



Evaluation of opioid substitution therapy in the Kyrgyz Republic

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ABSTRACT

An evaluation of the Opioid Substitution Therapy programme in the Kyrgyz Republic took place from the 13th to the 17th October 2008. A delegation from World Health Organization Regional Office for Europe met with representatives of the Government, Drug Control Agency, Ministry of Health, Ministry of Justice, UN agencies; international NGOs, staff of drug treatment services and NGOs. Focus group discussions and one to one interviews were conducted with injecting drug users (IDU) at several OST programmes.

The Kyrgyz Republic has successfully created a decentralized system of provision of Opioid Substitution Therapy both in specialized institutions and family medicine centers. Opioid Substitution Therapy is provided by the team of specialists in a comprehensive way and with links to the external sources of support provided by NGOs. Provision of Opioid Substitution Therapy through family medicine centers offers a potential of further integration of drug treatment of IDU with family medicine and further reduction of their stigma.

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Acronyms

AIDS	<i>Acquired Immunodeficiency Syndrome</i>
ARV	<i>Antiretroviral (drug/therapy)</i>
CA	<i>Central Asia</i>
CMCC	<i>Country Multisectoral Coordination Committee</i>
CIS	<i>Commonwealth of Independent States</i>
EMCDDA	<i>European Monitoring Centre for Drugs and Drug Addiction</i>
EU	<i>European Union</i>
FGD	<i>Focus Group Discussion</i>
GF	<i>Global Fund to Fight AIDS, Tuberculosis and Malaria</i>
GUIN	<i>The Main Penalty Execution Department</i>
HBV	<i>Hepatitis B Virus</i>
HCV	<i>Hepatitis C Virus</i>
HIV	<i>Human Immunodeficiency Virus</i>
IDU	<i>Injecting Drug Use / User</i>
INGO	<i>International Non-governmental Organization</i>
MMT	<i>Methadone Maintenance Treatment</i>
M&E	<i>Monitoring and Evaluation</i>
NGO	<i>Non-governmental organization</i>
OST	<i>Opioid Substitution Therapy</i>
PCC	<i>Physician consultative commission</i>
STI	<i>Sexually Transmitted Infections</i>
TB	<i>Tuberculosis</i>
UN	<i>United Nations</i>
UNAIDS	<i>Joint United Nations Programme on HIV/AIDS</i>
UNDP	<i>United Nations Development Programme</i>
UNGASS	<i>United Nations General Assembly Special Session</i>
UNODC	<i>United Nations Office on Drugs and Crime</i>
WHO	<i>World Health Organization</i>

Executive summary

The main findings and recommendations are summarized below:

Due to the sustained and coordinated efforts of the Government of the Kyrgyz Republic in collaboration with UN organizations and international and local NGO partners, opioid substitution therapy (OST) with methadone has significantly expanded during the years of 2006 – 2008. The number of drug service centers, which provided OST with methadone, increased from 2 in 2006 to 13 in 2008. The number of injecting drug user (IDU) patients in OST increased 5 times from 145 in October 2006 to 729 in October 2008.

The country has successfully created the decentralized system of provision of OST both in specialized institutions and family medicine centers. OST was provided by the team of specialists in a comprehensive way and with links to the external sources of support provided by NGOs. Provision of OST through family medicine centers offered a potential of further integration of drug treatment of IDU with family medicine and further reduction of their stigma.

The country has developed a Clinical Protocol for the providers of OST in the institutions both under the Ministry of Health and Ministry of Justice (2008). The pilot project of OST with methadone was introduced in penitentiary institution No 47 in August 2008. Since August 2008 in this penitentiary institution OST is provided alongside with other programs for IDU: withdrawal treatment, psychosocial abstinence-oriented treatment and harm reduction program for HIV prevention with needle/syringe exchange. The spectrum of different interventions increases opportunities for the individualized approach to different types of drug users

At the same time only 13.5% of registered heroin users and 2.9% of estimated injecting drug users are covered with OST. Thus OST still has limited access and the impact of OST in preventing of HIV among IDU is not yet fully disclosed.

