EVALUATION OF OPIOID SUBSTITUTION THERAPY IN THE REPUBLIC OF MOLDOVA

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Content

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drug/therapy)
CAS	Staff Attitude and Satisfaction Questionnaire
CBA	Cost-benefit analysis
CEA	Cost- effectiveness analysis
EU	European Union
FG	Focus Group (discussion)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use / User
MARP	Most at Risk Populations
MDL	Moldovan Leu
M&E	Monitoring and Evaluation
NAP	National Program on Prevention and Control of HIV/AIDS and STIs 2011-2015
NGO	Non-governmental organization
OST	Opioid Substitution Therapy
PCC	Physician consultative commission at OST programme
PI	Penitentiary Institution
QALY	Quality-adjusted Life Years
RND	Republican Narcological Dispensary
SIZO	The Remand prison
STI	Sexually Transmitted Infections
TPQ	Treatment Perception Questionnaire
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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Executive summary

The assessment of opioid substitution therapy (OST) in Moldova was organized by joint efforts of PAS Centre, UNODC and WHO Offices in Moldova.

The assessment aimed at identifying constraints towards ensuring OST coverage among injection drug users (IDU), accessibility and quality of OST services and most important steps for achieving progress and efficiency in OST implementation through provision of comprehensive and integrated care to OST patients, cost-efficiency analysis including future cost implications on national budget.

The assessment methodology included quantitative and qualitative methods as well as the review of available documents. The assessment also included 2 field missions to the Republic of Moldova by international consultants: Dr. Liuba Murauskiene, consultant on cost-benefit analysis, November 13-16, 2012 and Mr. Emilis Subata, November 18-28, 2012.

Main findings of the assessment indicated that the coverage was low around 1% of the estimated number of IDU. OST medical services were appreciated by the patients. At the same time the quality of OST was insufficient because of number of factors: high work-loads of physicians, gaps in professional knowledge on OST among medical staff, poor integration of OST into the mainstream narcology. The coordination of the multi-disciplinary treatment (including medical services and psychosocial assistance) did not exist as a system.

The system of referral of OST patients to services (such as HIV infection, TB) was not established. Recommendations on treatment of opioid dependent patients with HIV and TB were not included in national treatment protocols.

Continuous psychosocial support provided by NGOs improved the accessibility of the psychosocial and medical individualized care to OST patients. NGOs varied in the degree of provision of professional psychosocial assistance. Staff of NGOs also had gaps in evidence-based information on OST as an effective public health intervention.

The assessment showed that the image of OST was negative among most IDU. The main barrier for patients to enter OST was the “attachment” to the treatment site preventing patients to have a perspective of normal life. Another major barrier included

misconceptions about OST. In penitentiary system in spite of the shortage of medical specialists, professionalism of staff ensured easy access to OST and flexible dosing. There were gaps in coordinating services with police at different levels.

The cost-benefit analysis indicated that expansion and improvement of the quality of OST program will require increase in financing (from public sources increase from 67 to $189-286 per client annually). However, OST was highly beneficial in monetary terms due to crimes averted. Expanded OST could demonstrate many QALY gained on relatively low costs ($1714-2691 per QALY).

The results of the assessment suggest the following recommendations for the further development of OST:

For the Ministry of Health:

1. To mandate the Republican Narcological Dispensary to develop an action plan aimed at the improvement of access, coverage and quality of OST.

2. To develop cooperation agreements/protocols between narcological, AIDS and TB/infectious disease sectors on coordinated information sharing and treatment of patients who have opioid dependence and concomitant infectious diseases. To develop mutual educative events/trainings on comprehensive treatment of OST and infectious diseases.

3. In order to increase the adherence to OST and increase its quality, to initiate the change of legal acts/protocols in line of WHO recommendations, which would allow doses of opioid medications (methadone) to be used at home for patients in stable remission on the individual basis. Patients should be responsible for the use of their medications according medical recommendations.

4. To update a National Clinical Protocol in accordance with WHO Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009) in cooperation of infectious disease, TB specialists and social workers.

5. To develop technical criteria for minimal requirements for ongoing quality of OST. This should define the necessary staff, medical procedures and equipment for OST as a medical service.

6. To consider expansion of the access to OST in different cities by integrating OST into existing infrastructure of narcological service.

7. To provide systematic educational activities/materials on “the state of art” of opioid dependence treatment among narcologists and physicians of other specialties.

8. To develop further cooperation with Ministry of Interior in implementing not only repressive and preventive drug control measures, but also in referral and better coordination of treatment of drug dependent patients, including the developing and monitoring the take-home medication system for socially stable patients, promoting information exchange while ensuring the confidentiality of patients. To provide professional educational activities to law enforcement staff on drug treatment at national and local levels.

9. To increase the sustainability of high quality of OST programs by the gradual inclusion of social workers into the staff of narcological treatment sites, which could coordinate multi-disciplinary services for patients with multiple medical and psychosocial needs; to integrate OST into existing services, to develop necessary internal procedures, standards, job description, case load norms for physicians and other specialists.

   For the Republican narcological Dispensary and Balti Municipal Clinical hospital:

10. To review the workload of physicians and nurses in the existing OST sites, in order to optimize their time for provision of care of OST and other narcological services;

11. To allocate office space close to OST sites for counseling of OST patients by NGO designated trained case managers at certain hours; to develop protocols of coordinated multidisciplinary care of OST patients including NGOs and medical professionals.

12. The quality of the OST and its adequateness to the needs of patients and international standards should be regularly monitored, e.g. regular anonymous patient surveys, FG discussions on the satisfaction of patients, working hours of methadone dispensing unit, etc.;

13. To develop “job aids” kits for service providers and educational materials for OST patients and IDU not in treatment by addressing existing prejudices and myths on OST among them; to communicate solid up-to-date scientific information systematically.

14. To design a strategy of provision of scientifically based information of the community, including medical specialists at various levels, law enforcement staff, etc. To continue and increase cooperation with law enforcement agencies not only in preventive activities, but also in implementing drug treatment activities.

    For Medical University “N.Testemitanu” Department of Psychiatry

15. To incorporate OST as a regular subject into curricula of psychiatry and narcology for medical students and postgraduate physicians residents in psychiatry-narcology and toxicology. To provide an opportunity for all physician residents in psychiatry and narcology to develop practical skills in diagnosis of opioid dependence, administration of initial and maintenance doses of methadone and organizing the multi-disciplinary care.

    For WHO, UNODC, UNAIDS, Soros Foundation Moldova, PAS Centre

16. To increase consistently professional requirements and standards for the NGO staff in provision of psychosocial care to OST clients by encouraging them to employ higher numbers of professional and qualified social workers, training the existent non-professional staff in professional case management of OST patients.

17. To provide relevant training of NGO workers on OST as an evidence based and effective public health intervention in-line with WHO/UNODC/UNAIDS position and clinical recommendations.

18. To facilitate cooperation of the medical institutions and NGOs in exchanging information, organizing joint specialist assessment of patients, multidisciplinary treatment planning and monitoring. To facilitate joint trainings for the teams of specialists on team work and case management.

Background

Eastern Europe and Central Asia is the only region where HIV prevalence clearly remains on the rise. The HIV epidemic that is mainly IDU-driven poses one of the most formidable challenges to the development, progress and stability of the countries of the region. Moldova has a significant HIV epidemic which is particularly concentrated among certain sub-populations, such as injecting drug users. HIV prevalence among the general population is currently 0.37%. As of January 1, 2012, a cumulative number of 7,125 HIV cases were registered, including 2,268 in the Transnistrian region.

National policy framework guiding the HIV response in the Republic of Moldova is implemented through the National Program on Prevention and Control of HIV/AIDS and STIs for 2011-2015 (NAP). Harm reduction programs are part of the NAP and are the focus of Government interventions as a response to the epidemic in the next years.

In Moldova among all areas of prevention, HIV prevention among most at risk populations (MARP) has experienced the most rapid growth. Since 2003, with support from Global Fund Round 1 and 6 and 8, there has been commendable progress in mobilization of resources and efforts for the scale-up of prevention programs for major MARP (IDUs, SWs, MSMs), including in penitentiary system. Due to rapid scale-up of Harm Reduction Programs among MARP, both in the civil sector (IDUs, SWs, MSM) and in penitentiaries (IDUs), the Republic of Moldova is known as an example of best practice. Currently under the Global Fund Grant Round 8 a component aims at ensuring higher rates of enrolment by identifying IDUs and referring them to OST. There is a special focus on active IDUs, who typically require more support to remain adherent to OST, with the aim to reduce high drop-out rates that are currently registered. The program sustains and enhances community centers established in the four regions of the country to provide psycho—social services to PLWH. In addition to care and support services provided onsite, these centers also serve as key vehicles for the delivery of other components of the overall care and support package, including counseling and self-help groups.

There are 17 harm reduction sites targeting IDUs across the country. As of January 2012, there were a cumulative number of 14 815 people who ever used drugs reached by interventions/ needle syringe programs.

The HIV response in Moldova is also a good example of partnership between public and civil society sectors, as over 40 NGOs are involved in HIV activities. At national level there is a Union of Organizations working in the Field of Harm Reduction (UOHR) functioning as an institutionalized association of NGOs that implements Harm Reduction Strategies for different categories of population at high risk of infection. Even though progress has been registered in the field of harm reduction in Moldova, there are still a range of constraints related to availability, coverage and quality of comprehensive harm reduction services to most-at-risk populations.

Relatively lax border control from the East, a geographic position that makes Moldova a transit country for illicit drugs bound for the Balkans, and production of poppy and cannabis locally, all contribute towards high rates of opiate use in Moldova.

Republican Narcology Dispensary (RND) routine statistics reflects the following situation, at the end of 2010, there were 8960 people who used drugs, including 3361 injecting drugs; 32 people who tested HIV positive in 2010 of the total number of newly registered HIV cases among injecting drug users.

Currently HIV prevention in IDUs relies 100% on GFATM Round 6-8 funds and there are no committed funds for OST in the next NAP 2011-2015.[1]

Given the evidence on the effectiveness of drug-dependence treatment for HIV/AIDS prevention among injecting drug users, it is strongly recommended that a full and comprehensive range of high-quality treatment services be established in affected communities and that as many injecting drug users as possible have access to them (WHO, UNAIDS and UNODC). Substitution treatment with methadone has been recognized as an effective tool for prevention of spread of HIV infection among IDUs and increases the adherence of IDU living with HIV to ARV therapy.

Substitution treatment with methadone (OST) is part of the NAP for 2011-2015 and is implemented in Moldova since 2004 in civil sector and since 2005 in prisons in three sites (RND, Department of Penitentiary Institutions and Clinical Hospital in Balti city). Even though the projects cover three country sites, the number of beneficiaries/coverage with services is very low. OST is currently provided to IDUs through three OST sites located in the cities of Chisinau and Balti and seven sites in the penitentiary sector. By the end of 2011, there were a total of 880 patients enrolled in

[1] Moldova HIV prevention evaluation report, 2011

OST in three sites. At the same time, the uptake of new patients has slightly declined starting with 2007 from 222 new patients in that year to 189 new patients in 2010. [2]

On the course of OST program implementation, a series of independent evaluations had taken place in 2007, 2008, 2009. These identified a series of constraints related to coverage of IDU with services and extension of those at country level. A range of external recommendations have been implemented and improvements were in place. Nevertheless, regretfully, current quantitative indicators related to OST services are worrisome. Both prison and civil sector report low number of patients involved in programs. Factors contributing to the trend require additional research.

Despite the psycho-social support services provided to OST patients since 2010 aimed at increasing adherence to OST, also all other efforts towards an integrated approach to OST, the dropout rates from the maintenance treatment program ***remain high***. Evidence suggests that OST treatment lasting more than 6 months is optimal for an impact. According to the latest available data, only 56% of individuals who initiated OST completed 6 months of continuous treatment.

Remaining issues in OST relate to coverage and quality. Nationally, OST ***coverage is low*** and is not yet at levels necessary to impact HIV incidence at population levels. The estimated coverage is less than 1% at the moment. Geographical availability of the OST in the country is still low, with OST programs available only in Chisinau and Balti and part of the penitentiary institutions. OST in health care facilities still ***lacks full multidisciplinary approach to address multiple social needs of patients*** and the complete package of services does not always include wraparound services, such as employment support or the provision of OST to pregnant women who are active IDUs. There is a sizeable attrition rate of clients in OST programs. The verticality of the health care system undermines the provision of integrated services and reduces the effectiveness of individual medical interventions.

A qualitative assessment among people using methadone maintenance therapy has been undertaken in northern part of Moldova capital, Balti city. In order to assess people using drugs' feedback to OST program in Balti city, a small survey among 41 clients who entered OST was conducted in late 2009. Its results have shown that most clients entered the OST program in order to come off drugs (65.8%) and avoid withdrawal (17%). The majority of OST clients (78%) considered that the program allowed them to avoid problems with police and made them able to find a job, 19.5%

[2] Soros Foundation Moldova. Activity report, 2010. Unpublished report.

thought they felt better. The shortcomings of the program, based on the opinions of ***39% of respondents, were lack of flexibility*** of the program (short work hours, impossibility to leave town, no take-home doses) and some ***15% clients*** considered they had a worse dependence from methadone. Some ***34% of OST patients admitted to still using other drugs in addition to OST and thought more than half of their friends on OST (58.5%)*** were still using other drugs. The vast majority (95%) had good or excellent relationship with medical staff. As barriers for higher uptake of OST in Balti were mentioned lack of information about OST (39%), the requirement to be on narcology registry (22%) and negative attitudes towards methadone (12%) in the community of IDUs.[3]

According to program reports, the ***average daily dose for OST clients in Chisinau was 42 mg***, in Balti 47.4 mg[4], i.e. significantly below the WHO daily recommended dose of 60 to 120 mg of methadone, necessary to avoid any withdrawal symptoms. Higher doses were administered at prison hospital 64.4 mg. The under dosing might be one of the reasons for parallel use of street drugs as a way to self-medicate withdrawal symptoms in patients on OST.

It appears that IDU community has biased attitudes towards OST. A survey to investigate attitudes of IDUs towards entering OST program in Balti showed that of 152 IDUs clients of harm reduction program that were not in OST, only ***23% would want to enter*** OST, 13% were not sure, while ***64% did not want to enter OST***, the main reasons being the belief that methadone is worse than street drugs (36%), the intention to come off drugs using another method (30%) and various inconveniences related to methadone program (8%). This might be one of important barriers in scaling up the program.

Latest trends of lower number of patients included into OST, high rate of dropout rate alert national partners and question sustainability of resources invested on behalf of the Global Fund. In Moldova, OST is fully covered by the external funds. As a consequence of these, United Nations Office on Drugs and Crime (UNODC) and the Centre for Health Policies and Studies (PAS Center) mandated the assessment of the situation and were ready to support the Government in identifying barriers towards improving and successfully implementation of OST programs in Moldova.

[3] NGO The Youth for Right To Live. Rapid assessment of OST patients opinions about the OST program in Balti, 2009. Unpublished report

[4] Republican Narcology Dispensary. Annual activity report 2009. Unpublished report

Methodology of the assessment

The overall legal framework of OST (at national health care system level), national clinical guidelines (at treatment program and patient levels) was evaluated against the WHO recommendations in *"Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, 2009"*[5].

The methodology of the assessment of the quality of opioid substitution therapy included the combination of ***quantitative and qualitative methods***.

Quantitative methods

Quantitative methods aimed to investigate the perception of strengths and weaknesses of OST in a) *a sample of OST patients* in the community and prison, b) *a sample of staff* (nurses, physicians, psychologists, social workers, peer-to-peer educators, outreach coordinators) in the community and prisons. ***Instruments for quantitative methods*** *included Treatment Perception Questionnaire (TPQ) and Staff attitude and Satisfaction Questionnaire (CAS).* [6]Both questionnaires are attached as **Appendixes 1 and 2.**

TPQ (Treatment Perception Questionnaire)[7] was a self-administered by patients with the support of interviewer. The TPQ was planned to be administered to representative samples of RND patients (130 out of 192), to all patients in Balti and all patients in prisons. The support of national assessment consultants in filling the questionnaires was available and confidentiality of responses was essential.

CAS (Staff Attitude and Satisfaction Questionnaire[8]***)*** was self-administered by staff, participating in OST. It was planned to be delivered and collected by national assessment consultants. CAS was planned to be delivered to all OST staff in direct contact with patients: 18 medical staff (physicians, nurses, psychologists) in Chisinau and 5 in Balti; NGO peer-to-peer educators and outreach coordinators in Balti and Chisinau (25 persons) as well as NGO workers from day-centers in Cahul and Tiraspol (15

[5] Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, WHO, 2009. http://whqlibdoc.who.int/publications/2009/9789241547543_eng.pdf

[6]WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV http://archives.who.int/eml/expcom/expcom14/methadone/buprenorphine_meth_PreliminaryReport_WHO_Study25feb05Final.pdf

[7] http://www.emcdda.europa.eu/html.cfm/index4322EN.html

[8]http://archives.who.int/eml/expcom/expcom14/methadone/buprenorphine_meth_PreliminaryReport_WHO_Study25feb05Final.pdf

persons). OST staff working in prisons (13 medical staff and 7 persons from NGO) was also planned to be included.

Filled questionnaires entered into the SPSS database and statistically analyzed.

