superior while delegitimizing effective local health practices functioned as a deliberate tactic to consolidate control over newly incorporated Central Asian states. Despite suppression, these indigenous and Islamic healing traditions demonstrated remarkable resilience and continue to inform health practices in the region today (Latypov, 2023).

These authoritarian and moralistic techniques of governing populations through addiction treatment persisted after the collapse of the Soviet Union, shaping domains of health and law in the newly formed independent republics. Across EECA, variants of narcology endured: compulsory registries, coercive treatment, and incarceration for drug use remain central features of state health policy. Even where the gold standard for treating opioid use disorder (Degenhardt et al., 2019) with opioid agonist therapies (OAT) like methadone or buprenorphine was introduced, they were absorbed into narcological, surveillance-driven systems that reproduced stigma and control, thereby limiting access and undermining uptake. As documented repeatedly in Ukraine, narcological governance fundamentally reshapes OAT into a mechanism of control rather than care (Bojko et al., 2015, 2016; Makarenko et al., 2016).

Contemporary Russia has aggressively revived this narcological model. Domestically, it maintains a complete ban on OAT, embraces abstinence-only programs, and regularly equates drug use with criminality. Anti-drug rhetoric has become a staple of Putin's speeches, positioning the fight against drugs as a civilizational struggle to defend Russian values. In this framing, harm reduction and the medicalization of drug use are portrayed as markers of Western decadence or abjection, a narrative that Russia actively exports as soft power across the region (Carroll, 2018). This rhetoric not only justifies harsh domestic crackdowns but is used by Russia as a weapon of domination (Marshall, 2014).

Far from softening, Russia's intransigent stance against harm reduction has grown more militant and far-reaching in recent years. After years of exporting its abstinence-only ideology through international forums and bilateral influence, Russia's recent military aggression has directly imposed narcology on occupied territories. When Russia annexed Crimea in 2014, the occupying administration abruptly shut down methadone programs, leaving 800 patients without treatment; roughly 10 % died within six months (Carroll, 2018; Kuzmenko, 2015). Following the full-scale invasion of Ukraine in 2022, Russian authorities again discontinued OAT in occupied areas. This was a deliberate act of harm: it forced thousands into withdrawal, heightened risks of overdose and HIV, and sent a clear signal of dominance by targeting a marginalized population reliant on 'Western-style' medicine. Ukrainian civil society and health workers scrambled to fill the void—smuggling medications, running clandestine syringe programs, and sustaining services under fire (Altice et al., 2022). These extraordinary efforts by service workers coupled with adaptive service models led to increased OAT coverage during the first year of the war (Morozova et al., 2023), a finding that mirrored Ukraine's response to the COVID-19 pandemic (Ivasiy et al., 2024; Meteliuk et al., 2021). Yet, the damage in occupied areas was immediate and continues to unfold.

The present dual crisis: authoritarian resurgence and Western retreat

The closure of OAT in occupied Ukraine (Ivasiy et al., 2022) represents the most extreme expression of a broader logic that has long characterized Russian narcology and is increasingly mirrored across the region. These outcomes echo a longstanding pattern. By banning evidence-based interventions and criminalizing people who use drugs, Russian policy effectively pushes vulnerable populations away from healthcare and into the shadows (Sarang et al., 2010). The narrative of a 'war on drugs' functions as part of a broader authoritarian playbook that conflates public health with state security (Crick, 2012; Lilja, 2021). Unfortunately, several EECA governments, whether by ideological alignment or geopolitical pressure, have mirrored these tactics. In some Central Asian states, narcology-style registries and compulsory treatments remain in use (Liberman et al., 2024a; Liberman et al., 2024b, 2025; O'Hara et al., 2025), and slow uptake of OAT can be partly attributed to official ambivalence or hostility. Even where OAT is technically legal, authorities often impose heavy restrictions (limited dosing, burdensome clinic rules, daily observed consumption) that reduce its accessibility and appeal (Liberman et al., 2024a, 2025). The net effect region-wide is low treatment coverage—far below international recommendations. In Ukraine, prior to Russia's invasion, OAT reached only 2–3 % of people who inject drugs, compared to the 40 % coverage the WHO estimates is needed to curb HIV transmission (Alistar et al., 2011), and neighboring countries often record even lower figures. This shortfall is not due to lack of need or efficacy—OAT consistently reduces overdose and prevents HIV—but to political and structural barriers rooted in narcological, punitive governance. The dynamic is ongoing: in 2025, the pro-Russia government in Georgia shuttered all private OAT programs and brought them under state control, consolidating patient data and deepening surveillance of those enrolled (Civil Georgia, 2025).