To expand MMT and its impact in HIV prevention in the Kyrgyz Republic it is recommended:

1. Efforts should be continued to increase further the access of IDU to OST in Kyrgyz Republic in order to increase impact on the prevention of HIV, hepatitis B and C, TB, and STI. It is recommended to expand further OST in Family Medicine Centers with capacity building of existing staff.
2. Comprehensive health care should be continuously available in health care institutions, including infectious disease prevention and care, psychosocial support. Naloxone should be available in drug treatment service centers to prevent deaths from opioid overdose in patients, who are not in OST. Testing for hepatitis C among all patients at a volunteer basis should be promoted.
3. Cooperation of drug treatment service with family physicians should be strengthened by encouraging patients to use the services of Family Health Centers. Inclusion of NGOs in providing social and legal support for OST patients should be continued at all levels.
4. Capacity building of the OST staff, family physicians, and infectious disease specialists should include the system of provision of basic and continuous training on OST. For this purpose it is recommended to develop a training module for the multidisciplinary staff. Training should be provided by local experts.

5. The monitoring and evaluation plan to monitor the treatment outcomes should be established in the country. Monitoring and evaluation activities should be an integral and continuous part of each OST programme as is indicated in the clinical protocol. For the monitoring purposes a short data collection tool should be developed to follow dynamics in drug use, health, social integration and risk behavior, based on ready available methodologies.
6. It is recommended to finish an outcome evaluation study of the pilot OST programme in penitentiary institution No 47 in comparing the number of indicators at the baseline, after 3 and after 6 months. Based on the results of the evaluation of pilot OST is recommended to consider the expansion of OST in penitentiary system.
7. It is recommended do develop an information dissemination strategy on OST among government employees, law enforcement officers, and medical professionals to avoid misconception about OST at all levels.

Background and objectives

Opioid substitution therapy (OST) has been recognized as an effective tool to prevent HIV among injecting drug users (IDU) and to increase the adherence of eligible people with HIV/AIDS to anti-retroviral (ARV) therapy (WHO, 1998; WHO, UNODC, UNAIDS, 2004; WHO, 2005a).

Methadone and buprenorphine has proven highly effective in the treatment of opioid dependence and HIV prevention (WHO, 2004cd). The effectiveness of OST in reduction of illegal opioid use and injecting risk behavior, increase of the quality of life, improvement of health and the reduction of criminality with methadone and buprenorphine was studied not only in economically developed countries (Mattic RP, Breen C., Kimber J., Davoli M., 2003, Gowing L. Farrel M., Bornemann R. Ali R, 2004), but also in a lower resourced countries and different cultures, such as China, Indonesia, Iran, Thailand, Lithuania, Poland Ukraine (Lawrinson P., Ali. R., Buavirat A. et al., 2008).

The latest scientific research data suggest that opioid dependence is a chronic brain illness with frequent relapses. Opioid dependence nowadays is often compared with other chronic diseases, such as hypertension, diabetes and asthma (McLellan A.T. and al., 2000, WHO, 2004). There are no particularly “cures” for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, also the behavior change in patients, it possible to eliminate or reduce symptoms of chronic diseases and reach high quality of life. OST in this context is recognized as cost-effective strategy, which allows achieving high retention rates of IDU in therapeutic programmes, significant reduction of illegal opioid and reduction of injecting risk behavior. Both methadone and buprenorphine have been included into WHO XIV Edition of the Model List of Essential Medicines (WHO, 2005b).

OST has become the most frequently used therapeutic approach for heroin dependence in the European Union. It is estimated that 594,000 opioid users received substitution treatment in the European Union, with an increase since 2005 (EMCDDA, 2008).

Substitution maintenance therapy also offers opportunities for improving the delivery of antiretroviral treatment to drug users living with HIV/AIDS, notably by increasing access to treatment and improving retention in programmes and adherence to treatment.

The new WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence recommend that opioid substitution treatment (OST) with methadone or buprenorphine be used in preference to detoxification for most patients, that methadone be used in preference to buprenorphine, and that both methadone substitution therapy and detoxification services be made widely available (WHO, in press)

Over the recent years there was the growing number of studies and recommendations that methadone and buprenorphine maintenance therapy should be a part of HIV prevention strategies in prisons as important and highly effective public health intervention (WHO, 2005c) and practical guides for the introduction of OST in prisons has been developed (WHO 2007; Kastelic A., Pont J., Stover H., 2008, UNODC, 2008).