Qualitative assessments

For quality assessments PAS Centre and UNODC hired national assessment consultants. According the assessment plan they have moderated following Focus Group (FG) discussions:

1. FG discussion with OST patients in Chisinau (November 6, 2012, 10 persons, transcripts 28 pages)
2. FG discussion with OST patients in Balti (October 31, 2012, 8 persons, transcripts 24 pages)
3. FG discussion with former OST patients (November 6, 2012, 10 persons, transcripts 35 pages);
4. FG discussion with "difficult" OST patients (October 31, 2012, 9 persons, transcripts 19 pages)
5. FG discussion with IDU, who were eligible for OST, but were not entering treatment (November 3, 2012, transcripts 22 pages);
6. FG discussion with OST nurses (date unknown, 4 nurses, transcripts 16 pages)

National assessment consultants made In-depth interviews with medical staff and NGO representatives of OST sites in Chisinau, Balti and Penitentiary Department:

1. In-depth interview with physician narcologist at OST site in RND, Chisinau (November 11, 2012, transcripts 15 pages)
2. In-depth interview with physician narcologist at Balti Municipal Hospital OST site (October 27, 2012, transcripts 6 pages)
3. In-depth interview with medical specialist from Penitentiary Department (transcripts 6 pages)
4. In-depth interview with OST assistant in Penitentiary Institution (transcripts 7 pages)
5. In-depth interview with NGO representative (October 27, 2012, transcripts 7 pages)
6. In-depth interview with the social worker at NGO in Balti (November 5, 2012, transcripts 5 pages)

7. In-depth interview with an outreach worker at NGO (November 8, 2012, transcripts 4 pages)
8. In-depth interview with the psychologist (November 11, 2012, transcripts 6 pages)
9. In-depth interview with director of the NGO (transcripts 7 pages)

Transcripts from FG discussions and in-depth interviews were written down in English or Russian.

Findings from qualitative studies were verified by the consultant during meetings with representatives of the Governmental organizations, medical institutions and NGOs.

Relevant legal acts of the Ministry of Health were reviewed with the help of national consultants. The qualitative assessment methods of OST programs during the consultant's field mission to Moldova included semi-structured inspection of OST facilities in Chisinau and Balti.

The overall findings and recommendations of the assessment were verified during meeting with UNODC, UNAIDS, PAS Centre on November 23 and during public presentation of preliminary findings of the assessment and roundtable discussion November 26, 2012.

The methodology and the context of cost-benefit analysis were presented by in the separate chapter this report.

Challenges and Limitations

During the visit November 18 -28, 2012 the international consultant was able to spend a limited time in OST programmes. The consultant met with the limited number of OST staff and other stakeholders (Appendix 3). Nevertheless the consultant's previous involvement through evaluation missions in 2007, 2008 and 2009 allowed observe the improvements and challenges in the development of the OST. The consultant had not a possibility to verify the confidentiality issues in acquiring quantitative information with the help of questionnaires from patients and staff.
As there was a big amount of information collected through quantitative assessment, it was not possible to include all the results of the study in this report. Therefore, the international consultant included selected study results, which he considered as most illustrative.

Results of the quantitative studies

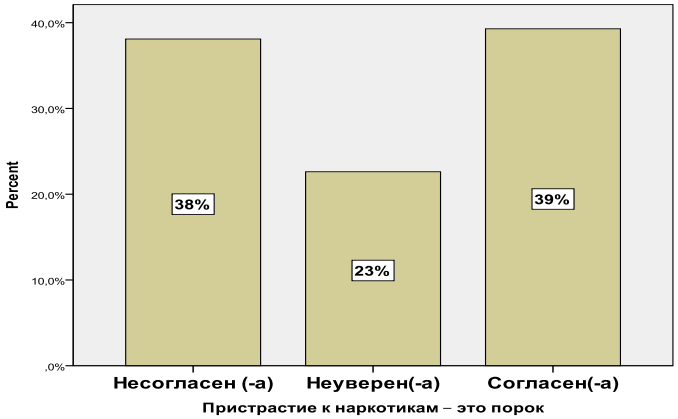
Staff attitudes towards OST

84 staff members answered CAS questionnaires. 25 were employed in medical institutions (21 physician and nurses among them, other psychologists, etc.) and 59 employed by NGOs. The following domains of staff attitudes were researched:

- Staff attitudes towards dependence
- Abstinence versus Maintenance orientation as a treatment goal
- Negative opinions about patients
- Incorrect information on OST
- Satisfaction with work

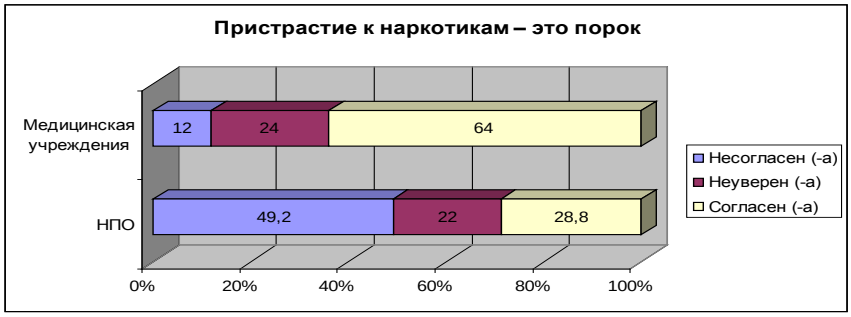
Staff attitudes towards dependence. While latest scientific data of neuroscience (McLellan et al, 2000, WHO, 2004) indicated that dependence is a chronic brain disease, big proportion of the staff, who worked directly with patients in OST were not sure if the dependence was a disease or a moral weakness. As indicated in Chart 1 39% of respondents agreed and 38% disagreed with the assumption "Drug addiction is a vice", while 23% were hesitant.

Chart 1 "Drug addiction is a vice"



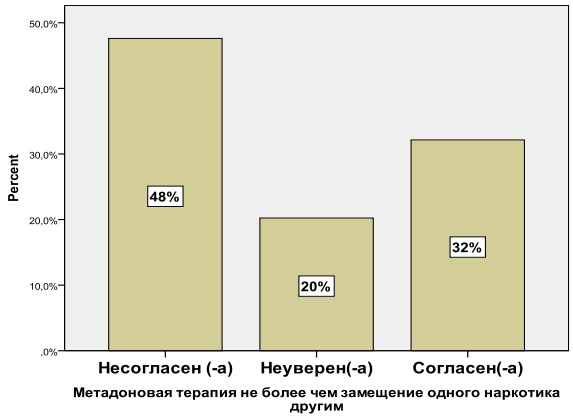
NGO employed staff more often agreed (49.2%) that the dependence was rather the disease than a vice, as indicated in Chart 2.

Chart 2 “Drug addiction is a vice”



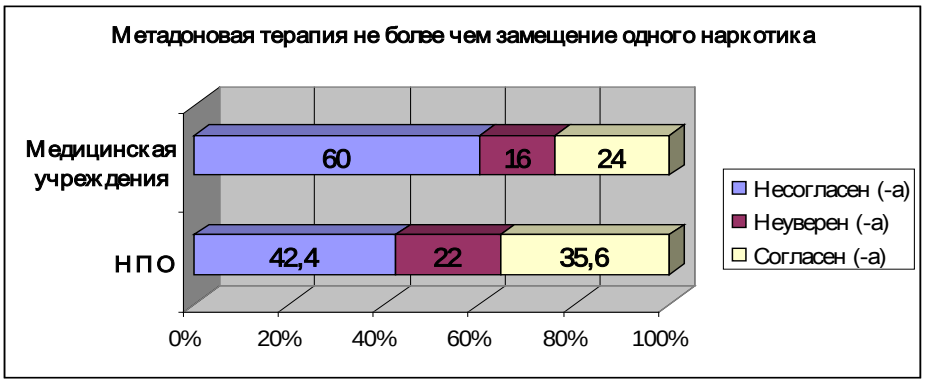
The other responses, which illustrated difference in staff opinions regarding drug dependence on OST was the assumption: “Methadone does no more than substitute one drug for another”. As indicated in Chart 3 32% of respondents agreed with this assumption, 48% disagreed and 28% hesitant.

Chart 3 “Methadone does no more than substitute one drug for another”



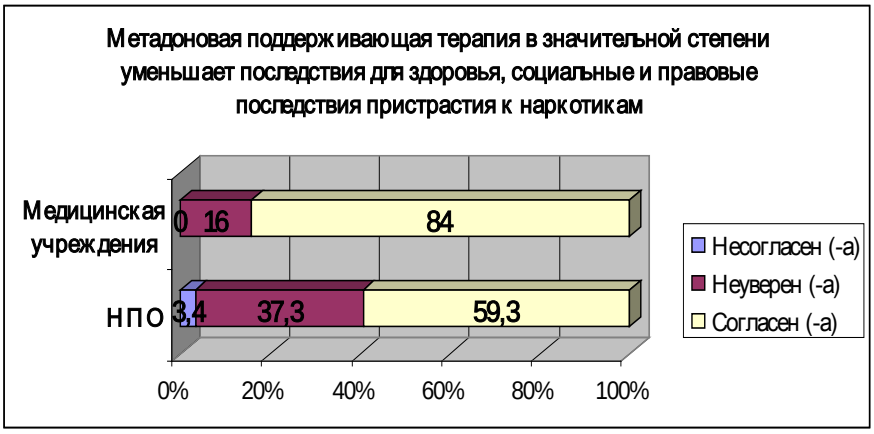
In this case medical staff more often than staff employed by NGOs believed that OST with methadone is “treatment” rather just the replacement of one drug with another (Chart 4).

Chart 4 “Methadone does no more than substitute one drug for another”



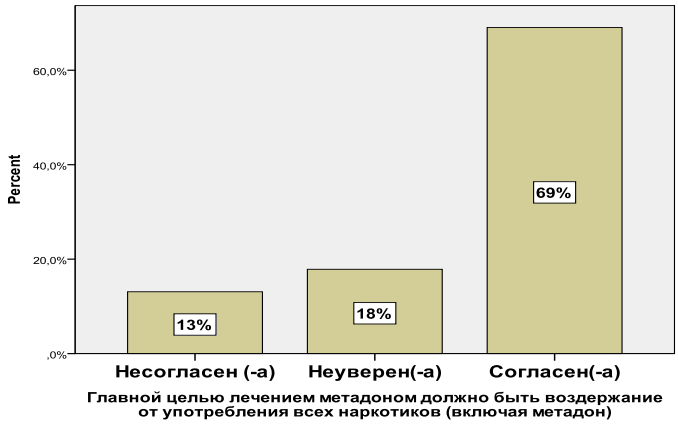
Responses to other assumptions showed general trend that both medical staff and NGO employed staff had some diametrically opposite attitudes with a comparably big proportion of the staff members, who were unsure about their attitudes. At the same time much higher proportion of medical staff (Chart 5) believed that OST reduced negative health, social and criminal consequences of heroin dependence (84% agreed with the assumption "Methadone maintenance greatly reduces the health, social and legal consequences of narcotics addiction" against 59.3% who agreed from the NGO staff).

Chart 5 "Methadone maintenance greatly reduces the health, social and legal consequences of narcotics addiction"



Abstinence versus Maintenance orientation as a treatment goal. The current scientifically based information indicates that long-term pharmacotherapy with methadone an buprenorphine is effective in terms of staying in treatment, reduced heroin use, improved health and social status, reduced criminality and injecting risk behavior. Abstinence from all drugs and methadone as a medication could be not a realistic option for many patients. Nevertheless, majority of staff members (69%) thought that abstinence from all drug (including methadone) should be the principal goal of OST (Chart 6) and only 13% did not agreed with this assumption ("Abstinence from all narcotics (including methadone) should be the principal goal of methadone treatment").

Chart 6 “Abstinence from all narcotics (including methadone) should be the principal goal of methadone treatment”



There is evidence that optimal methadone doses in the range of 60-120 mg per day prevent the opioid withdrawal symptoms and keep patient’s mental and physical functions normal or very close to normal. Sufficient dose reduces or eliminates craving for heroin and block opioid receptors. This prevents patients to feel euphoria from heroin. Unfortunately, 42% of staff agrees (Chart 7) with the assumption “Methadone patients who continue to use heroin should have their dose of methadone reduced”, which contradicts one of the basic clinical recommendations. This belief is even more common among medical staff (56%) than among NGO staff (Chart 8)

Chart 7 “Methadone patients who continue to use heroin should have their dose of methadone reduced”

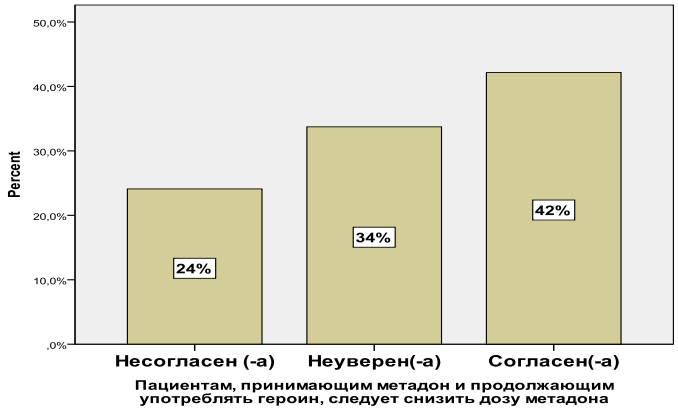
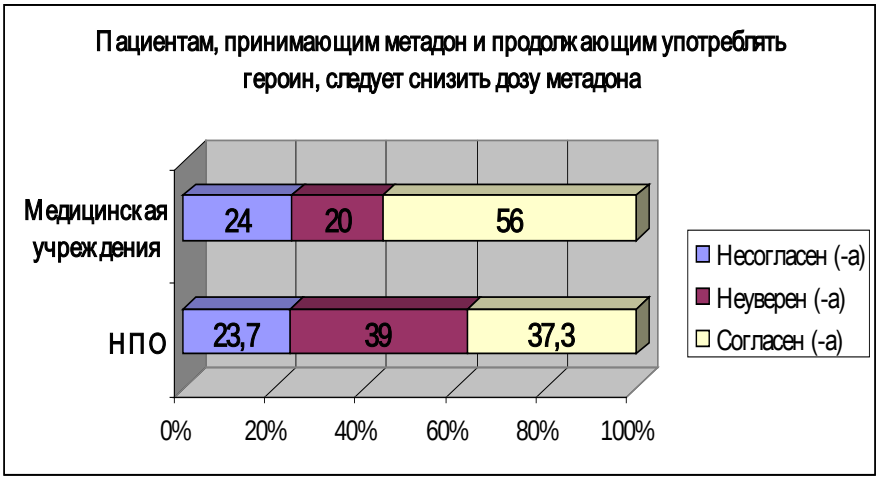
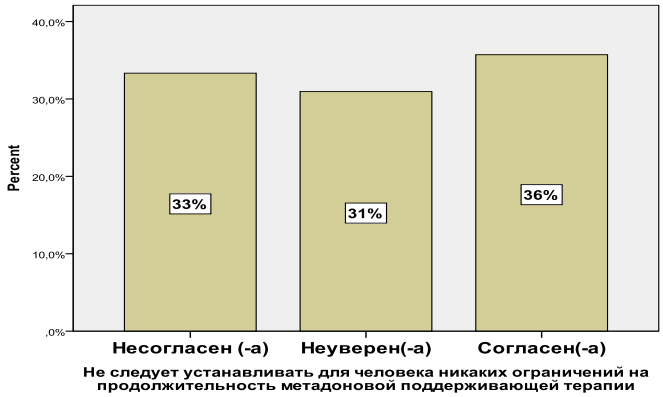


Chart 8 “Methadone patients who continue to use heroin should have their dose of methadone reduced”



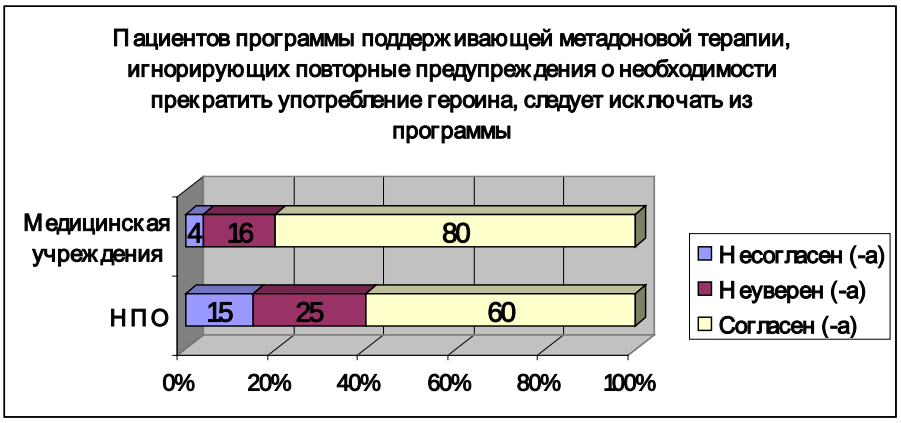
According the WHO Guidelines on Pharmacological treatment of opioid dependence there should not be time limits for the duration of OST. OST should be provided as long as risks for the relapse remain high. Study results indicated that roughly 1/3 of staff agreed with current evidence-based recommendation *“*No limits should be set on the amount of legal time a person can be on methadone maintenance”, 1/3 disagreed and 1/3 were unsure (Chart 9).

Chart 9 “No limits should be set on the amount of legal time a person can be on Methadone maintenance”



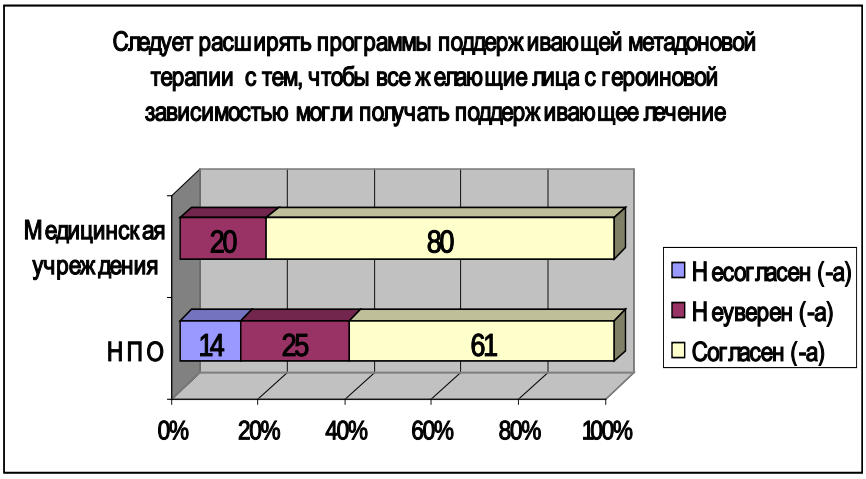
For patients, who continue to use heroin, the usual recommendation is the substantial increase of the methadone dose to reduce craving and block effects of euphoria, also to increase counseling. Nevertheless, majority of medical staff and NGO employees thought that such patients should be discharged from OST as indicated in Chart 10. 80% of medical staff and 60% of NGO workers believed that such patients should be discharged from treatment.