While Russian narcology has expanded, Western commitment has waned (Harm Reduction International, 2024; UNAIDS, 2024). For two decades, U.S.- and EU-funded initiatives such as PEPFAR and the Global Fund supported ART, NSPs, and OAT across EECA with varying degrees of sustainability and preparation for government funding independence (Stuikyte et al., 2024). These initiatives helped reframe addiction as a medical condition and provided a counterweight to punitive policies, but they were also introduced in ways that often failed to account for local governance practices and histories of narcological control. In many cases, OAT programs were delivered through standardized models that were readily absorbed into existing surveillance and punitive infrastructures, limiting uptake despite nominal expansion (Azbel et al., 2021). This fragile architecture is now under severe strain. In Tajikistan, for example, OAT reaches only 3 % of people who inject drugs and remains almost entirely donor-funded and highly vulnerable to disruptions, as illustrated by the 2025 U.S. funding freezes (Harm Reduction International, 2025a, 2025b). More broadly, international donors have scaled down their support, expecting national governments to assume costs; few have, producing major gaps in service delivery. In 2025, the World Health Organization warned that U.S. aid cuts could disrupt ART for millions, risking 'undoing 20 years of progress' and potentially causing over 10 million additional infections (Sunny & Santhosh, 2025). Ukraine, already under Russian assault, was among the countries flagged as at risk of treatment interruptions. The sudden withdrawal of donor programs, while very different from Russia's outright bans, generates its own set of harms: patients forced into withdrawal, clinics shuttered, and fragile trust in medical institutions eroded. This mistrust has long been visible. In Kyrgyz prisons, rumors that 'Americans invented Dimedrol to combine with methadone to kill the drug-using population' (Azbel, 2020, p. 136) illustrate how methadone became geopolitically coded reproducing global power struggles locally, while obscuring the possibility of user-led alternatives.

The current crisis in EECA is shaped by two intertwined dynamics: the expansion of Russian narcology as a weapon of domination, and the retreat of Western donors from the region. These are not equivalent—one is marked by overt violence and occupation, the other by the erosion of aid and fragile commitments—but both reproduce imperial logics that sideline local agency. Russian narcology enforces abstinence and surveillance through punitive infrastructures; Western programs often arrived as top-down interventions, insensitive to local practices and histories, and were easily absorbed into the very narcological systems they sought to reform (Daniels et al., 2021; Lasco, 2022). Together, these dynamics create a convergence in which people who use drugs

remain governed through control, instability, and exclusion.

Decolonial approaches: non-reformist reform and transformative discomfort

Confronted with this dual crisis, decolonial approaches call for more than reforming punitive systems at the margins; they seek to dismantle the enduring colonial hierarchies of knowledge and governance that shape addiction treatment in EECA (Chaudhuri et al., 2021). Colonial drug treatment infrastructures not only persist but sustain themselves by presenting as solutions to the very harms they produce. That is, narcological systems generate mistrust and resistance through surveillance and coercion; these outcomes are then invoked as 'non-compliance' that justifies even stricter controls; the resulting low uptake becomes evidence that more regulation is needed. Global health reinforces this logic by privileging targets such as "40 % OAT coverage" (Morozova et al., 2023), while dismissing low uptake or resistance as cultural stigma or "negative attitudes." Yet reluctance to enter treatment is better understood as a rational response to a century of narcological governance, where treatment has been entwined with punishment. In such a context, simply tweaking registries, shifting delivery from prison to probation, or loosening take-home rules risks reinforcing rather than dismantling the underlying colonial framework.

Two conceptual tools help frame alternatives. First, "non-reformist reform" describes strategies that reduce immediate harms while also shrinking the long-term reach of oppressive systems (Honeywell, 2025). Originally coined by André Gorz (1968) and developed into a framework for navigating prison and police reform by abolitionists, (Mathiesen 2015; Davis 2003; Gilmore 2007), non-reformist reform offers a framework for engaging existing institutions, legal mechanisms, and governance structures without treating them as neutral, corrective, or inherently beneficial. Instead, such structures are approached as intrinsically limited and complicit in the harms they claim to manage. Non-reformist reform therefore entails strategically mobilising elements of these systems only insofar as they can deliver immediate reductions in suffering in specific contexts, while at the same time constraining system expansion and rendering visible their structural inability to resolve crises to which they are themselves fundamentally bound. In global health, this approach resonates with recent work on decolonial praxis that calls for dismantling the colonial structures sustained by drug and health governance systems and redistributing authority through relational, rather than extractive, forms of collaboration (Daniels et al., 2021; Abimbola, 2021). For example, rather than expanding narcology-style methadone clinics, this might mean investing in peer-run services, user-led drop-in centers, community-organized syringe distribution, or underground naloxone networks. These initiatives bypass rather than bolster punitive infrastructures, and they build capacity outside state control.