The Kyrgyz Republic was the first country of Central Asia having initiated a pilot OST programme in 2002. The first evaluation of the OST program (Asanov T., 2005) indicated that OST was effective in the reduction of illegal drug use and increased social adaptation of OST patients. By 2006 the number of the OST delivery centers was low (2 centers in Bishkek and Osh) and the number of patients in OST actually decreased (145). Thus OST could not play any significant role in the prevention of HIV before 2006 (Subata E., Pkhakadze G., 2006). Nevertheless the evaluation report (Subata E., Pkhakadze G., 2006) concluded that during the pilot phase of OST programme in 2002-2006, substitution therapy with methadone in Bishkek and Osh drug treatment centers was implemented in a comprehensive way, in cooperation with other medical institutions and NGOs. In

implementation of OST programme local medical staff became experienced in providing OST. Recommendations of the evaluation included further expansion of OST in geographically decentralized way and with adequate capacity building of existent staff. Evaluation mission paid specific attention to drug use and HIV situation in penitentiary system. Recommendations included the introduction of the pilot OST program in penitentiary system. Descriptive model of OST in prison was included into evaluation report.

The objective of the latest evaluation performed by the WHO Regional Office for Europe in October 2008 was the follow-up evaluation on the development of OST programme in the Kyrgyz Republic since 2006. The evaluation mission aimed to provide the Government of the Kyrgyz Republic (namely Ministries of Health and Justice) with results of the evaluation on recent expansion of OST in the country and develop further recommendations.

Methodology

The evaluation team undertook a field mission to the Kyrgyz Republic from the 13th to the 17th October 2008 and met with representatives of the Government, Drug Control Agency, Ministry of Health, Ministry of Justice, UN agencies; international NGOs, staff of drug treatment services and NGOs. Focus group discussions and one to one interviews were conducted with IDU at several OST programmes. A list of persons, whom evaluation team met, is presented in the Appendix 1.

Most of the information obtained through the meetings with policymakers, stakeholders, and IDU was of a qualitative nature. Wherever possible, actual numbers of beneficiaries (IDU, number of staff, number of treatment service centers) were obtained. Evaluation team did a desk review of the documents produced by the Government of the Kyrgyz Republic, UN organizations, Republican Narcological Centre and NGOs.

Challenges and Limitations

Overall, the methodological approach was in line with the purposes of this mission. Field visits and meetings with the representatives of stakeholder organizations allowed the evaluation team to interact with key persons in a relatively short period of time. Evaluation team had opportunity to visit the number of drug treatment centers (including in prison No 47) and meet with multidisciplinary staff. It was not possible for the evaluation team to visit all drug treatment service centers. The team of evaluators has met with a limited number of patients of OST and IDU as well as with limited number of their family members. The evaluation team was not able to meet inmates at prison No 47, to interview them and have a focus group discussion.

HIV and illegal drug use situation in the Kyrgyz Republic

The Kyrgyz Republic is a low HIV prevalence country with a concentrated epidemic¹.

At 1 December 2008 a total of 1828 HIV infected cases were registered in the Kyrgyz Republic. The number of AIDS cases were 137. 217 HIV infected persons have died, including 92 from AIDS (Republican Association "AIDS", 2008).

HIV cases were registered in all parts of the Kyrgyz Republic. Nevertheless, in Osh oblast the number of registered HIV cases was 860, i.e. 50% of the total number in the country.

¹ A concentrated epidemic is defined as one in which HIV prevalence in high-risk subpopulations is 5 % or higher, but is still less than 5 % among women attending antenatal clinics.

The most prevalent route of transmission is injecting drug use, which account for 72% according to the National AIDS Center and UNODC (UNODC Regional Office for Central Asia, 2008). Heterosexual route accounts for 22% and vertical mother-to-child transmission 1%, and due to recent hospital infection transmission outbreak in Osh the intra-hospital transmission route increased to 3%.

By 1 December 2008 there have been 97 pregnant HIV infected women with 72 deliveries, 14 – abortion or miscarriages and 14 with ongoing pregnancy. Due to early detection of pregnancy in HIV infected women 44 women and 45 newborns received preventive ARV therapy. In reaction to the mother-to-child transmission route of HIV the Ministry of Health issued during November 2007 a special decree which should ensure HIV testing of all pregnant women.

1 December 2008 there were 139 HIV infected children from the Kyrgyz Republic and 1 from the Republic of Uzbekistan. 110 children were detected as HIV infected due to the outbreak in Osh in June 2007 due to nosocomial spread in the hospital. In 5 cases the mother-to child-transmission route was determined as a route of infection.