Chart 10 “Methadone patients, who ignore repeated warnings to stop using heroin should be expelled from treatment”



Nevertheless, majority of medical staff (80%) and NGO workers (61%) agreed with the assumption “Methadone services should be expanded so that all heroin addicts who want methadone maintenance can receive it” and believed that OST should be expanded across the country to be easily accessible for every heroin-dependent person (Chart 11).

Chart 11 “Methadone services should be expanded so that all heroin addicts who want methadone maintenance can receive it”



Negative opinions about patients . Many members of the staff (44%) thought that patients were generally uncooperative (Chart 12). NGO staff more often thought (Chart 13) that OST patients were uncooperative (49%)

Picture 12. “Many patients here are generally uncooperative”

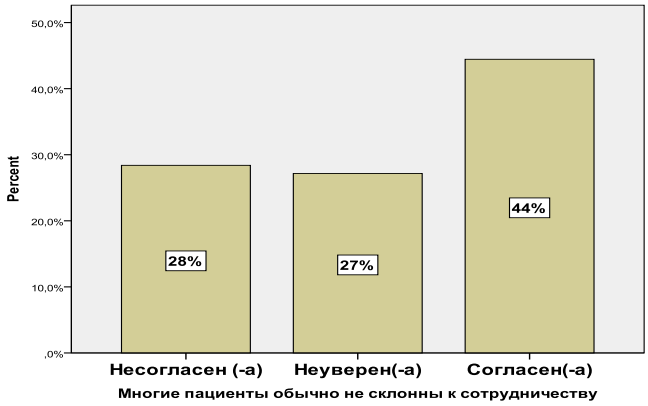
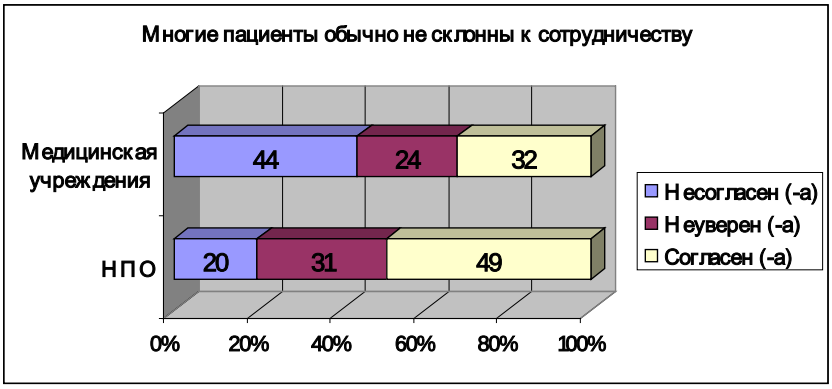


Chart 13 “Many patients here are generally uncooperative”



Incorrect medical information. Available evidence so far did not demonstrate that even a long-term treatment with methadone (years and decades) had toxic effects on brain, liver, kidney or other human organs or tissues. As a matter of fact, methadone was allowed to be used for pregnant women because unlike alcohol it does not have toxic effects on fetus’ tissues. The study showed that roughly 1/3 (33%) of all staff believed that methadone could damage liver and agreed with the assumption “Methadone maintenance can cause liver damage” and around ½ (49%) were uncertain (Chart 14). Almost half of OST staff (49%) was uncertain about methadone’s maintenance benefits against heroin use for pregnant women (Chart 15) and possible damage to kidneys (Chart 16).

Chart 14 “Methadone maintenance can cause liver damage”

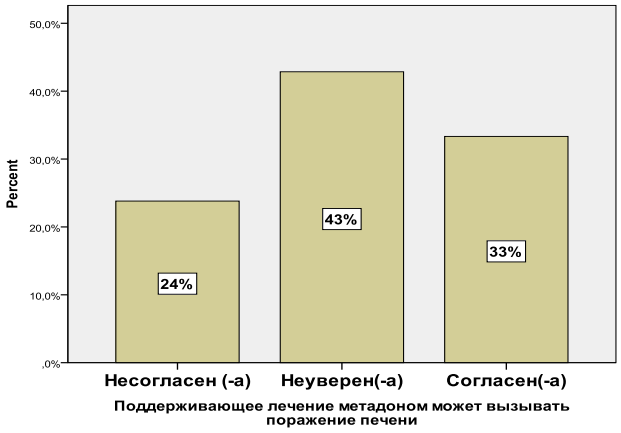


Chart 15 “Methadone is more dangerous than heroin to the unborn child”

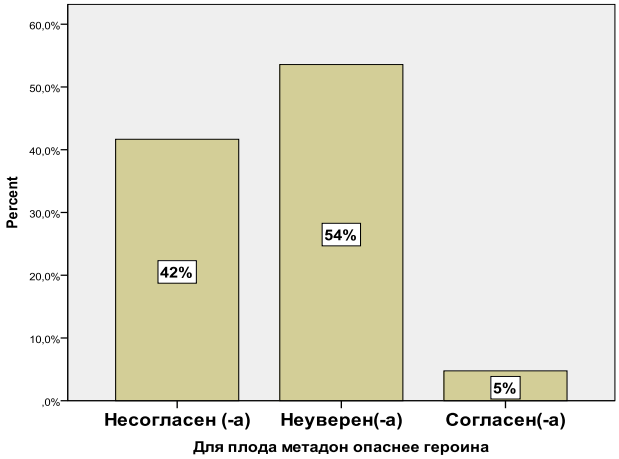
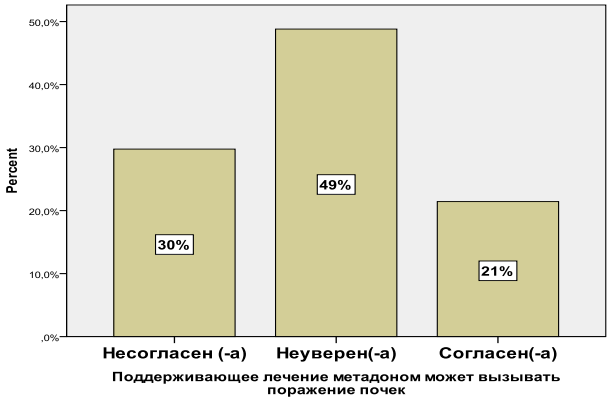


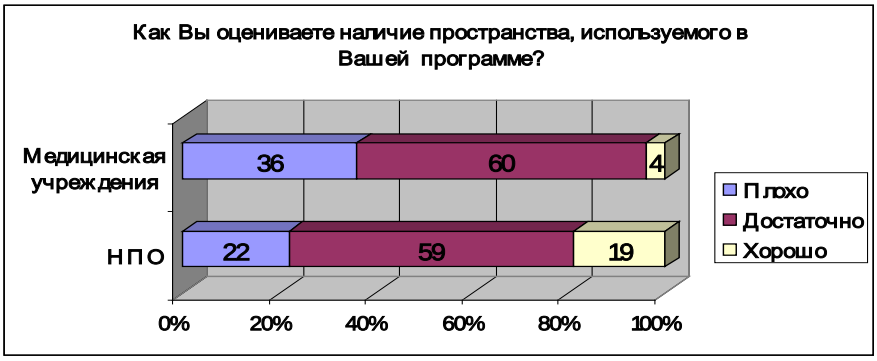
Chart 16 “Methadone maintenance can cause kidney damage”



Satisfaction with work environment. Medical staff indicated that they were more often not satisfied (if compared with NGO staff) with the premises allocated for their work

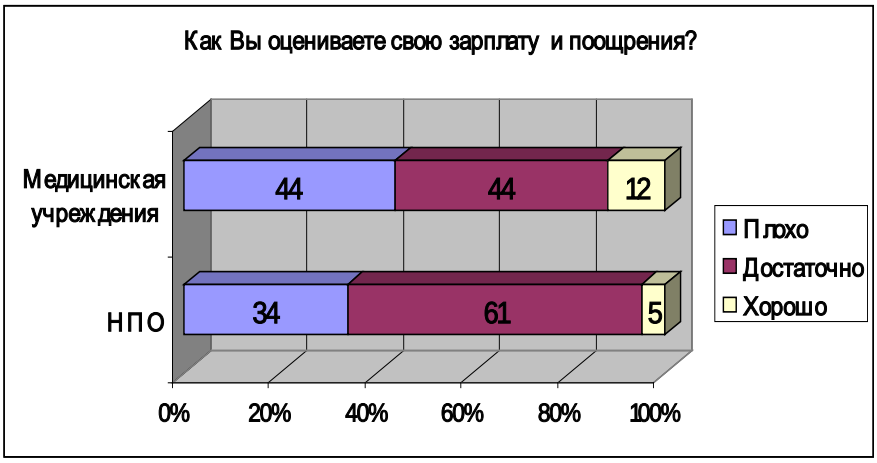
with OST patients (36% against 22%), though majority (60% and 59%) considered premises as “satisfactory” (Chart 17).

Chart 17 “How would you rate the availability of usable space in your program?”



Medical staff was less satisfied with salary and other work incentives and evaluated negatively it in 44% cases in comparison with 34% in NGOs (Chart 18)

Chart 18 “How would you rate your salary and benefits?”



Most of the medical and NGO staff were critical (not very much positive) about effectiveness of the treatment they provided. 76% of medical staff and 61% of NGO staff indicated basically their neutral/moderate attitude regarding the effectiveness of treatment (Chart 19). Similarly (68% and 61%) they were neutral about general satisfaction with their job (Chart 20).

Chart 19 “How would you rate treatment effectiveness in your program?

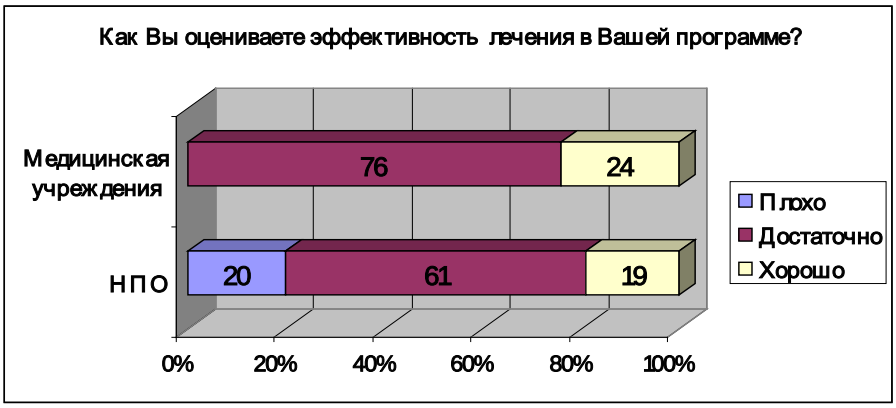
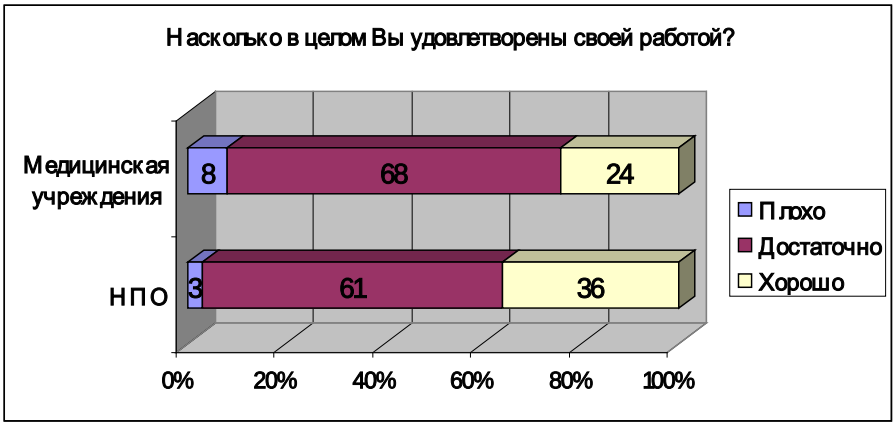
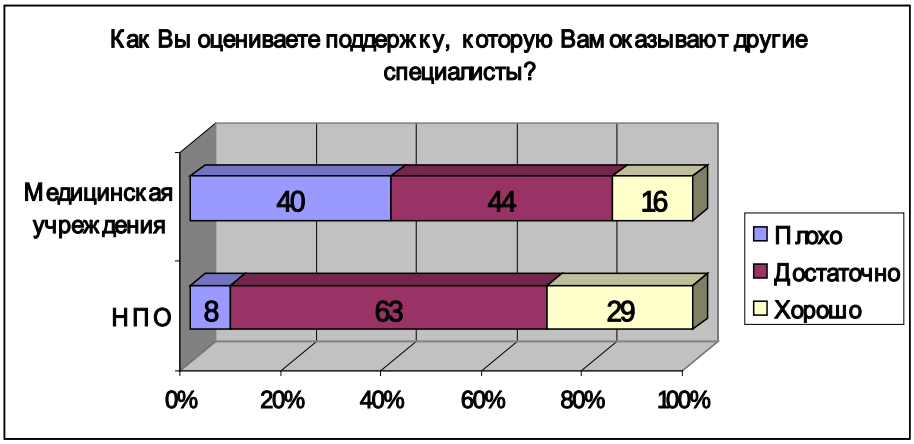


Chart 20 “Overall how satisfied are you with your job?”



It is important to note that 40% of medical staff indicated that they had not enough support from other specialists. This indicated gaps in the provision of the coordinated multidisciplinary team services for OST patients (Chart 21)

Chart 21 “How would rate the support you receive from other specialists?”



In summary, the quantitative study showed wide gaps of evidence based knowledge about OST among medical and NGO staff. There could be risks that a patient received contradictory messages from physicians, nurses, psychologists, NGO specialists and outreach workers, which were directly involved in services. In the absence of common adherence to evidence-based information about OST by staff, the coordinated multidisciplinary approach could not work. There were also high risk for different myths and false information to prevail among OST patients and IDU population.

Attitudes of patients towards OST

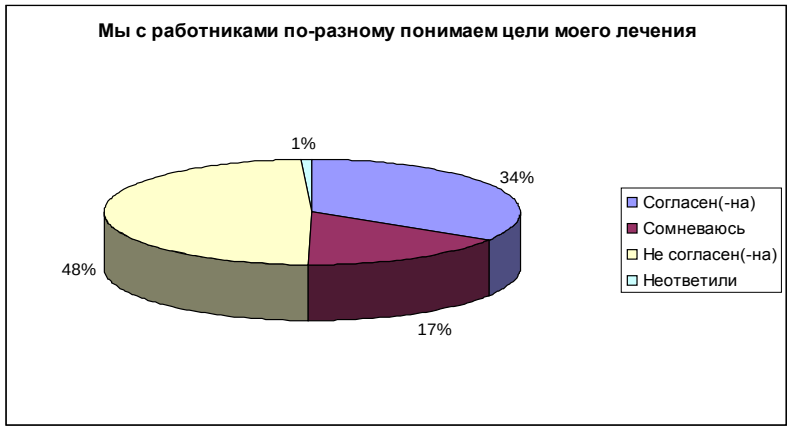
260 patients answered TPQ questionnaire about their attitude to OST services: 103 at Chisinau RND, 61 at RND Grenobl street, 48 at Balti and 48 at penitentiary institutions (PI).

The study results indicated that the staff and patients had sometimes different understanding about the services patients needed. 28% or patients agreed with the assumption "The staff have not always understood the kind of help I want" (Chart 22) and that means that there was not always a "therapeutic alliance" of supporting staff and client, which is needed to attain treatment goals and objectives.

Chart 22 "The staff has not always understood the kind of help I want".

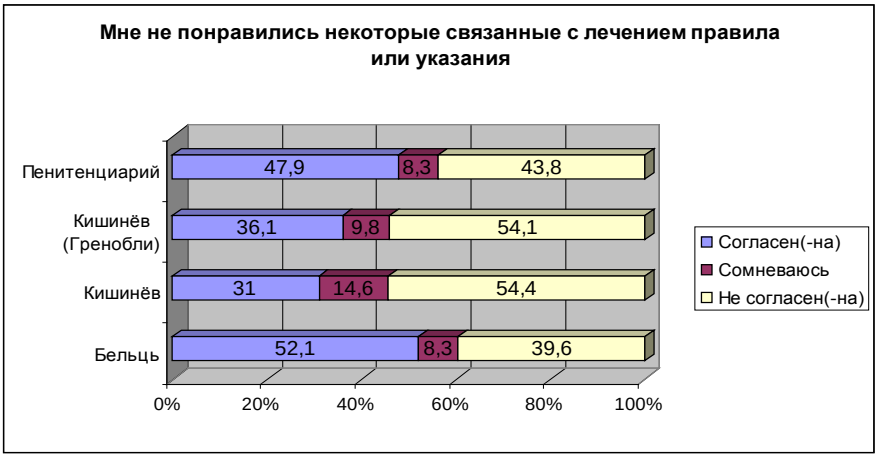
Similarly 34% of patients agreed with the assumption "The staff and have different ideas about what my treatment objectives should be" (Chart 23)

Chart 23 "The staff and have different ideas about what my treatment objectives should be"



31-47.9% of patients, as indicated in Chart 24 did not like some of the regulations of OST (agreed with the assumption “I have not liked some of the treatment rules or regulations”).