Second, an ethic of "transformative discomfort" (Azbel & Hakim 2025, in press) asks practitioners to sit with the paradoxes that emerge when evidence-based interventions encounter colonial histories. Instead of reflexively trying to "fix" local resistance by doubling down on fidelity to global templates, discomfort can be embraced as productive, signaling the need to let interventions be reshaped by community priorities. This may include peer-dispensed OAT, hybrid heroin-assisted treatment in contexts where heroin carries more legitimacy than methadone, or other approaches that global health actors may find unfamiliar. By accepting discomfort as part of the process, practitioners and researchers can open space for hybrid models that blend global evidence with local systems of care, and for decolonial partnerships where communities of people who use drugs define both the problems and the solutions.

Mutual aid and informal addiction treatment in Kyrgyz prisons

Kyrgyzstan's prisons provide a striking case of how harm reduction can emerge outside formal state policy. Over decades, prisoner hierarchies developed an internal governance system for heroin distribution that functioned as a form of collective care: established users received small, controlled doses to prevent withdrawal, new initiation was discouraged, and clean needles were circulated (Slade & Azbel, 2022). Tacitly tolerated by prison authorities because it reduced disorder and medical crises, this prisoner-run system has operated as a de facto harm-reduction program, grounded in solidarity rather than external oversight.

By contrast, state methadone programs have struggled for legitimacy. Many prisoners perceive methadone as an external imposition—coded as disruptive to collective solidarity and associated with surveillance (Bojko et al., 2013, 2015; Mazhnaya et al., 2016) and state control. Some prisoners combine it with injected diphenhydramine (Dimedrol) to intensify its effects, producing harms that paradoxically deepen mistrust (Meyer et al., 2020; Liberman et al., 2021, 2022). Uptake remains low, not because of pharmacology, but because of how methadone has been socially and geopolitically framed.

Rather than drawing a moral boundary between licit and illicit, a decolonial perspective asks what forms of care, expertise, and collective governance are rendered invisible by that distinction. The lesson is not necessarily that heroin is medically preferable, but that interventions succeed or fail according to trust, legitimacy, and social organization. The Kyrgyz case exemplifies a non-reformist reform: it mitigates immediate harms while bypassing, rather than reinforcing, punitive infrastructures. Yet such models remain largely absent from global-health discourse precisely because they unsettle established evidence-based frameworks. A decolonial approach insists that we take them seriously—not to romanticize illicit practices, but to recognize how communities engineer survival outside the state and to ask what an ethics of transformative discomfort might make possible if global health interventions were willing to learn from them.

Conclusion: toward decolonial and community-driven futures

Moving forward, addiction treatment in EECA requires more than modest reform: it demands a reorientation that balances local autonomy with global solidarity. Decolonial approaches do not mean rejecting global expertise or evidence-based medicine; rather, they require reconfiguring partnerships so that communities of people who use drugs are in the driver's seat. International actors should support rather than supplant user-led infrastructures, funding drop-in centers, peer outreach, and naloxone distribution directly; protecting activists; and allowing experimentation with unconventional delivery models, especially in times of conflict or donor withdrawal.

The case of Kyrgyzstan's prisons makes this imperative concrete. There, heroin distribution governed by the prisoner collective has functioned as a form of harm reduction, coded as solidarity and mutual care, while methadone was experienced as disruptive to that collective body and tied to state control (Azbel et al., 2020; Slade & Azbel, 2022). The success of an intervention depends less on its pharmacology than on how well it aligns with local systems of governance and legitimacy. Too often, global health clings to rigid targets—like OAT coverage thresholds—that reproduce mistrust when pursued through coercive infrastructures. By contrast, continuity under crisis, overdose reduction, and quality of life as defined by patients themselves may be more meaningful indicators.

In practical terms, a decolonial response might include: emergency support for OAT and HIV services that can survive war and donor withdrawal; direct investment in the capacity of user-led organizations; platforms for knowledge exchange where informal and alternative models—such as the Kyrgyz prison system, can be discussed openly; and advocacy that reframes metrics of success around dignity, survival, and reductions in harm rather than narrow coverage numbers. Such measures make it possible to hold onto rules and policies where needed, while allowing interventions themselves to be transformed through

community governance.

Ultimately, decolonizing addiction treatment in EECA requires restoring agency to those most affected and recognizing that interventions must be judged not only pharmacologically but socially and politically. Global health actors must therefore embrace what we call an ethics of *transformative discomfort*: accepting that effective models may unsettle established evidence hierarchies, conflict with donor mandates, or emerge from settings deemed illicit. In the context of converging crises—Russian imperial violence and Western retreat—this discomfort is not a weakness but a necessary condition for building ethical, sustainable, and user-led infrastructures.

CRediT authorship contribution statement

Lyu Azbel: Writing – review & editing, Writing – original draft, Conceptualization. **Mary Tate:** Writing – review & editing, Conceptualization. **Viktoria Akerø:** Writing – review & editing, Conceptualization. **Frederick L. Altice:** Writing – review & editing, Supervision, Conceptualization. **Sergii Dvoriak:** Writing – review & editing, Supervision, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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