ARV therapy has been available 2005 and by 1 December 2008 there were 82 adults and 54 children on ARV therapy (Republican Association “AIDS”, 2008).

From 2000 to 2007 the number of registered drug users increased from 4 479 to 8 464. The most prevalent illegal drug is opioids (heroin 3 351 and opium 2 005), who accounts for 63% of all registered drug users. There were 5 386 injecting drug users among registered drug users, who accounts for 64%. Cannabis users accounts for 27% of registered drug users.

The number of drug users treated in 2007 was rather low with 575 persons treated (UNODC Regional Office for Central Asia, 2008), while the estimated number of the number of opioid users through UNODC surveys in 2006 was 26 000 and of injecting drug users 25 000 (UNODC Regional Office for Central Asia, 2007).

The UNODC survey indicated that the mean age of drug use initiation in the Kyrgyz Republic was 17.5 years and the mean age of problem drug users were 31.8 years. 13.7% of problem drug users were women.

Access of IDU to OST in the Kyrgyz Republic

The Kyrgyz Republic was the first country of Central Asia (CA) and Commonwealth of Independent States (CIS) that in 2002 started a pilot OST programme with methadone. The pilot OST programme was implemented in the Republican Center of Narcology (Bishkek) and Osh Oblast Center of Narcology.

The independent evaluation from 2006 stated that OST was implemented in a comprehensive way. Integrated medical treatment, psychosocial and legal support was provided within OST programmes and in collaboration with NGOs. HIV infected IDU were admitted to OST without delay and restrictions. HIV testing and ARV therapy were available free of charge. At the same time the access of IDU to OST were limited to two drug treatment service centers in Bishkek and Osh. By November 1, 2006 there were only 145 patients. There were 29 HIV infected patients altogether and ten patients received ARV therapy (Subata E., Pkhakadze G., 2006).

The report recommended the Government of the Kyrgyz Republic to increase the accessibility of OST to IDU and its impact to the prevention of HIV, hepatitis B and C, TB and STI through the expansion of OST programmes in geographically decentralized way with appropriate control, to

ensure the quality of OST by provision of comprehensive services. The particular recommendation was included to develop and introduce the pilot OST program in the penitentiary system.

In the response to the recommendations and subsequent discussion by the stakeholders the Order of the Ministry of Health and Drug Control Agency of February 2007 elaborated the mechanisms for further geographic expansion of OST with appropriate controls (Drug Control Agency, Ministry of Health, 2007). This legal act provided the legal base for the expansion of OST programs in the Kyrgyz Republic as the funding was available from Global Fund to Fight AIDS, Tuberculosis and Malaria (GF).

Six new drug treatment service centers were opened in 2007 (two at Family medicine centers Nr. 1 and Nr. 8 in Bishkek), three at Family Medicine Centers in the cities of Kant, Kara-Balta and Tokmok (Chui region) and one in Osh Narcology centre (Esenamanova A., 2008).

In 2008 additional five new drug treatment service centers were opened: three in Family medicine centers of the Alamedinskiy, Sokulinskiy and Moskovskiy districts, one at Family medicine centre in Bishkek (Nr. 6) and one in drug treatment centre in the colony Nr 47 (Esenamanova A., 2008)

By 1 October 2008 there were in total 13 drug treatment service centers in the Kyrgyz Republic. By the end of 2008 it was planned to open two new drug treatment service centers in AIDS centre of Osh and at Karasu Family medicine centre.

The overall number in OST by 1 October 2008 were 729 patients. The number of patients is shown in figure 1 during the period 2002-2008. There is no waiting lists for patients to enter OST in existing drug treatment service centers (Esenamanova A., 2008)