Chart 24 “I have not liked some of the treatment rules or regulations”



In Balti 43.7% of patients indicated that working hours of dispensing methadone were not comfortable for patients (agreed with assumption “Working hours of methadone dispensing suits me”), while in Chisinau situation was better (Chart 25). 47.8% of patients also indicated that in Balti they were not satisfied with the geographical location of methadone dispensing unit (Chart 26).

Chart 25 “Working hours of methadone dispensing suits me”

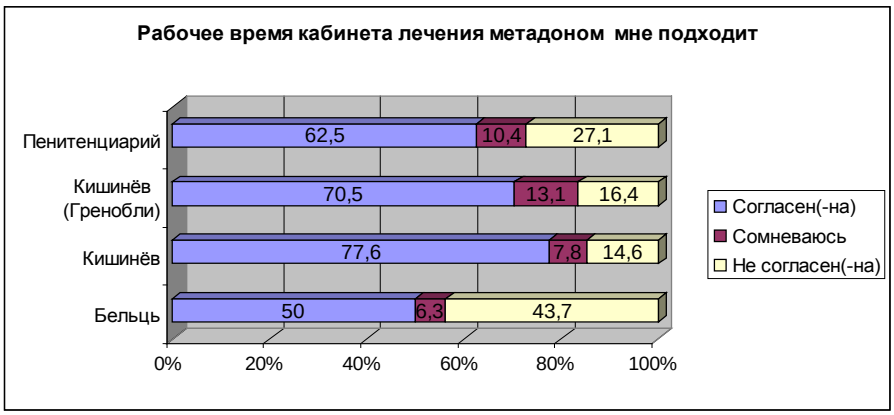
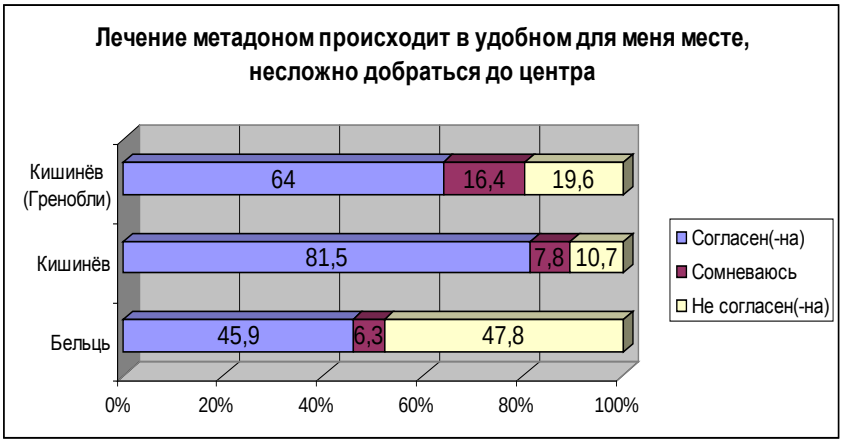
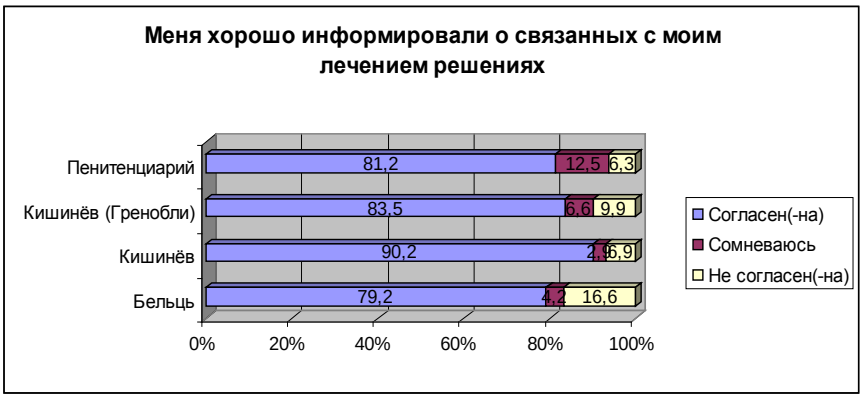


Chart 26 “OST is in the location comfortable for me”



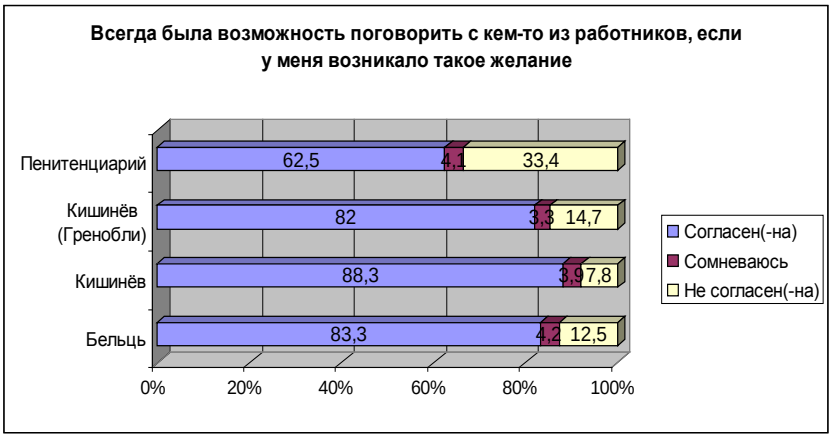
Many answers were generally positive about provision of OST. Around 80% or more patients were generally satisfied with the information they received about OST (agreed with the assumption “I have been well informed about decisions made about my treatment”) as indicated in Chart 27

Chart 27 “I have been well informed about decisions made about my treatment”



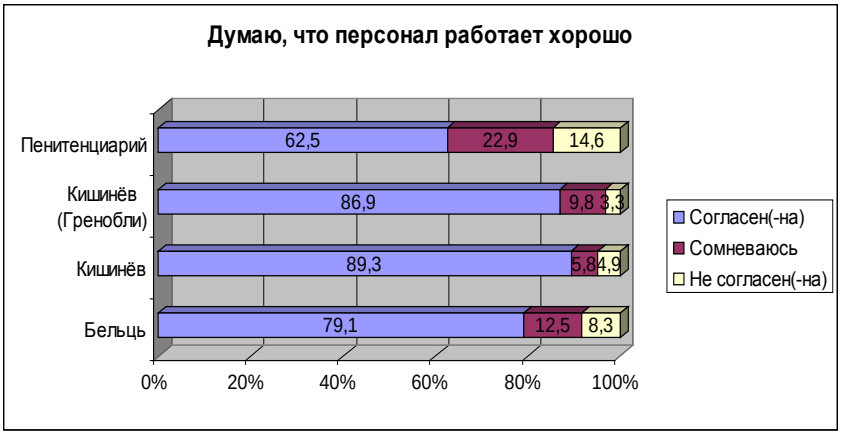
More than 80% of patients in civil sector agreed with the assumption “There has always been a member of staff available when I have wanted to talk” as indicated in Chart 28.

Chart 28 “There has always been a member of staff available when I have wanted to talk”



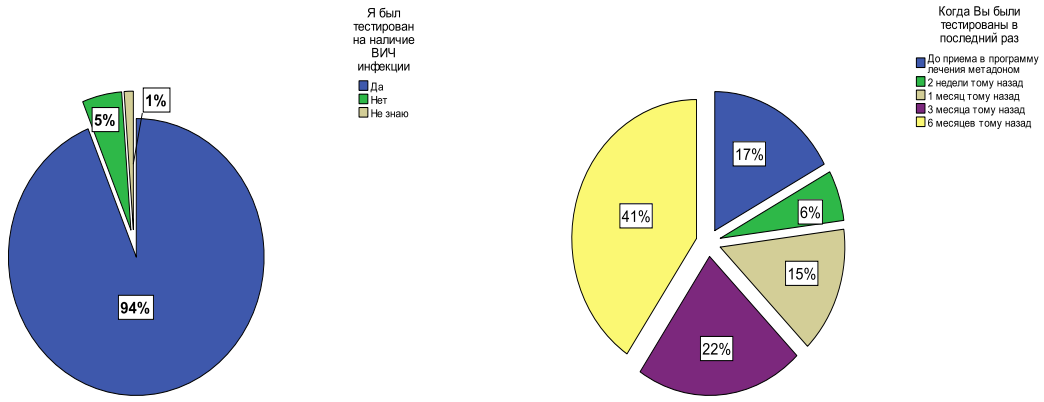
80% or more patients in the civil sector agreed with the assumption “I think staff has been good at their jobs” (Chart 29).

Chart 29 “I think staff has been good at their jobs”



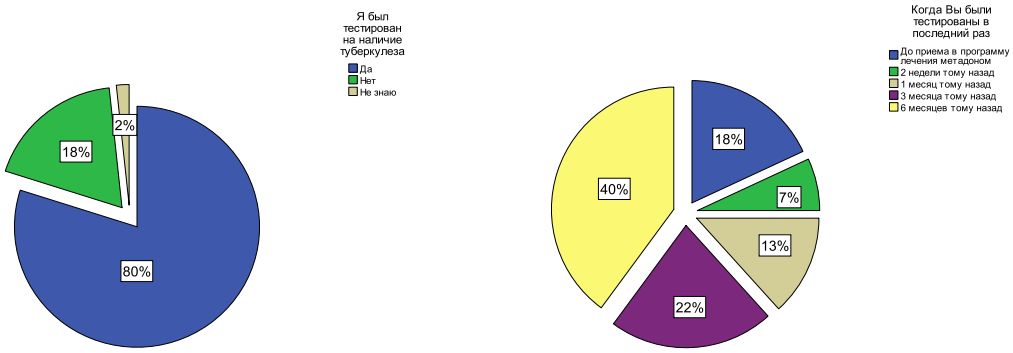
Quantitative research aimed also at services which were provided to OST patients at civil sector. 94% of patients were tested for HIV (Chart 30), with 59% of patients tested during the previous 6 months.

Chart 30 “I have been tested for HIV”



80% of patients were tested for TB (Chart 31) with 60% being tested during the previous 6 months.

Chart 32 “I was tested for TB”



68 % of patients indicated that they were tested for STI in the course of the last 6 months, 91% did a routine blood test, and 84% routine urine tests. 84% of patients were urine screened for psychoactive substance use.

75% of patients received consultation of physician internist (Chart 32). 49% of patients thought they did not need this consultation (Chart 33). Ultimately 81.2% from those, who thought they needed that consultation, received it. But also 70.9% of patients, who thought they did not need such consultation, nevertheless received it. Patients valued

consultation of internist for reasons*: "because of bad physical condition", because of chronic diseases, asthma", "because of heart problems", etc.*

Chart 32 "You had a consultation the physician internist"

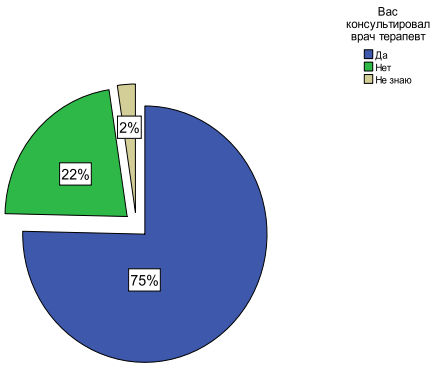
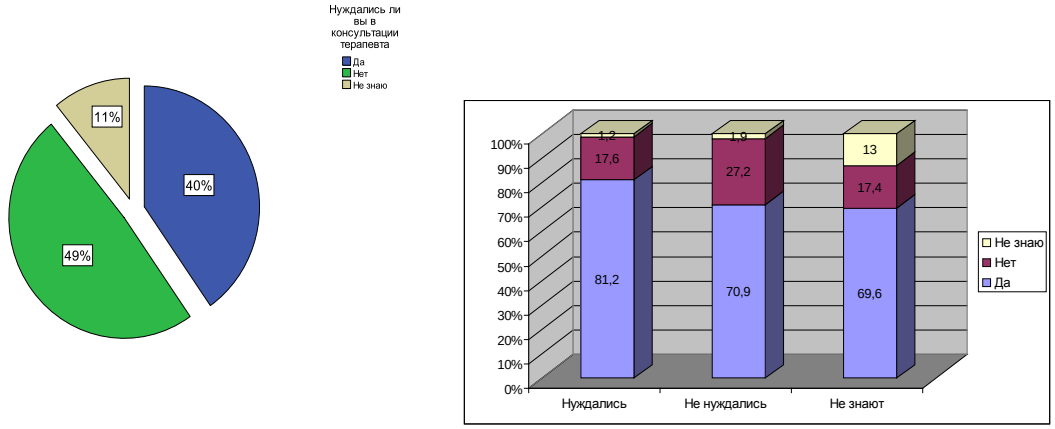
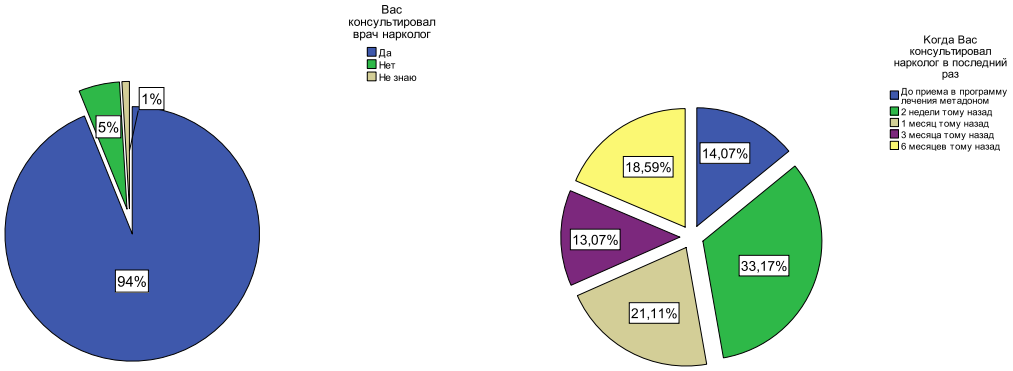


Chart 33 "Do you think you needed a consultation of physician internist?"



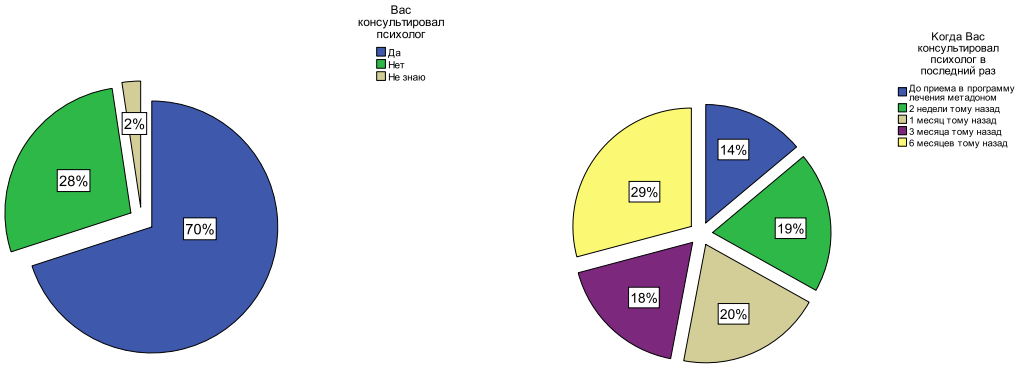
94% of OST patients indicated that they had consultation of psychiatrist-narcologist (Chart 34). 18.59% indicated that the last consultation of psychiatrist-narcologist was 6 months ago and 13.07% indicated that the last consultation was 3 months ago. Patients valued consultation of the psychiatrist (narcologist*) "because of psychological traumas", "to understand better methadone treatment", "wanted to finish OST", "because of questions associated with methadone", "just for prevention", etc.*

Chart 34 “Have you received consultation of psychiatrist (narcologist)?”



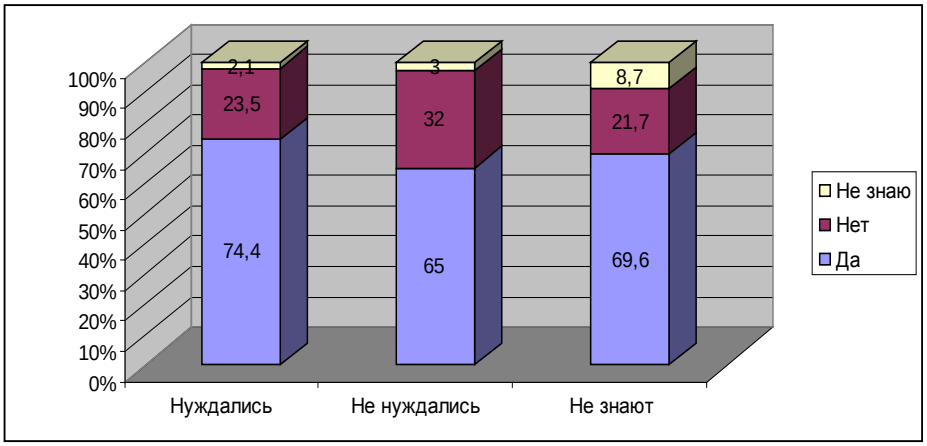
70% of OST patients indicated that they have received a consultation of a psychologist (Chart 35). 29% from those, were consulted by a psychologist, received it 6 months ago. Patients valued consultation of the psychologist for the reasons: *“I feel mentally bad”, “because of stress situation”, feeling bad after death of parents”, “because of psychosis and paranoia, “because of depression”, etc.*

Chart 35 “Have you received a consultation of the psychologist””



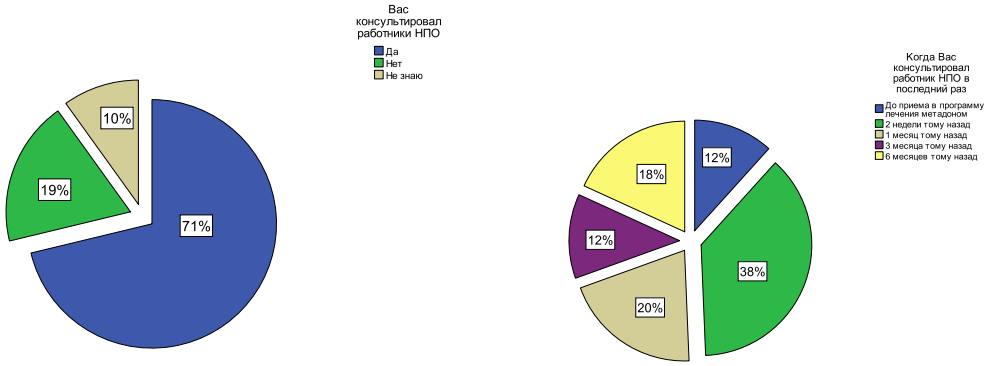
Only 35% of OST patients indicated that they needed a consultation of the psychologist, 50% indicated that they did not need, and 15% were unsure about the consultation. From those, who needed, 74.4% received a consultation of a psychologist, but also 65% from those, who considered they did not need, nevertheless, received a consultation (Chart 36).