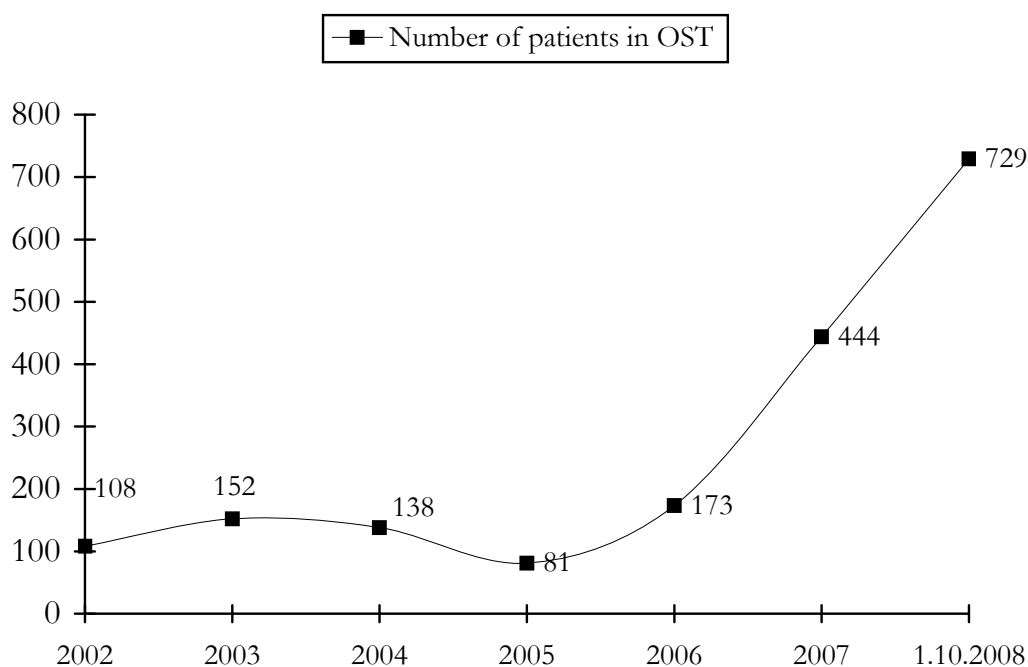


Figure 1. Number of patients in opioid substitution therapy with methadone during 2002-2008.

There were 95 HIV infected patients (13%) in OST, three on ARV therapy (all in Bishkek).

729 IDU comprised 13.5 % of the officially registered number of IDU in the Kyrgyz Republic (5386 in 2008) or 2.9% from the estimated number of IDU (25 000, UNODC Regional Office for Central Asia).

Organization of methadone supply to drug treatment service centers and funding

The Clinical Protocol on Substitution methadone maintenance therapy has been developed and adopted by the Ministry of Health in April 2008 (Ministry of Health, Ministry of Justice, 2008). It includes requirements for pharmacists in the preparation of methadone solution. The 0.1 % solution of methadone hydrochloride is prepared in licensed pharmacies in Bishkek narcological centre and Osh pharmacy “Osh-Farm-KA”. A week amount of methadone solution is transported to different drug treatment service centers under the supervision of the responsible person. Methadone is kept in safes in health facilities in premises which meet the security criteria set by the Ministry of Health.

Methadone is dispensed to patients on daily basis and is consumed under the supervision of the nurse. The patient signs the documentation after receiving medication. The Clinical Protocol also describes requirements of the cooperation of health care facilities under the Ministry of Health and in penitentiary institutions under the Ministry of Justice in supplying the medication and transfer of patients between different health care facilities.

Funding of OST

In 2007 the amount of methadone consumed were 5516 grams, and in 2006 the number were 2837 grams. Methadone is imported as a raw material (powder) from pharmaceutical company in the Slovak Republic. In 2007 the price of 1 kg of raw methadone was 1200 USD (1 USD – 36 soms). The average dose of 80 mg of methadone per day is 0.1 USD and the cost of the methadone for one year treatment is 36 USD. (Tokubaev R., 2008a). The cost of first line ART is approximately 300 USD a year.

At present OST in the Kyrgyz Republic is fully funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF). The Kyrgyz Republic has been awarded grant from the GF at the 7th round and funding for OST is available for minimum 1500 patients 2009 – 2013 (personal communication).

The quality of OST provision

The Clinical Protocol on Methadone Substitution Maintenance Therapy has been adopted by the Ministry of Health in April 2008 (Ministry of Health, Ministry of Justice, 2008). The Clinical Protocol describes basic requirements for diagnosis of opioid dependence syndrome, indications for OST, initial and maintenance doses of methadone, requirements for psychosocial support, termination of treatment, drug interactions with methadone and treatment effectiveness evaluation forms. The optimal dose of methadone as indicated in protocol is higher than 60 mg/day and the maximum dose indicated 200 mg/day.

A patient, willing to enter OST is usually assessed by a physician-narcologist. The formal entrance of the patient into OST had to be made by the physician consultative commission (PCC). As the network of drug treatment centers geographically expanded, the decision process on the entrance to the OST programme was decentralized by creating a PCC at Family Medicine Centers with the involvement of the responsible staff from Family Medicine Centers. The intake of the patient usually

took not longer than 1-2 days but a full list of requirements have to be fulfilled. These requirements are in line with the requirements of other countries. Most often the first dose of methadone patients could receive after few hours on the first day.

Methadone is dispensed for patients every day, including weekends. With a special permission and if a family member agreed there could be dispensed methadone for two more days which could be used for shorter travels. With the expanding network of drug treatment service centers, the distance of daily travel of patients has been significantly reduced. Patients could choose which drug treatment service centre to attend. In case of patient's travel inside the country, pick-up of methadone could be arranged from the nearest drug treatment service centre.

The usual working hours for drug treatment service centers was from 8 a.m. till 1 p.m., which allowed patients to pick-up their medication either before working hours or during lunch break.

In addition of provision of OST, physician-narcologists referred IDU to HIV testing (free of charge) at AIDS centers. Hepatitis C testing was available on the project basis. Referrals were also available to in-patient units for withdrawal treatment in narcological hospitals/centers. The staff was not always aware about the availability of naloxone for overdose prevention in non-methadone IDU. Social workers, who worked in a team with narcologists, were increasingly engaged in helping patients to acquire personal documents and registration, as well as to seek health care in family medicine centers. Existence of drug treatment service centers at Family medicine centers offered an infrastructure and potential for the development of "shared care" model of narcologists and family physicians. As a certain number of IDU patients usually suffer from hepatitis B and C, HIV, TB, STI availability of "shared care" integrated model in family health clinic look particularly promising.

ARV therapy was provided mostly by the National and municipal AIDS centers where available, or through family physicians in remote areas free of charge. ARV therapy was funded by the GF. To improve integration of HIV and drug treatment services in Osh oblast, where roughly half of HIV positive cases are registered, the drug treatment service centre was planned to be opened in Osh municipal AIDS Centre before the end of 2008. This program of comprehensive OST and HIV care in one institution could serve as another promising model of integrated service to IDU.

OST staff both in specialized and drug treatment centers based at family medicine centers employed a team of specialists, which included narcologists, nurses, social workers and psychologists or psychotherapists. The staff also referred patients when available to external NGOs for psychosocial or legal support. For example, for some years high quality legal support are available from the NGO "Adilet".

In the focus group discussions at drug treatment service centers visited OST patients indicated that physicians prescribed adequate doses of methadone, which varied from 20 mg to 160 mg/day and depended on the clinical status of the patient. They indicated that OST programmes provided comprehensive services including psychosocial support. Multidisciplinary staff of physicians-narcologists, nurses, social workers, and psychotherapists was available in most of the drug treatment centers visited and were judged by patients as friendly to patients. Patients indicated that the usual reaction to dirty urine screens was the change of medication dose by the physician and psychosocial counseling.

By 2008 there were 93 full time employees working in OST programme in Kyrgyz Republic in different cities. They included 19 positions of psychiatrist-narcologist, 6 positions of psychologist-psychotherapists, 15 positions of nurse, 11 positions of social workers, 14 consultants, 3 pharmacists, 9 outreach workers. All positions of the staff were funded by the GF.

Republican Narcological centre monitored OST patients in the country by collecting data on the number of patients in drug treatment service centers by telephone on weekly basis, also by recording the amount of methadone consumed. The specific outcome and process evaluation studies of OST in the Kyrgyz Republic have not been done yet.

OST in penitentiary system

In August 2008 a pilot study was established in prison No. 47 to provide methadone to opioid dependent prisoners. Prison No. 47 is also the central prison hospital in the Kyrgyz Republic. It houses in total approximately 400 prisoners. A number of prisoners worked in maintenance jobs at the penitentiary institution and also provided services for the prison hospital.

There has been renovated and established a methadone health centre in the prison, where since the 8 August 2008 until the 15 October 2008 40 patients have received OST with methadone. Three patients dropped out from the treatment. One was transferred to another prison, one stopped treatment due to side-effects and one died most probably due to acute asthmatic status just one day after receiving the first dose of methadone (20 mg). Due to an incidence in another prison, where two security staff members were killed, all officers in other prisons were removed from duty. And in this particular case on that date no prison doctor was available for the sick prisoner at prison No 47.