Chart 36 “did you needed the consultation of psychologist?”



71% of patients received a consultation from a NGO worker. 58% from those, who received it, were consulted during the last month (Chart 37)

Chart 37 “Have you received consultation from a NGO worker?”



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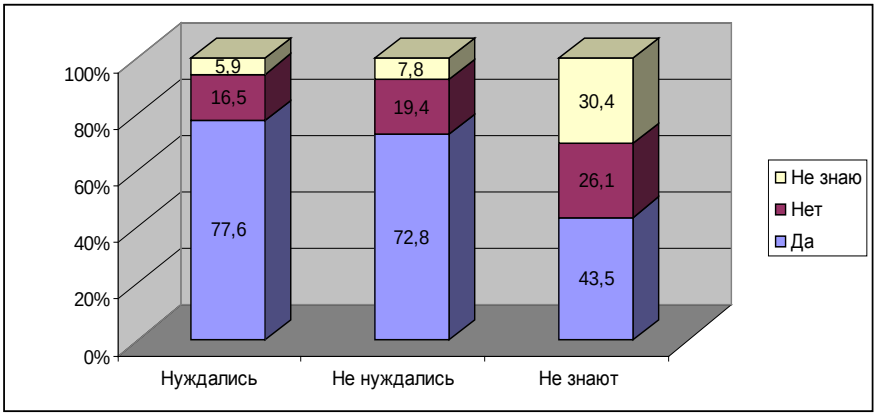
77.6% from those, who wanted a consultation from a NGO worker, received it, while 72.8% who did not need, also received it (Chart 38). Respondents indicated different reasons why they wanted to contact NGO workers: *“communication”, “financial problems”, “personal problems”, “they could understand my situation”, “interesting”, because of legal problems”, “for the self-help”, “I was interested in their opinion”, “I feel there like in my family”, “I want that they could help me to find a rehabilitation centre”*, etc.

Chart 37 “Did you need a consultation from an NGO worker?“



61.8% of OST patients indicated that they had to pay for the daily transport to OST site, 13.7% indicated that they had to pay for additional medicines. 1.4% indicated that they paid or made presents to the staff of OST.

In summary, patients had a positive attitude to OST as a treatment. Most of patients were positive about the staff and the work they were doing. Great proportion of patients received consultation of the narcologist, physician internist, were tested on HIV, TB and STI. Nevertheless, in about 1/3 cases staff’s and patient understood differently goals and objectives of treatment. There was not enough staff-patient communication and efforts to formulate “therapeutic alliance” between the staff and the patient. This alliance is important for treatment of all chronic diseases, including dependence. Patients received consultations, they considered as unnecessary, e.g. from physician internist or psychologist. Operation hours of OST sites and their geographical location were not always acceptable for patients. The data showed the potential at OST sites to increase the quality by individualized treatment planning and matching treatment to patient needs. One of the outcomes would be the more efficient use of human and financial resources at OST sites.

Provision of services at OST sites in the community (qualitative study)

Current OST was provided according the written orders Nr 29 and Nr 30 of the Ministry of Health July 18, 2007. By 2012 OST was provided in Republican Narcological Centre in Chisinau (two locations) and Balti Municipal Hospital. At the moment of the visit to RND in Chisinau there were 201 patients. By November 20, 2012 cumulatively there were 1047 patients since 2004 (128 women), 556 in RND, 200 in Balti and 291 in Penitentiary Institutions[9].

Clinical Guidelines. Administration of RND and physicians indicated that they organized their work related to OST according the National Clinical Protocol for opioid dependence treatment, which was available since 2008[10] and printed in 2011.

National Clinical Protocol for opioid dependence was not entirely in line with the WHO *"Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, 2009"*[11]. The latter guidelines, which were developed through rigorous assessment of the scientific data and expert opinion, provided well defined recommendations for OST at the *national health care system level*, *national clinical guidelines* at treatment program and patient levels. Current National Clinical Protocol in Moldova was not entirely in line with WHO Guidelines regarding recommended initial doses of methadone and recommendation to provide medication for home use in case of stable remissions. The important clinical recommendations on effective maintenance doses, duration of treatment, recommendations for treatment of special patient groups (pregnant and breastfeeding women, adolescents, patients with co-morbid disorders and multi-substance use, integration of OST with infectious disease services, including testing and management (HIV, HCV, TB) were not enough elaborated for everyday practical use.

Both at RND and Balti Municipal Hospital the consultant was could not identify any internal *written policy or procedures on OST*, which would describe in detail the process of OST institution, job descriptions of the physician, nurse and other staff, clarifying their boundaries of functions in OST. The consultant was not able to identify neither written "minimal requirements" document for OST from the Ministry of Health or

[9] Presentation of L.Andreyeva at RND November 20, 2012
[10] Tulburarile Mentale si de Comportament Legate de Consumul de Opiacee, Ministry of Health, Chisinau, 2008
[11] Guidelines for psychosocially assisted pharmacological treatment of opioid dependence, WHO, 2009. http://whqlibdoc.who.int/publications/2009/9789241547543_eng.pdf

medical institution, specifying the core specialists for OST, staffing levels, minimum number of specialist consultations per month, type and number of obligatory examinations of OST patients (e.g. for HIV, TB, HCV, STI, routine blood or urine tests, etc.).

Services. At RND physicians were in charge for management of patients. There were no internal standards of the case load for physician-narcologist[12]. One physician at RND had a case load of 130 patients, the other 71 (the total number of patients was 201). Narcologists did not have other staff to assist them with the management and monitoring of patients, referrals and medical records. The official hours of methadone dispensing in RND main location were from 8 till 11 on workdays, though as indicated by nurses FG methadone was dispensed till 14.00.

In Balti Municipal Hospital 2 physicians shared a case load of around 70 patients. Working hours in Balti were from 8 till 11.00. Physicians had much of other routine work to do besides OST. OST so far was considered as an "extra workload" on the GF project basis for the additional fee to their "main" and "regular" duties. Nurses' main function was to dispense methadone and to keep accountability for methadone.

In Balti the hours of methadone dispensing from 8 till 11 were considered too short by participants of FG discussion.[13] It interfered with patients' work and was too early as some patients had to travel every day 20-30 km from nearby places. In Balti the office space was very small. During time, allocated for methadone dispensing, police used to bring arrested persons for medical examinations and urine screening for drug use. In FG discussions, patients indicated that policemen interrogated methadone patients waiting for their medications, searched patients for drug possession. Patients did not feel safe at OST in Balti and their confidentiality was at risk. Patients indicated police interference in FG discussion as deterring factor for some IDUs to enter the OST or encouraging stop OST[14].

At both sites physicians indicated that there was no support on the site from other staff for continuous assessment of medical, social and psychological condition of the patient, developing treatment plans and also implementation of treatment plan. Services for NGO were in different place and there was little coordination.

[12] Meeting at RND 2012 11 20
[13] FG discussion with OST patients in Balti (October 31, 2012)
[14] FG discussion with OST patients in Balti (October 31, 2012)

Quality of services of the OST. The consultant was could not identify the internal institutional system of quality control. As indicated above, institutions' *internal written policy or procedures on OST minimal requirements* were absent. From the data available, it seemed that entering into OST was comparatively easy. Patient had to be diagnosed as opioid dependent and included at the national registry of drug dependent patients. He also signed an informed agreement on entering to OST and he/she could get methadone the same day. However some data of the qualitative analysis indicated that due to high workload, patients could get not enough detailed information from physicians about the spectrum of services, including OST as a treatment, with its benefits and limitations. Cases when wrong patients (not actively opioid dependent) were included in OST were also indicated in FG discussions[15].

FG discussions of current OST patients generally appreciated medical staff work, their professional and positive approach towards patients. Nevertheless, the average dose at RND in Chisinau was 49.3 mg in 2010, 52.3 mg in 2011 and 57.8 mg in 2012[16]. The average dose of methadone was below 60 mg which was recommended by WHO as an average minimal dose and also as OST quality measure by WHO/UNODC/UNAIDS Guide (2009)[17]. 40% of OST patients in RND received 40 mg or less daily methadone dose[18]. Various FG discussions indicated that one of the reasons was many patients' willingness to reduce doses and leave the OST as soon as possible. Patients who wanted to be less attached to treatment institution had no other choice than to reduce their dose and interrupt OST. Many of patients resumed OST after some time. Thus the turn-over of patients in OST was high.

FG group discussions of "difficult" OST patients[19] indicated that there was different approach of methadone dosing at different sites. At RND main location patients indicated that it was easy to increase the methadone dose by 10 mg after the talk with a physician. At Grenobl st. OST site it was more complicated and needed more efforts from the side of patients. At Balti, patients were allowed to choose the dose themselves and usually physicians agreed. As participants indicated, there was hardly acceptable practice to ask for 10-15 mg increase for one day, if this patient planned to skip the next day and to "survive" without methadone that day.

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[15] Transcript of the Focus group discussion of former OST patients
[16] Presentation "Evolution of OST in Moldova: Problems and Achievements", November 20, 2012 by L. Andreyeva
[17] WHO/UNODC/UNAIDS. 2009. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Accessed 11 December 2009 at: http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf
[18] Personal communication by L. Andreyeva
[19] FG discussion with "difficult" OST patients, October 31, 2012

Patients in the same FG discussion were also critical that local narcologists, who were physically present in different locations, could not dispense methadone. Thus they had to travel 20-30 km every day to Balti.

The same group indicated that 40% of OST patients used other psychoactive drugs. The reasons were: *"I use other drugs because I do not wish to increase methadone dose" or "….because I could not sleep"* , etc.

As indicated by the physician, urine screens were not always available due financial reasons in RND for the last 2 years.

Attitude of medical staff towards OST. FG discussion of nurses indicated that they understood the seriousness of opioid dependence as a disease. They considered generally OST as effective. Generally they observed that most of patients significantly improved after 1 month in treatment[20]. Nurses indicated that patients after 1 month improved in their clothing, their behavior was more positive. They admitted as one of the problems the concomitant use of other psychoactive substances. They judged about it from the appearance of patients and also performed urine screens. Some nurses indicated that concomitant use could reach up to 70% of all patients, but it did not happen on the regular basis. The major reasons for concomitant drug use, as they indicated, were: joblessness, environment (former friends, drug users, who were not in treatment), some wanted to feel "high" from time to time and methadone did not them allow to feel "high". Most often were used diphenilhydramine (Dimedrol), diazepam and clonazepam (sedatives). The concomitant use was identified as the main negative factor of OST. As possible solutions of this problem nurses named positive and negative reinforcement of behaviour, "human factor", and social support.

Nurses indicated that only "few", "3-4%" stopped heroin use successfully through methadone detoxification. Nevertheless, they believed that OST prevented HIV and HCV infections, tissue infections, phlebitis, gangrenes, helped to integrate into the society. They indicated that nurses needed much of patience: some patients could use from time to time obscene language and were aggressive.

Some of the nurses in FG discussions indicated that they did not notice any side-effects of methadone. Others were not so sure and thought they have read information on the negative impact of methadone on the liver. Similar interviews with OST physicians

[20] FG discussion of nurses

indicated the understanding of the seriousness of the disease, extensive medical, psychosocial needs patients had, and limited resources[21].

While some of the staff had an attitude to dependence as a long-term treatment of chronic disease, other part of staff was more abstinence-oriented. Some of the staff as means for improvement of quality of program suggested to implement more discipline for patients and to discharge patients for not following medical advice and concomitant use of psychoactive drugs[22]

FG groups discussions with former and current OST patients indicated that quite often negative information on OST was transferred from other physicians, and even from narcologists, who were not engaged in OST[23]. FG discussion mentioned communication from the narcologist: *"methadone up to 25-30 mg was a medication. In higher dose than that, it was still a medication, but with some toxicity*"[24].

In FG discussion of "difficult" OST patients one participant stated, what he heard from a narcologist: *"We have methadone. If you want – you are welcome. But my professional opinion is that it is not worth trying it for you, because it is the most horrible thing*"[25]. In the same FG discussion it was clear that patients do not know why in some cases higher methadone dosing (100-150 mg) was needed. Clearly medical staff did not provide enough information on the advantages of higher dosing.

Attitude of current patients to OST. FG discussion of patients indicated that they had generally positive look at OST. Some of them stayed in OST for 5-7 years. They could identify main advantages of OST: improved health, reduction of criminal activities, increased overall stability, possibility to work, clear thinking[26]. One of the main problems was regulations, which did not allow ever, even for a stabilized patient, to receive methadone to use at home. This considerably interfered with normal patient life activities, such as work and leisure. The necessity to travel everyday was also mentioned as an important factor, which increased time loss and expenses. Nevertheless, some participants realistically assessed their dependence as a chronic disease and the need for a long term treatment with methadone. Some of them didn't dream any more about *"ending OST and emigrating to Germany or Canada in the nearest future"* as many

[21] In-depth interview with physician at RND
[22] In-depth interview with a psychologist (November 8, 2012)
[23] FG discussion of OST patients, November 6, 2012
[24] FG discussion of OST patients, November 6, 2012
[25] FG discussion with "difficult" patients October 31, 2012
[26] FG discussion with OST patients November 6, 2012.

patients in OST did. Some of participants indicated that psychosocial support was an essential component to OST and introduction of the "system of privileges" in return for positive behavior changes was important. This support was available at NGOs, but geographically it was in a remote place. Many OST patients were "lost" on the way to the NGOs. The concomitant psychoactive substance use OST patient attributed to previous behavior patterns, which were difficult to change for many patients. Most of OST patients in the focus groups would recommend OST to their friends.

Attitudes to OST of IDUs, who were eligible to OST, but did not enter treatment. In the focus group discussion[27] the main reasons for **not entering OST** were the following:

- OST was method of control of IDUs. Police can easily find any IDU in treatment programs *("they can keep under control everything");*
- OST was harmful for health *("after 3 years a person gets rotten from inside – on the full scale"), ("methadone is a dope, which free of charge"); "methadone has been specially designed by governments to annihilate drug users");*
- *"Methadone with the pressure from physicians was provided in high doses (100, 200 mg) instead of gradual reduction of methadone doses"*;
- "*OST is a trap to catch a drug user in difficult situation*";
- "*The rest of the world has refused to use methadone*"

One prevailing and harmful myth discovered was that gradual reduction of methadone dose with concomitant increased use of other psychoactive substances (sedatives) was an effective way to detoxify from street opioids. As there was almost no positive perception of OST among active IDU, they preferred continuation of injecting drug use, "detoxification-relapse" cycle instead of continuous treatment and social rehabilitation.

Coordination of with other medical services. There were no legal documents or written mutual agreements between medical institutions in Chisinau and Balti on how to continue OST for patients, who were hospitalized for TB, HIV infection, other somatic and mental illnesses. It was done on "case by case" basis. Medical staff was responsible for methadone consumed by patient who was hospitalized. Medical staff (physicians, nurses) transported methadone in many different ways, often taking methadone at home and delivering methadone next day to patients at hospital. There were no legal regulations allowing the possibility to leave several day doses of methadone at hospital to be dispensed there by responsible staff. The consultant could not identify any written

[27] FG discussion with IDU, who were eligible for OST but did not enter treatment

agreements on how HIV, TB and HCV should be controlled (screened, diagnosed and treated) for OST patients.

Coordination of OST with police. In case OST patient was arrested and put into police custody, upon notification either police brought a patient to OST site or medical staff brought methadone for supervised consumption by patient in the custody. There were no regulations, describing the procedure neither from the side of Ministry of Interior, neither from the Ministry of Health or medical institutions[28]. Though from the side of police representatives the continuation of OST in the custody was not considered as problematic, there were signs that not always continuation was smooth.

FG discussions with former patients[29] in Balti indicated that police officers interfered with treatment procedures. Patients waiting for their medications, or even in inside the physician's office, sometimes were interrogated and searched for drug possession in the hospital with the consent of physicians. The confidentiality of patients was severely compromised. Police officers had a general positive attitude towards OST as a factor, which reduced crime. At the same time they were disturbed that some OST patients continued to use other psychoactive drugs (e.g. sedatives). They felt as their obligation to continue to suppress any illegal use while patients were in treatment[30].

Coordination of care with NGOs. All patients in RND and Balti Municipal Hospital were informed in the written form by OST physicians about the psychosocial support provided by the NGO "New life" in Chisinau and "Youth for the Right to Live" in Balti. Outreach workers from NGOs regularly came to the premises of RND and Balti Municipal Hospital to make contacts with OST patients and other IDU and to invite them to their services.

There were no written protocols or agreements on how the cooperation was ensured in coordinating care for OST patients. It was not clear how data about OST patients was shared among medical institutions and NGOs. OST in medical institutions and psychosocial support in NGO for a patient happened in parallel, uncoordinated. Thus the multi-disciplinary approached was not properly ensured.