The service centre in the prison provided withdrawal treatment (detoxification), drug-free psychosocial treatment (“Atlantis” programme) and methadone substitution therapy. There was also a needle and syringe exchange programme in the prison (as in all other prisons)..

Patients included in the OST methadone programme were all prisoners in an out-patient facility and they all worked in the prison. There were no patients from the prison hospital involved in the methadone project. The reason for this was that prisoners in the hospital only stayed until the end of hospital treatment and then left for other penitentiary institutions. Therefore they were not suitable for the continuation of OST, as methadone was not available in other prisons. There has been some delay in the inclusion of new patients in the OST methadone project due to lack of urine tests to detect use of illicit drugs. One of the requirements for inclusion into the project was a positive urine test for opiates. At least 10 new prisoners were on a waiting list to start the treatment.

Patients were included if the narcologist found them suitable to participate in the project and if they fulfilled criteria's in the Clinical Protocol (Ministry of Health, Ministry of Justice, 2008). All patients, who participated in the project received training on the risks of taking any other drugs, about side effects and information about methadone. The starting dose was 20 mg with the subsequent increase of 5 mg. a day if needed. Many prisoners stayed on 30 mg a day. The highest dose at the moment was 60 mg/day.

It was not possible for the evaluation team during the evaluation mission to meet and interview prisoners, who used methadone. The evaluators met with the staff, which was included in the project and outcome evaluation study. The evaluators also looked at the forms which were used to monitor the treatment outcome study. All forms were used in the correct way. Completed forms were sent to WHO to be computerized and later to be use for statistic analysis. According to the design of the treatment outcome study, all patients included into OST with methadone should be interviewed by using the evaluation forms at the baseline, after three months and after six months since the beginning of OST. The study targeted to have 100 patients included for a minimum of six months before the actual scientific outcome evaluation could provide statistically significant results.

All treatment seemed to be following the National Clinical Protocol. The staff seemed to be highly motivated and well trained for the provision of OST. The spectrum of different services for IDU, such as withdrawal treatment, drug-free treatment at “Atlantis” program, OST with methadone and

harm reduction measures through provision of clean needles/syringes was an excellent example for a spectrum of different drug interventions in penitentiary institution and potential of individualized approach to different types of drug users.

During the evaluation mission the evaluators were told that there was an ongoing criminal investigation going on in Osh as one nurse from the narcological centre had been accused to sell methadone to drug users that was not in a treatment regime. It has not been possible to add more about this incident into this report.

Conclusions and recommendations on the development of OST in the Kyrgyz Republic

Due to the sustained and coordinated efforts of the Government of the Kyrgyz Republic, UN organizations, international and local NGOs, OST has significantly expanded during the years of 2006 – 2008. The number of drug service centers, which provided OST with methadone increased from 2 in 2006 to 13 in 2008. The number of IDU in OST in two years increased 5 times from 145 in October 2006 to 729 in October 2008.

The country has created the decentralized system of provision of OST both in specialized institutions and Family Medicine Centers. OST was provided by teams of specialists in a comprehensive way and with links to the external sources of support provided by NGOs. Provision of OST through family medicine centers offered potential possibilities of further integration of drug treatment with family medicine and further reduction of stigma of IDU.

The country has developed the Clinical Protocol for the providers of OST in health care institutions both under the Ministry of Health and Ministry of Justice. The pilot OST with methadone project was introduced in penitentiary institution No 47. In this institution OST was provided alongside with withdrawal treatment for IDU, psychosocial drug-free program and harm reduction program of needle/syringe exchange to prevent HIV/AIDS. The spectrum of different interventions increases opportunities for the individualized approach to different types of drug users.

At the same time only 13.5% of registered heroin users and 2.9% of estimated injecting drug users are covered with OST. Thus OST still has limited access and the impact of OST in preventing of HIV among IDU is not yet fully disclosed.