Coordination of care with penitentiary institutions*.* OST patients, released from penitentiary institutions, could continue OST in Chisinau and Balti upon a telephone call from a PI staff and by forwarding the approved document from a PI. If OST patient in

[28] Meeting at the Ministry of Interior Affairs November 21, 2012
[29] FG discussion with former patients November 7, 2012.
[30] Meeting with police officers at Balti city police headquarters, November 22, 2012.

penitentiary had to be released to the area where no OST was available, patients used to terminate OST in penitentiary institution and left penitentiary with great risk of the relapse and opioid overdose. Cases of lethal overdoses of heroin among patients who left OST and prison were reported by PI medical staff. Unfortunately most of narcologist in local areas, where OST was not available had negative attitudes on OST, which they communicated to patients/inmates.[31]

[31] In-depth interview with a medical specialist from Penitentiary Department

Provision of psychosocial services for OST patients

Under the project of the Global Fund from 2010 2 NGO regional centers in Chisinau and Balti provided psychosocial assistance to OST patients. In Chisinau psychosocial assistance for OST patients was provided by the NGO "New Life". This NGO was established around 2000 as mutual self help group of drug users. They registered as NGO in 2004. Most of their activities continued to be based on self-help own experience. Besides community based premises in Chisinau, the "New Life" had a 9 month residential psychosocial treatment program at rehabilitation house in the countryside for 20 drug users.

The "Youth for the Right to Live" has been operating since 1997 in Balti and provided services for vulnerable populations. They had a long-time experience of harm reduction interventions, professional counseling, etc.

Target groups for services. Both NGO were assigned by PAS to provide psychosocial assistance to OST patients. OST patients were contacted by NGO outreach workers near OST sites. As there was no office space provided for NGO workers in medical institutions, NGO outreach workers made a contact with OST patients in the yard or corridors of medical institutions. Through this outreach work OST patients were invited to visit NGO community centers and talk to a specialist or outreach worker. During the consultation, specialists (social worker) or outreach workers at the NGO assessed the psychosocial and medical needs of the client. In the NGO "Youth of the right to Live" a social worker took the responsibility of *case management* of the client. Written social support plan, priority objectives for 3 months usually was negotiated and agreed between the social worker and a client. This social support plan was signed both by the client and the specialist. The social assistance plan was implemented with the support of the outreach workers under the supervision and coordination of the social worker. The implementation of the social assistance plan was monitored every 3 months. Social assistance plans could include also different medical services, including screening for TB and HIV. Often patients were accompanied by outreach workers to different institutions to facilitate the implementation of the plan. With some medical institutions "green corridors" were negotiated in advance, as some drug users were impatient to wait in cues. In addition, different educative and self-help 12 step groups were organized for the OST patients according their needs.

The NGO 'New Life" implemented some elements of case management as well. Clients were not assigned a permanent case manager. Written social assistance plans were not

discussed and agreed with the client. Priorities were usually determined by the NGO staff. In general, in "New Life" the procedures and services tended to be less professional, less documented. The organization employed less professional workers (a social assistant and a psychologist).

On their premises besides services to OST patients, the "New life" provided different educational group activities for different client groups, e.g. women, family members of dependent clients, active IDU, etc. Some leisure activities were available – internet, table tennis, etc. Due to the history of formation of the NGO, the "New Life" had a strong component of self-help philosophy and activities, which were based on 12 steps of Narcotics Anonymous. Much of the work with active IDU was understood as the implementation of the 12th step, which means activities in the support of active drug users in achieving their abstinence from drugs. In this case continues methadone use could be also conceived as an obstacle for achieving drug-free life.

Attitudes to OST by NGO staff and volunteers. A social worker[32] in Balti admitted that individual effectiveness of OST depended to some extent on what patient expected from treatment. Generally it reduced the dependence from illegal drugs. Among the main advantages of the OST a social worker identified the possibility to avoid criminal behavior and the opportunity to talk about painful problems of the patient. About 55 patients out of 70 were receiving some kind of social assistance.

An outreach worker[33] indicated the OST as a generally effective approach. Though, OST in its reality in Moldova was not of high quality. He stated that physicians and other specialists should spend more time in explaining to a patient what were the goal and principles OST, its positive and negative aspects before actual start of treatment. Without that, new OST patients were exposed to negative influence of "subculture" around OST site, where patterns of concomitant drug use prevailed. There were different patients in OST, and there should be comprehensive psychosocial support to level off the negative influence of this "subculture". There should be individualized approach and positive behavior changes should be encouraged, e.g. with provision of methadone for home use and possibility to travel. Director of the NGO indicated[34] that first 1-2 months for patients in OST were critical. He believed, that if during that period a patient did not start his social reintegration, then he started to use other psychoactive drugs and became difficult to rehabilitate.

[32] In-depth interview with a social worker November 5, 2012
[33] In-depth interview with an NGO oureach worker November 8, 2012
[34] In-depth interview with the director of the NGO

There were 22 OST patients in Chisinau, who finished OST and became drug-free[35]. Some of them finished rehabilitation program run by NGO "New Life". FG discussion with former OST patients[36] indicated very mixed, even opposite attitudes and understanding of OST and methadone. Some GF discussion participants were convinced that OST brought a person to feel normal and blocked heroin effects. Others strongly stated that it provided euphoria. Some former patients stated that this was a treatment, others that it was a *"replacement of heroin with synthetic narcotic"*, which slowed-down patient's thinking/activity and they became like *"vegetables".* One participant said: *"Most such persons (methadone patients) become vegetables"*, mostly because they lost previous a goal of drug-seeking behavior and could not find other meaningful activities. Also there was concomitant psychoactive substance sue. Some participants indicated that it was very difficult to leave OST. Others indicated that it was easy. Some former patients considered OST as a break from drug use, which allowed think and undertake important decisions regarding continuation of rehabilitation. While others categorically maintained that entering OST was a *"worst option"* and it was as *"a bottom*" for any drug user. Some former patients expressed their attitude that OST was a *"100% service*", while other said that it was a *"complete mess".*

Former OST patients were critical about OST because of the lack of psychosocial support. *"A person drinks (methadone) and with this everything is ended. He/she is left alone". "There should be a comprehensive support. Specialists have to work with a person"* one of the participants said advocating for more psychosocial support in OST services.

FG group discussion and personal interviews suggested that some former drug users in "New Life" had strong belief that drug-free treatment, including 12 step approach, was superior to other types of treatment. This bias and negative attitudes, *stigmatization* could significantly interfere in provision social care for some difficult patients in OST, where significant social and personal problems and concomitant psychoactive drug use came together.

Cooperation with OST sites. There were no formal framework for the cooperation between RND and the "New Life" in Chisinau. From the transcripts of FG discussion there was evidence that there existed a mistrust and even controversy between the staffs of RND and the "New Life"[37]. The cooperation between OST site in Balti and

[35] Meeting with Lilia Fiodorova at RND, November 20, 2012
[36] FG discussion of former OST patients
[37] Interview with medical staff in Chisinau

“Youth for the Right to Live” were also not formally coordinated and the activities took place in parallel. Though due to the longtime cooperation, one of OST physicians visited NGO regularly.

Cooperation with other institutions and agencies. The “New life” and “Youth for the right to Live” provided through their outreach workers and volunteers the service of accompanying clients to different institutions, e.g. night shelters, hospitals, social departments, etc. NGO were primary organizations which referred to HIV testing and TB screening as well as the organization of ART. Definitely, social support and referrals to infectious disease medical institutions filled the gap of the necessity to meet psychosocial and other medical needs of great number of patients in OST and increased the quality of OST. At the same time medical and psychosocial services remain uncoordinated.

Provision of OST in penitentiary institutions

There were 7 PI in Moldova, which provided OST, including 2 remand prisons in Chisinau and Balti. In-depth interviews with Penitentiary Department of Ministry of Justice and medical staff were positive about OST developments in PI. They indicated that patients were *"calm, contained, they could participate in educational programs, they wanted to work"*[38].

OST on individual basis was initiated in PI by physicians of PI Medical Service , who usually were not narcologists. Narcologists from civil sector were contracted and were available for consultation. OST, if needed, could be started in one day. Dose adjustments were made on the decision of the physician of the Medical Service of PI[39]. The low number of inmates, who received OST was explained that informal hierarchical system of inmates did not allow for "higher rank" inmates to receive OST[40]. This was considered by top informal hierarchical figures as the "weakness". OST through reduction of the demand for heroin could be regarded as potential threat for inmates, involved in drug dealing. There was a problem to transfer inmates, who received methadone and were infected with TB, to TB treatment. The PI, which specialized in TB treatment, did not have OST. Therefore, such patients had to be detoxified from methadone before transfer to TB treatment.

FG discussions indicated that patients usually had no problems of getting into OST in prisons[41].

PI provided opportunity for the "New Life" workers (ex drug users and ex-prisoners) to have meetings with inmates inside PI 3-4 times per month. Medical staff was concerned about these meetings, because there were signs that negative attitudes towards OST were communicated to inmates. Some patients eventually decided to stop OST after these meetings. There was request from the medical staff of penitentiary department that NGO should provide more professional services. There should be more coordination between medical and psychosocial services.[42] Otherwise, in PI OST patients were regarded as other inmates and were dispersed into different regimens. They could benefit from regular psychosocial support available in PI. In case of transfer from one PI to another, continuation of methadone coordinated.

[38] In-depth interview with medical staff from Penitentiary Department
[39] Meeting with Medical Service staff in PI
[40] In-depth interview with medical staff from PI
[41] FG discussion with "difficult" OST patients
[42] In-depth interview with medical staff from PI

Penitentiary Department indicated that narcologists, who worked in civil sector under the Ministry of Health (district level narcologists), had incorrect knowledge on OST, which they transferred to inmates[43]. Thus drug users were often confused about different and opposite messages regarding the value of OST, including often discouragement of IDU to enter OST.

Continuity of OST in civil sector was viewed as an important component, as there were lethal overdoses known of patients leaving PI to places where OST was not available[44]. OST for continuation was not available at 25 districts and were available only in Chisinau and Balti.

OST and the police

Interview with the representatives of Ministry of Justice[45] indicated that different sectors of the police were not enough informed about the drug dependence treatment options in the Republic of Moldova. Current cooperation with health care institutions was limited to preventive activities. Different units of the police showed interest in learning more about drug treatment modalities in the country and were open for possible cooperation. The interest of the police was expressed in wider access of IDU and better quality of treatment. This potentially could reduce the number of criminal offences and reduce the illegal drug market for drug dealers, as well to reduce of number of incarcerated drug users.

[43] In-depth interview with medical staff of the Department of PI
[44] Meeting with Medical Service at PI
[45] Meeting with the Ministry of Interior Affairs, November 21, 2012

Evidence of Economic Effectiveness OST in Moldova (Dr. L. Murauskiene)

The objective of the assessment of economic effectiveness was to conduct cost-effectiveness analysis of OST in Moldova and develop arguments for scale-up and quality increase as well as to address future cost implications of OST on national budget.

Overview of main approaches

Economic evaluation focuses on comparing *costs* (monetary expression of employed resources) and *outcomes* of the intervention by assessing at least 2 alternative ways of the use of scarce resources.

There are two main classes of economic analysis in healthcare:

1.Cost-utility analysis (CUA) and cost-effectiveness analysis (CEA), where outcomes are presented in natural/composite units (e.g., "cases prevented", "number of lives saved", „number of Disability-adjusted Life Years lost (DALY) prevented or „Quality-adjusted Life Years (QALY) gained“).

2.Cost-benefit analysis (CBA), where outcomes are presented in monetary terms.

CEA uses a particular outcome measure, so its value is limited by a single outcome. Cost-benefit Analysis (CBA), based on monetary expression of both costs and outcomes (benefits), overcomes such limitation. However CBA is faced to serious challenges in attempts to monetarize the outcomes.

Cost minimization (while future costs saving due to the intervention) or cost-outcome (while single intervention without any options is considered) are partial economic evaluations.

International research literature

Scientific evidence-based, methadone OST has proved to be cost-effective in reducing heroin and other illicit drugs use, as well as minimizing involvement in criminal activity and imprisonment rate, preventing HIV infection, improving health related quality of life. However, the range of studies and the client groups are of crucial importance in terms of particular economic evaluations.

Primary economic benefits occur from reduced crime and post-treatment reduction in healthcare costs. Residential prison treatment is cost-effective but only in conjunction with post-release aftercare services[46]. In community with high HIV prevalence, expanded methadone capacity yields in additional 1 year of QALY at a cost of $8,200[47]. It should be noted that in general, $500 hundred or £300 hundred is an acceptable "price" for additional one QALY acquired due to the intervention.

There are several studies which have demonstrated the benefit-cost ratio of methadone maintenance therapy in the range 2:1 to 5:1; and even 15:1. Net benefits were mainly savings from reduced criminal activity versus treatment costs. Net benefits increased with length of stay in MMT[48]. For every extra £1 spent on methadone treatment there was a return of more than £3 in terms of cost savings associated with victim costs of crime and reduced demands upon the criminal justice system[49]. Improved employment related benefits were also regarded as one of the major benefits, and together with those for crime averting comprised about 55-80% of the total benefits.

Methods and sources of information

For economic evaluation purposes desk research and field visit had been conducted in November 2012 followed up with modeling costs and benefits of OST in Moldova.

In absence of particular studies on OST performance in Moldova, an assessment was rough and partially based on the findings of other studies available in the field.

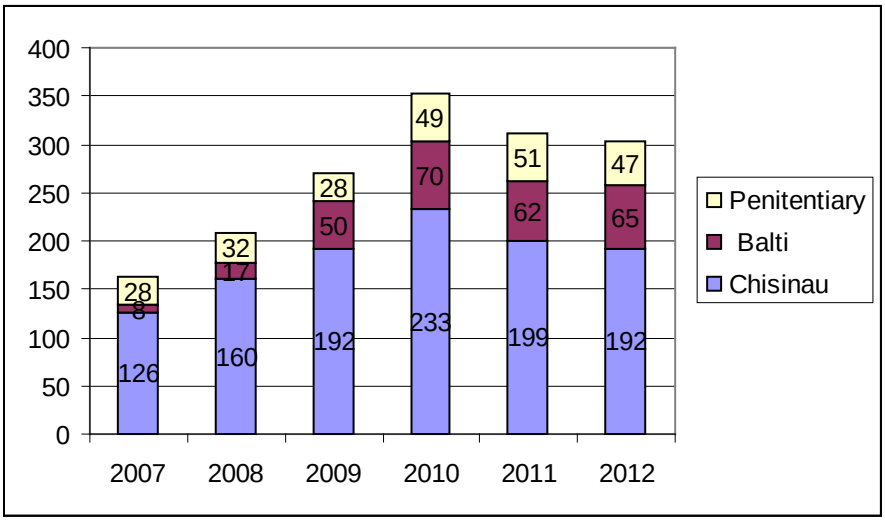
Costs of OST

Costs of OST from the donor and public funds were analysed. Private (patients and family member) costs were not included[50].

A number of constant clients in OST in 2012 was 304, a number of all clients was 880 (at the end of 2011). OST was provided in one setting in Balti, 2 sites in Chisinau and in 7 prisons subordinated to Department of Penitentiary Institutions (Chart 38).

[46] Economic Benefits of Drug Treatment: A critical review of the evidences for policy makers. Treatment Research Institute at the University of Pennsylvania.2005.
[47] Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment: A Literature Review. National Evaluation Data Services. 2002.
[48] B. Fischer, J. Rehm, K. Kalousek. Illicit Opioid Use and Economic Costs, and Options for Costs Reduction: An Overview and Estimations. Vancouver, 2006.
[49] Annete Verster, Ernst Buning. Methdadone Guidlenes.
[50] Regarding patient costs, at least transportation costs could be identified for the client living in the cities (according to the patients'survey data 62% of the patients pay for transportation).

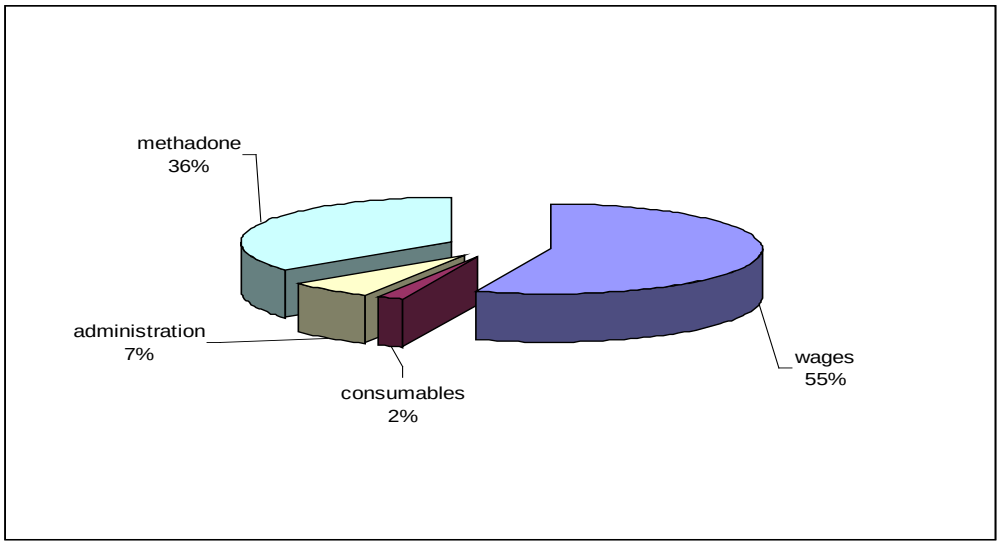
Chart 38 Number of constant clients at three groups of sites 2007-2012 (source: PAS)



OST was financed directly from the donor (Global Fund - GFATM), but some local resources of medical institutions were also employed. Under the current arrangements, the GFATM paid bonuses to wages for directly involved staff and covered some current costs in 3 types of settings. Some pieces of equipment (capital investments) had been also purchased from the GFATM means. Other financing was coming from the medical institution budget. However, current organisation and accounting system did not allow assess allocated resources to OST properly.

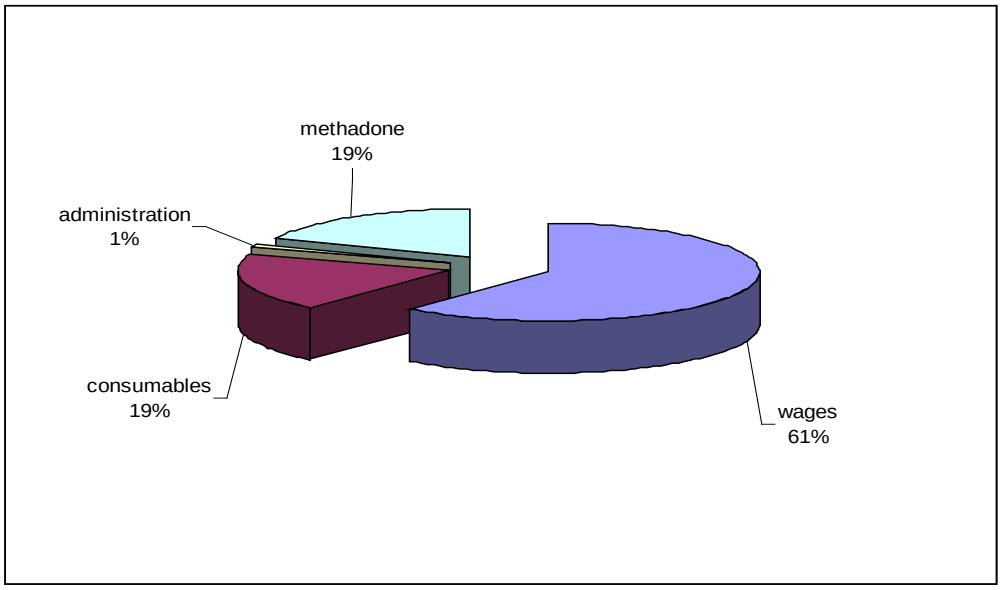
A. *"Minimum" costs or negotiated price.* In this case current donor financing was considered as a price negotiated and agreed with medical institutions for implementing OST. 2012 annual costs were $93,035. The costs covered wages to directly employed staff, costs of consumables and those for administrative purposes as well as the costs of methadone. ***Cost per year per patient was $106.***

Chart 39 Externally covered costs of OST in 2012



B. Medical institution & donor funding. According to the data, collected during interviews with medical staff, medical institutions costs covered mostly wages of the staff and additional spending on phone, some consumables and tests.

Chart 40 Total costs of OST in 2012



In 2012 costs per patient per year were $173 of which $67 had been covered by medical institutions.

C. *Increased quality of OST costs.* Better quality of OST (and consequently increasing involvement of patients into the program) could be reached through:

- Changing (improving) skills and increasing staffing;
- Improving availability of consumables (e.g. drug tests);
- Assuring continuous personnel training and upgrading of equipment.

Such arrangements will results in:
1) increased labor costs (Table 1) varying between maximum workload as identified for the 1st hundred of the clients, and minimal workload due to economy of scale for serving 500 clients. Relatively, labor costs were in range of $118-195 per patient annually;
2) increasing costs of consumables - $12 annually (it was assumed that drug tests should be available at least 3 times per year on the costs of 48MDL and other supplies of 100MDL per year) and small increase of administrative costs comparing to current level for covering lacking costs for communication.
3) inclusion of capital costs for premises and equipment - $6,400[51] and maintenance costs for both current and new sites ($800 annually during the first 5 years and $1,120 annually later on);
4) inclusion of the costs for training and information – $400 per year.

Table 1 Incremental staffing FTE/ patients

	Incremental staffing FTE/ patients							
	The 1st hundred	The 2nd hundred	The third hundred	The forth hundred	The fifth hundred	Total for 500 clients	Monthly wage/FTE, MDL	Monthly wage, MDL
Physician	1	0,5	0,5	0,5	0,5	3	3660	10980
Nurse	1,5	0,5		1		3	2660	7980
Guard	0,5	0,5		0,5		1,5	2000	3000
Social worker	3	2	3	2	2	12	2660	31920
Internist	0,5		0,5			1	3660	3660
Psychologist	0,5		0,5			1	3660	3660

Incremental OST costs **per every new patient will be $189-286 per year.** It should be also noted that a share of increasing costs could be allocated to NGOs.

[51] Extension of the services outside current OST settings involve capital costs for the premises adjustment (or rent) and equipment (e.g. dispenser, safe, PC, etc.) & furniture purchasing. The costs could vary a lot, minimum possible estimation – 20,000 MDL. Costs of 4 new sites are included.

Benefits of expanding the OST

1. ***The most obvious benefits are savings due to reduced use of illicit drugs*.**

The qualitative assessment of 41 patients in Balti city demonstrated reduction in use of illicit drugs (65.8%) and reduction of criminal activities (78%),

During interviews, it was assessed that daily dose price for „shirka"(home-made poppy straw extract) was 110 MDL, common heroin – 1000-2000 MDL. Crime expenses should be bigger than the price of the daily dose.

By assuming the average expenses of heroin use by 1000 MDL/day, the reducing crime expenses by 10% among „constant" OST patients (304) would reach $876,000 annually.

Cost-benefits ratio even for the current OST program is very high (about 0.17).

2. ***Reduction of HIV transmission and related increase of QALYs gained*.**

Due to the lack of studies on the effectiveness of OST in Moldova, CEA modeling was based on findings of the study conducted in Ukraine (2011). Based on assumptions of 85% decrease in injection equipment sharing and higher likelihood of receiving ART (25 % instead of 2% access among IDUs not receiving OST), in 20 years OST for 25% IDU was recognized as the most cost-effective option as such expansion could avert 4700 HIV infections and add 76000 QALYs[52].

Keeping all assumptions the same (comparison of the situations (Table 2), it meant that expanding of Moldavian OST up to 25% of IDUs will avert 380 HIV infections and gain 6151 QALY.

[52] Effectiveness and cost effectiveness of expanding harm reduction and antiretroviral therapy in a mixed HIV epidemic: a modeling anglysis for Ukraine. Alistar SS, Owens DK, Brandeau ML, PLos Med. 2011 Mar; 8(3):e1000423.

Table 2 Comparison of situation in Ukraine and Moldova

	Ukraine	Moldova
Estimated number of IDUs	In 2007– 390 000	In 2012 31 562 21061 (Right Bank) + 10501 (Left Bank)[53]
HIV	43% prevalence in IDUs IDUs accounted for 84% of all new HIV cases	HIV cases in 2012: 15437[54] 20% prevalence in IDUs
Status quo projection	During 20 years + 33 700 new HIV infections with 18000 in IDUs, 15700 in non-IDUs; 1685 HIV injections annually	In 2015 - 18 805 HIV infections (during 2012-2015 +3368 HIV infections); 1122 HIV infections annually
Coverage by OST	minor	2011 - 880 clients
OST 6 months retention rate	75%	56%

Having in mind that during 20 years the incremental costs of OST program (expanded to 4000 clients during 4 years) will amount to $10,542,000-16,049,000 (discounted with 3% discount rate similarly to the benefits discounted in the abovementioned study). **It implied costs of $1714-2690 per QALY gained**.

Conclusions

Currently, external funding was the major source for OST in Moldova. Improvement of the quality of OST program will require increase in financing (from public sources increase from 67 to $189-286 per client annually). However, OST was highly beneficial in monetary terms (due to crimes averted CBA ratio 1:6) and expanded OST could demonstrate many QALY gained on relatively low costs ($1714-2691 per QALY)

[53] Estimating Sizes of Populations of People who Inject Drugs, Sex Workers, and Men who have Sex with Men, Republic of Moldova 2011.

[54] Estimări şi prognoze a epidemiei HIV în Republica Moldova, 2012
Chişinău, 2012

Key findings of the assessment of OST in the Republic of Moldova

The key findings of the assessment during this mission were the following:

1. OST was accessible in 2 cities in the civil sector and 7 penitentiary institutions. The coverage was around 1% of estimated number of IDU. Therefore provision of OST had so far a low overall impact in the prevention of HIV infection in the Republic of Moldova.

2. Quantitative and qualitative research data showed that OST medical services in Chisinau and Balti were appreciated by the patients, as well as the professionalism and personal positive attitudes of medical staff. At the same time physicians had very high work-load of OST patients and other regular duties of narcologist. There was a high risk for informing insufficiently and inadequately of patients about OST at the start and in the course of treatment.

3. The existent OST in the community did not provide coordinated multidisciplinary services. Maintenance of doses of methadone were below recommended minimal average dose of 60 mg. Outpatient detoxification with methadone was often preferred against the long-term therapy, the duration of treatment was often less than 6 months. All these and above mentioned findings indicated that quality of OST was poor.

4. The quantitative and qualitative research data indicated that OST medical staff (both in civil sector and penitentiary) had conflicting attitudes towards dependence and OST treatment. Large proportion of medical staff was not sure about basic goals and principles of OST. Data indicated wide gaps in professional knowledge on treatment issues. As a consequence patients received inconsistent and conflicting messages from OST medical staff, including incorrect negative information. Quantitative study indicated that other medical specialists, not involved in OST (narcologists, family and infectious disease physicians) were the source of incorrect negative information on OST as well.

5. The system of referral of OST patients to other outpatient and inpatient treatments (such as HIV infection, TB) and from HIV and TB treatment to narcological service was not established. Methadone was available in HIV and TB treatment inpatient units, when the staff brought medication every day,

including weekends and holidays, and was provided on “case by case” basis. The separation of functions in referral of OST patients to diagnostic and treatment services between medical institutions and NGOs remained unclear. Recommendations on treatment of opioid dependent patients with HIV and TB were not included in treatment protocols.

6. Continuous psychosocial support provided by NGOs improved the accessibility of the psychosocial and medical care to OST patients according their individual needs. NGOs varied in the degree of professional psychosocial assistance. In Balti the “Youth for the Right to Live” a professional social worker coordinated psychosocial assistance and was organized it on principles of case management and coordinated team work. While in the “New Life” there was a risk that “self-help” and abstinence oriented principles could prevail against the professional social work organization.

7. Quantitative and qualitative study indicated that the NGO staff had conflicting attitudes or gaps in information on OST goals and basic principles. Qualitative research indicated signs of stigmatization at least among some active NGO workers of not fully compliant patients. Therefore, attitudes towards OST appeared to be contradictory to WHO/UNODC/UNAIDS position to OST as an effective public health intervention.

8. The coordination of the treatment (including medical services and psychosocial assistance) did not exist as a system both in Chisinau and Balti. The exchange of information about services and specific patient/client was minimal. Medical institutions and NGOs, as well as medical specialists and psychosocial assistance staff worked in parallel. The gap was even widened by different geographic locations of different services. Therefore, patients could not get maximum benefit from the coordination of full multi-disciplinary approach. Only part of patients of the total number of OST patients received case management. There was a risk that some patients with serious medical, social and psychological problems were unable to reach-out for psychosocial support due to lack of coordination between services and, to some degree, due to stigmatization.

9. The results of the assessment showed that the image of OST was negative among IDU. The main barrier for patients to enter OST was the “attachment” to the treatment site. Methadone was strictly not allowed to be given for home use even for drug users in stable remission, thus preventing patients to have a

perspective of normal life. Another major barrier included misconceptions about OST. Other barriers included the necessity to bare expenses for the everyday travel to OST site and short hours for dispensing of methadone.

10. Police authorities on national and local level were neutral or moderately positive about OST as an intervention which reduced overall drug seeking crimes and withdrew patients from illegal heroin market. There were negligent signs of the diversion of methadone into the “black market”. Police on different levels had very limited knowledge on drug treatment, including OST. OST was allowed to be continued in all police custodies for health care facilities. There were so far no legal acts regulating continuation of OST in police custodies.

11. In penitentiary system in spite of the shortage of medical specialists, professionalism of OST staff has increased. Medical staff initiated OST without the delay, if necessary, and was capable of flexible dosing. Since 2009 OST became available at 2 remand prisons, where OST was continued or initiated for IDU not in treatment. At the same time psychosocial support was limited.

12. Currently, external funding was the major source for OST in Moldova. Improvement of the quality of OST program will require increase in financing (from public sources increase from 67 to $189-286 per client annually). However, OST was highly beneficial in monetary terms (due to crimes averted cost-benefit ratio was 1:6). Expanded OST could demonstrate many QALY gained on relatively low costs ($1714-2691 per QALY)

Recommendations

For the Ministry of Health:

19. To mandate the Republican Narcological Dispensary to develop an action plan aimed at the improvement of access, coverage and quality of OST.

20. To develop cooperation agreements/protocols between narcological, AIDS and TB/infectious disease sectors on coordinated information sharing and treatment of patients who have opioid dependence and concomitant infectious diseases. To develop mutual educative events/trainings on comprehensive treatment of OST and infectious diseases.

21. In order to increase the adherence to OST and increase its quality, to initiate the change of legal acts/protocols in line of WHO recommendations, which would allow doses of opioid medications (methadone) to be used at home for patients in stable remission on the individual basis. Patients should be responsible for the use of their medications according medical recommendations.

22. To update a National Clinical Protocol in accordance with WHO Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009) in cooperation of infectious disease, TB specialists and social workers.

23. To develop technical criteria for minimal requirements for ongoing quality of OST. This should define the necessary staff, medical procedures and equipment for OST as a medical service.

24. To consider expansion of the access to OST in different cities by integrating OST into existing infrastructure of narcological service.

25. To provide systematic educational activities/materials on “the state of art” of opioid dependence treatment among narcologists and physicians of other specialties.

26. To develop further cooperation with Ministry of Interior in implementing not only repressive and preventive drug control measures, but also in referral and better coordination of treatment of drug dependent patients, including the developing and monitoring the take-home medication system for socially stable

patients, promoting information exchange while ensuring the confidentiality of patients. To provide professional educational activities to law enforcement staff on drug treatment at national and local levels.

27. To increase the sustainability of high quality of OST programs by the gradual inclusion of social workers into the staff of narcological treatment sites, which could coordinate multi-disciplinary services for patients with multiple medical and psychosocial needs; to integrate OST into existing services, to develop necessary internal procedures, standards, job description, case load norms for physicians and other specialists.

For the Republican Narcological Dispensary and Balti Municipal Clinical hospital:

28. To review the workload of physicians and nurses in the existing OST sites, in order to optimize their time for provision of care of OST and other narcological services;

29. To allocate office space close to OST sites for counseling of OST patients by NGO designated trained case managers at certain hours; to develop protocols of coordinated multidisciplinary care of OST patients including NGOs and medical professionals.

30. The quality of the OST and its adequateness to the needs of patients and international standards should be regularly monitored, e.g. regular anonymous patient surveys, FG discussions on the satisfaction of patients, working hours of methadone dispensing unit, etc.;

31. To develop “job aids” kits for service providers and educational materials for OST patients and IDU not in treatment by addressing existing prejudices and myths on OST among them; to communicate solid up-to-date scientific information systematically.

32. To design a strategy of provision of scientifically based information of the community, including medical specialists at various levels, law enforcement staff, etc. To continue and increase cooperation with law enforcement agencies not only in preventive activities, but also in implementing drug treatment activities.

For Medical University "N.Testemitanu" Department of Psychiatry

33. To incorporate OST as a regular subject into curricula of psychiatry and narcology for medical students and postgraduate physicians residents in psychiatry-narcology and toxicology. To provide an opportunity for all physician residents in psychiatry and narcology to develop practical skills in diagnosis of opioid dependence, administration of initial and maintenance doses of methadone and organizing the multi-disciplinary care.

For WHO, UNODC, UNAIDS, Soros Foundation Moldova, PAS Centre

34. To increase consistently professional requirements and standards for the NGO staff in provision of psychosocial care to OST clients by encouraging them to employ higher numbers of professional and qualified social workers, training the existent non-professional staff in professional case management of OST patients.

35. To provide relevant training of NGO workers on OST as an evidence based and effective public health intervention in-line with WHO/UNODC/UNAIDS position and clinical recommendations.

36. To facilitate cooperation of the medical institutions and NGOs in exchanging information, organizing joint specialist assessment of patients, multidisciplinary treatment planning and monitoring. To facilitate joint trainings for the teams of specialists on team work and case management.

APPENDIX 1. Treatment Perception Questionnaire

АНКЕТА
ВАШЕ МНЕНИЕ О ПОДДЕРЖИВАЮЩЕМ ЛЕЧЕНИИ МЕТАДОНОМ

Просим Вас ответить, отмечая каждый соответствующий ответ посредством обведения цифры напротив подходящего варианта ответа (2. Ⓝет), на вопросы данной анкеты о поддерживающем лечении метадоном.

Гарантируем полную конфиденциальность Вашего мнения, поскольку с ответами на эту анкету заочно ознакомится только исследовательский персонал.

Искренне благодарим Вас за оказанную нам помощь.

1. Ваш пол?
Мужской
Женский

2. Сколько Вам лет? (напишите число) _____.