To expand MMT and its role in HIV prevention in the Kyrgyz Republic it is recommended:

1. Efforts should be continued to increase further the access of IDU to OST in Kyrgyz Republic in order to increase impact on the prevention of HIV, hepatitis B and C, TB, and STI. It is recommended to expand further OST in Family Medicine Centers with capacity building of existing staff.
2. Comprehensive health care should be continuously available in health care institutions, including infectious disease prevention and care, psychosocial support. Naloxone should be available in drug treatment service centers to prevent deaths from opioid overdose in patients, who are not in OST. Testing for hepatitis C among all patients at a volunteer basis should be promoted.
3. Cooperation of drug treatment service with family physicians should be strengthened by encouraging patients to use services of Family Health Centers. Inclusion of the NGOs in providing social and legal support for OST patients should be continued in all levels.

4. Capacity building of the OST staff, family physicians, and infectious disease specialists should include the system of provision of basic and continuous training on OST. For this purpose it is recommended to develop a training module for the multidisciplinary staff. Training should be provided by local experts.
5. The monitoring and evaluation plan to monitor the treatment outcomes should be established in the country. Monitoring and evaluation activities should be an integral and continuous part of each OST programme as is indicated in the clinical protocol. For the monitoring purposes a short data collection tool should be developed to follow dynamics in drug use, health, social integration and risk behavior, based on ready available methodologies.
6. It is recommended to finish an outcome evaluation study of the pilot OST programme in penitentiary institution No 47 in comparing the number of indicators at the baseline, after three months and after six months. Based on the results of the evaluation of pilot OST is recommended to consider the expansion of OST in penitentiary system.
7. It is recommended to develop an information dissemination strategy on OST among government employees, law enforcement officers, and medical professionals to avoid misconception about OST at different levels.

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Appendix 1

List of the meetings for WHO evaluation mission on OST in the Kyrgyz Republic

Timeframe: 13 – 17 October, 2008

1. Dr. Oskon Moldokulov, Head of WHO Country office in Kyrgyzstan;
2. Marat Mambetov, Minister of Health of the Kyrgyz Republic
3. Boris Dimitrov, Advisor of Minister of Health of the Kyrgyz Republic
4. Dinara Sagynbaeva, Head of Organization of Health Care Delivery and Licensing of Ministry of Health, KR
5. Elena Kuhranova, Prison expert, chief specialist of the main Department on Organization of Health Care Delivery and Licensing of Ministry of Health, KR
6. Mr. Ruslan Tokubaev, Director of the Republican Center for Narcology;
7. Ms. Tatiana Borisova, Deputy Director of the Republican Center for Narcology, and Chief Narcologist of the Ministry of Health;
8. Ms. Ainura Esenamanova, narcologist of the Republican Center for Narcology;
9. Mr. Timur Isakov, Chief of the department, Legal drug turnover and prevention of the Drug Control Agency;
10. Mr. Marat Jamankulov, Head of Reforming Department of ministry of Justice, KR
11. Mr. Kalykbek Nasbekov, Head of the Main Penalty Execution Department (GUIN) of the Ministry of Justice;
12. Mr. Jakshylyk Toktosunov, acting Head of the Medical Unit of the Main Penalty Execution Department (GUIN) of the Ministry of Justice;
13. Dr. Erkin Bakiev, Deputy Director General of the National AIDS Center, MoH
14. Mr. Mirlan Mamyrov, National Project Officer on HIV/AIDS, UNODC;
15. Mr. Talgat Subanbaev, Programme Manager of the GFATM, AIDS component;
16. Ms. Natalya Shumskaia, Manager AIDS Foundation East West;
17. Mr. Bolotkan Sydykanov, National Coordinator of Central Asia Regional HIV/AIDS Programme, Soros Foundation;
18. Ms. Zulaika Esentaeva, Public Health Programs' Assistant, Soros Foundation – Kyrgyzstan;
19. Igor Olyinik, Consultant, Health Programmes, Human Development Sector, International Bank of Reconstruction and Development
20. Ainura Kadyralieva, National Coordinator of the Central Asia AIDS Control Project (CAAP);
21. Mr. Erick Iriskulbekov, lawyer of the legal clinic “Adilet”;
22. Mr. Sergei Ujalovski, Director of the “Positive Initiative”;
23. Ms. Batma Estebesova, Head of NGO “Sotsium”
24. Dr. Damira Akmatova, chief narcologist, colony no.47
25. Mr. Tadjibaev Shahridin, narcologist, colony no.47
26. Ms. Djailova Roza, psychiatrist - narcologist, colony no.47
27. Focus group/MST programme patient