3. В программе лечения метадоном участвуете:
Первый раз
Второй раз
Третий раз и более

4. Как долго Вы участвуете в программе лечения метадоном – если участвуете не в первый раз, отметьте продолжительность лечения, в котором участвует сейчас:
До 1 месяца
От 1 до 3 месяцев
От 3 до 6 месяцев
От 6 месяцев до 1 года
Более чем 1 год
От 1 года до 2 лет
Более чем 2 года
Более чем 3 года
Более чем 5 лет
Не помню
ВАШЕ МНЕНИЕ О ЛЕЧЕНИИ
Во время моего лечения…

	Полностью согласен (-на)	Согласен (-на)	Сомневаюсь	Не согласен (-на)	Совсем не согласен (-на)
Работники не всегда понимали, в какой помощи я нуждаюсь:	1	2	3	4	5
Меня хорошо информировали о связанных с моим лечением решениях:	1	2	3	4	5

	Полностью согласен (-на)	Согласен (-на)	Сомневаюсь	Не согласен (-на)	Совсем не согласен (-на)
Мы с работниками по-разному понимаем цели моего лечения	1	2	3	4	5
Всегда была возможность поговорить с кем-то из работников, если у меня возникало такое желание:	1	2	3	4	5
Работники помогли мне почувствовать необходимость разбираться с моими проблемами:	1	2	3	4	5
Мне не понравились все связанные с лечением посещения:	1	2	3	4	5
У меня не было достаточно времени разобраться с моими проблемами:	1	2	3	4	5
Думаю, что персонал работает хорошо:	1	2	3	4	5
Я получил(-ла) необходимую мне помощь:	1	2	3	4	5
Мне не понравились некоторые связанные с лечением правила или указания:	1	2	3	4	5
Рабочее время кабинета лечения метадоном мне подходит:	1	2	3	4	5
Лечение метадоном происходит в удобном для меня месте, несложно добраться до центра:	1	2	3	4	5
Жители соседних домов воспринимают клиентов центра доброжелательно:	1	2	3	4	5

ВО ВРЕМЯ ЛЕЧЕНИЯ МЕТАДОНОМ:

18. Я был тестирован на употребление психотропных веществ:

1. Да ⇒ Если ответили ДА, то когда Вы были тестированы в последний раз:
   1. до приема в программу лечения метадоном
   2. 2 недели тому назад
   3. 1 месяц тому назад
   4. 3 месяца тому назад
   5. 6 месяцев тому назад
   6. 1 год тому назад

2. Нет. Напишите почему_____

3. Не знаю

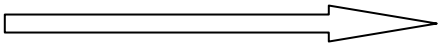
19. Я был тестирован на наличие ВИЧ инфекции:

1. Да ⇒ Если ответили ДА, то когда Вы были тестированы в последний раз:

2. Нет. Напишите почему_____
3. Не знаю

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

20. Я был тестирован на наличие туберкулеза:

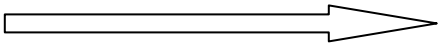
1. Да 

Если ответили ДА, то когда Вы были тестированы в последний раз:

2. Нет. Напишите почему_____
3. Не знаю

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

21. Я был тестирован на наличие передаваемых половым путем заболеваний:

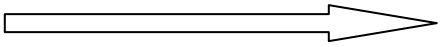
1. Да 

Если ответили ДА, то когда Вы были тестированы в последний раз:

2. Нет. Напишите почему_____
3. Не знаю

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

22. Я сдавал кровь на общее обследование:

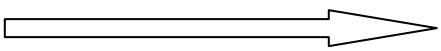
1. Да 

Если ответили ДА, то когда Вы сдавали кровь в последний раз:

2. Нет. Напишите почему_____
3. Не знаю

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

23. Я сдавал мочу на общее обследование:

1. Да 

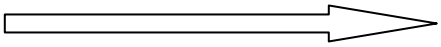
Если ответили ДА, то когда Вы сдавали мочу в последний раз:

2. Нет. Напишите почему_____
3. Не знаю

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад

4. 3 месяца тому назад
5. 6 месяцев тому назад

24. Вас консультировал врач терапевт:

1. Да 

Если ответили ДА, то когда Вас консультировал терапевт в последний раз:

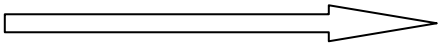
1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

2. Нет. Напишите почему_____
3. Не знаю

25. Нуждались ли вы в консультации терапевта:

1. Да. Напишите почему
_____
2. Нет. Напишите почему
_____
3. Не знаю.

26. Вас консультировал врач нарколог:

1. Да 

Если ответили ДА, то когда Вас консультировал нарколог в последний раз:

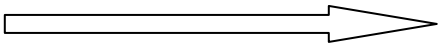
1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

2. Нет. Напишите почему_____
3. Не знаю

27. Нуждались ли вы в консультации нарколога:

❑ Да. Напишите почему
_____
❑ Нет. Напишите почему
_____
❑ Не знаю.

28. Вас консультировали другие врачи специалисты (не наркологи):

1. Да 

Если ответили ДА, то когда Вас консультировал другой врач специалист в последний раз:

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

2. Нет. Напишите почему_____
3. Не знаю

29. Нуждались ли вы в консультации других специалистов (не нарколога):

1. Да. Напишите почему

_____

2. Нет. Напишите почему

_____

3. Не знаю.

30. Вас консультировал психолог:

1. Да

2. Нет. Напишите почему_____

3. Не знаю

Если ответили ДА, то когда Вас консультировал психолог в последний раз:

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

31. Нуждались ли вы в консультации психолога:

1. Да. Напишите почему

_____

2. Нет. Напишите почему

_____

3. Не знаю.

32. Вас консультировал социальный работник:

1. Да

2. Нет. Напишите почему_____

3. Не знаю

Если ответили ДА, то когда Вас консультировал социальный работник в последний раз:

1. до приема в программу лечения метадоном
2. 2 недели тому назад
3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

33. Нуждались ли вы в консультации социального работника:

1. Да. Напишите почему

_____

2. Нет. Напишите почему

_____

3. Не знаю.

34. Вас консультировал работники НПО:

1. Да

2. Нет. Напишите почему_____

Если ответили ДА, то когда Вас консультировал работник НПО в последний раз:

1. до приема в программу лечения метадоном
2. 2 недели тому назад

3. Не знаю

3. 1 месяц тому назад
4. 3 месяца тому назад
5. 6 месяцев тому назад

35. Нуждались ли вы в консультации работника НПО:
1. Да. Напишите почему
_____
2. Нет. Напишите почему
_____
3. Не знаю.

36. Есть ли у Вас дополнительные затраты в связи с лечением метадоном:
Нет
Да, я плачу за проезд
Да, я плачу за лекарства
Да, я плачу неофициально/ делаю подарки работникам центра
Другой ответ (напишите)
_____

Учреждение, где Вы получаете лечение метадоном _____

Номер в журнале выдачи метадона _____

СПАСИБО ЗА ВАШУ ПОМОЩЬ.

APPENDIX 2. Staff Satisfaction Questionnare.

Опросник для оценки отношения и удовлетворенности персонала (CAS)

Этот анкетный опросник предназначен для документального подтверждения отношения (установок), объема медицинских знаний персонала в сфере метадоновой поддерживающей терапии и его удовлетворенности работой.

Согласны ли Вы или же не согласны с каждым из следующих утверждений? Пожалуйста, отметьте свой ответ посредством обведения цифры в столбце, соотносящемся с подходящим вариантом ответа. В каждой строке должен быть отмечен один ответ.

	Не согласен (-на)	**Не уверен(а)**	**Согласен (-на)**
Отношение к зависимости			
Современное общество слишком терпимо относится к наркозависимым	1	2	3
Взрослые, осужденные за продажу героина несовершеннолетним, должны находиться в тюрьме пожизненно	1	2	3
Лица, осужденные за продажу запрещенных наркотиков, не подлежат досрочному или условному освобождению из тюрьмы	1	2	3
Марихуану следует легализовать	1	2	3
Лица, пристрастившиеся к героину, должны обвинять в этом только себя	1	2	3
Метадоновая терапия - не более чем замещение одного наркотика другим	1	2	3
Обмен игл/шприцев следует внедрять во всех городах, в которых по имеющимся данным живет значительное количество потребителей инъекционных наркотиков	1	2	3
Врачи должны иметь возможность выписывать героин лицам с героиновой зависимостью	1	2	3
Метадоновая поддерживающая терапия в значительной степени	1	2	3
уменьшает последствия для здоровья, социальные и правовые последствия пристрастия к наркотикам	1	2	3
Пристрастие к наркотикам – это порок	1	2	3
Наркозависимые – это слабые люди, которые не могут устоять перед искушением их употребления	1	2	3
Воздержание и ориентация на поддерживающее лечение			
Главной целью лечением метадоном должно быть воздержание от употребления всех наркотиков (включая метадон)	1	2	3
Пациентам, принимающим метадон и продолжающим употреблять героин, следует снизить дозу метадона	1	2	3
Не следует устанавливать для человека никаких ограничений на продолжительность метадоновой	1	2	3

	Не согласен (-на)	Не уверен(а)	Согласен (-на)
поддерживающей терапии			
Пациент должен постепенно сокращать употребление метадона как только он(она) прекратит(а) употребление героина	1	2	3
Пациентам метадоновой программы следует давать метадон в количестве, достаточном только для предотвращения развития симптомов отмены	1	2	3
Неэтично держать наркозависимых на метадоновой терапии бесконечно	1	2	3
Пациентам программы метадоновой терапии, регулярно нарушающим график посещения сеансов психологического консультирования, следует постепенно отменять метадон	1	2	3
После периода стабильной поддерживающей терапии следует побуждать пациентов приступать к постепенному прекращению употребления метадона	1	2	3
Пациенту следует позволять оставаться на поддерживающем лечении метадоном столько времени, сколько он захочет	1	2	3
Пациент должен достаточно долго принимать только метадон, чтобы устранить токсическое действие запрещенных опиатов	1	2	3
Метадоновая терапия должна быть ограниченной во времени (например, меньше шести месяцев или меньше года)	1	2	3
Пациентов программы поддерживающей метадоновой терапии, игнорирующих повторные предупреждения о необходимости прекратить употребление героина, следует исключать из программы	1	2	3
Следует расширять программы поддерживающей метадоновой терапии с тем, чтобы все желающие лица с героиновой зависимостью могли получать поддерживающее лечение	1	2	3
Лицам с героиновой зависимостью следует проводить долгосрочное поддерживающее лечение только в том случае, если краткосрочное поддерживающее лечение оказалось неэффективным	1	2	3
Пациентов программы поддерживающей метадоновой терапии, продолжающих употреблять запрещенные наркотики, следует выписывать из программы, чтобы дать возможность лечиться тем, у кого вероятность получить пользу от такого лечения выше	1	2	3
Пациентам, принимающим метадон и продолжающим употреблять алкоголь, следует снижать дозу метадона	1	2	3
Лицам с болезненным пристрастием к героину следует	1	2	3

	Не согласен (-на)	Не уверен(а)	Согласен (-на)
проводить долгосрочное поддерживающее лечение только в том случае, если альтернативные методы лечения оказались неэффективными			
Пациентов, попавшихся на продаже или торговле своим метадоном, следует немедленно выписывать из программы	1	2	3
Пациентов программы поддерживающей метадоновой терапии, продолжающих употреблять инъекционные наркотики, следует выписывать из программы, чтобы освободить место тем, у кого выше вероятность сократить случаи поведения с риском инфицирования ВИЧ	1	2	3
Пациентов программы поддерживающей метадоновой терапии, игнорирующих повторные предупреждения прекратить употребление алкоголя или амфетамина, следует исключать из программы	1	2	3
Пациенты на высоких дозах метадона должны получать меньшее количество метадона для приема дома, чем пациенты на низких дозах	1	2	3
Пациентов программы поддерживающей метадоновой терапии, которые жалуются на свою программу, следует побуждать к уходу из нее	1	2	3
Мнения о пациентах			
Многие пациенты хотят лишь сделать перерыв в добыче наркотика(на самом деле не желая избавиться от пристрастия к героину)	1	2	3
Многие пациенты искренне стремятся к своему выздоровлению	1	2	3
Многие пациенты обычно не склонны к сотрудничеству	1	2	3
Большинство лиц с пристрастием к героину употребляют наркотик, потому что они должны (а не хотят) его употреблять	1	2	3
Медицинская информация			
Поддерживающее лечение метадоном может вызывать поражение печени	1	2	3
Для плода метадон опаснее героина	1	2	3
Стабильные дозы метадона существенно нарушают способность к вождению автомобиля и управлению движущимися механизмами	1	2	3
Поддерживающая метадоновая терапия усугубляет тяжесть уже имеющегося депрессивного расстройства	1	2	3
Поддерживающее лечение метадоном может вызывать поражение почек	1	2	3

APPENDIX 3 Agenda of Emilis Subata mission to Moldova November 18-28, 2012

	ORGANIZATION	PERSON/SPECIALIST ENCOUNTERED	CONTACT DETAILS	RESPONSIBLE PERSON
	18 November			
8.55	Arrival at the Chisinau International Airport. Accommodation to the hotel			
	19 NOVEMBER			
9.30 – 12.30	UN Office on Drugs and Crime PAS Centre UNAIDS Moldova	– Ms. Ina Tcaci UNODC HIV/AIDS Officef – Ms. Emilia Rusu, project assistant – Viorel Soltan, Director – Stela Bivol, Policy and Research Director – Liliana Caraulan, Program Coordinator – Gabriela Ionaşcu, Coordinator – Alexandrina Iovița, M&E specialist	+373 69325079 + 373 79347785 + 373 22 27 00 31 + 373 69300403	Ala Iatco
13. 00 – 14.00	Lunch			
14.30 – 16.30	Soros Fundation	– Vitalie Slobozian, Harm Reduction subprogram, Coordinator – Veronica Zorila, Harm Reduction subprogram, M&E specialist	+ 373 22 27 00 31	
	20 NOVEMBER			
9.00 – 11.00	Republican Narcological Dispensary	– Mihai Oprea, General Director and medical staff – Lilia Fiodorova, Liubovi		Ala Iatco

		Andreeva, Svetlana Timus, Tudor Vasiliev, medical staff		
11.30 – 13.00	OST site visit	– Lilia Fiodorova, medical staff	+ 373 69279390	Ala Iatco
13.30 – 14.30	Lunch			
15.00 – 18.00	NGO New Life Visit od Day center for psycho-social support for IDUs	– Ruslan Poverga, Director – Alexandru Curasov, coordinator – Victoria Manceva, M&E specialist	+ 373 69115457	Ala Iatco
	21 NOVEMBER			
9.00 – 13.00	Department of Penitentiary Institutions. OST site visit	– Veaceslav Ceban, Chief of the Department – Svetlana Doltu, Chief of the medical service – Ludmila Ciutac – international relation unit of the Department – Constantin Birca - Chief of the medical service penitenciary nr.15, Cricova, TSO consultant	+ 373 69777405	Ala Iatco
13.00 – 14.00	Lunch			
15.00 – 16.30	Ministry of Interior Affairs	– Vlad Scaian, specialist Antidrog Department; – Vitalie Moraru, Medical Department; – Valentin Beleavschi, Medical Department; – Vladimir Cazacov, Public order Department; – Dorel Nistor, Public order Department;		Ala Iatco
	22 NOVEMBER			
8.00 – 10.00	Trip to Balti city			
10.30 – 12.00	Municipal Clinical Hospital, Narcological Service	– Victor Crovoi, doctor of the Narcological Service, Balti Clinic Hospital	+ 373 69222127	Ala Iatco

	OST site visit	– **Zinaida Caraus, medical assistant, Narcological Service, Balti Clinic Hospital**		
12.30 – 13.30	**Lunch**			
14.00 – 15.00	**Bălți Police Department**	– **Valeriu Starii, Comisar** – **Cornel Guzun, Ihtiandr Cheptea, Stanislav Hortiuc, Alexandr Bodnarov - antidrog Inspectors**	**+373 79037755**	**Ala Iatco**
15.30 – 17.30	**NGO „Youth for the Right to Live”. Visit of Day center for psycho-social support for IDUs**	– **Ala Iațco, Director** – **Anastasia Bahilova, social assistant** – **Iurii Iscinin, Denis Hibovski, outreach workers/ pear to pear consultants**	**+373 79571441**	**Ala Iatco**
	Trip to Chisinau			
	23 NOVEMBER			
9.00 – 10.30	**Ministry of Health**	– **Țurcanu Gheorghe, vice-minister** – **Cristina Gaberi, Chief of the National Programs Department** – **Lilia Gantea, Budget and Finance Department** – **Mihai Oprea, General Director, Republican Narcological Dispenser**	**+ 373 69083483**	**Ala Iatco**
11.30 – 12.30	**Hospital of Dermatology and Communicable diseases**	– **Lucia Pirtina, National coordinator HIV Program**		
13.00 – 14.00	**Lunch**			
14.30 - 15.30	**Phthysiopneumology Institute**	– **Liliana Domente, Director**		
16.00 – 18.00	**UNODC, PAS Centre, SFM, WHO**	**General conclusion**		
	24 NOVEMBER	**SATURDAY**		
	25 NOVEMBER	**SUNDAY**		

	26 NOVEMBER			
9.00 – 17.00	**Presentation of the preliminary findings on OST assessment. Recommendations for the quality increase of OST in Moldova. Roundtable discussion**	**Hotel "Codru" conference centre, representatives from UNODC, WHO, UNAIDS, PAS Centre, Soros foundation, Ministry of Health, Ministry of Interior Affairs, Ministry of Justice Penitentiary Department, RND, medical institutions, NGOs**	**+ 373 79401559**	**Ala Iatco**
	27 NOVEMBER			
9.00 – 12.00 **12.00 – 13. 00**	**Medical University „N. Testemitanu" Department of Psychiatry, Narcology and Social medicine. Information session Meeting with the equip of the Department of Psychiatry**	– **Anatol Nacu, Chief of the Department** – **Mircea Revenco, Inga Deliv, Igor Cobileanschi, Igor Nastas, professors and medical staff of Hospital of Psychiatry.** – **Vitalie Slobozian, Soros Foundation Moldova**	**+ 373 79401559**	**Ala Iatco**
	28 NOVEMBER			
8.00	**Flight to Vilnius**			