EVALUATION OF PILOT METHADONE MAINTENANCE TREATMENT IN THE KYRGYZ REPUBLIC

Photo: Methadone Maintenance Programme in Osh

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drug/therapy)
CA	Central Asia
CMCC	Country Multisectoral Coordination Committee
CIS	Commonwealth of Independent States
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FGD	Focus Group Discussion
FSW	Female Sex Worker
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GUIN	The Main Penalty Execution Department
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use / User
INGO	International Non-governmental Organization
MMT	Methadone Maintenance Treatment
M&E	Monitoring and Evaluation
NGO	Non-governmental organization
PGR	Population Growth Rate
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
UNTG	UN Theme Group on HIV/AIDS
WHO	World Health Organization

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Executive summary

This mission was contracted by UNDP and UNAIDS to evaluate existing methadone maintenance programmes, their impact on HIV/AIDS and to provide recommendations for the expansion of methadone maintenance treatment (MMT) programmes in the country, including penitentiary system.

International consultants work included desk review of available documents and field mission to Kyrgyz Republic the October 31 to November 17, 2006 (including field trip to Osh November 5-7, 2006). The following institutions were interviewed: a/government ministries/departments/agencies, b/UN agencies, c/INGOs and NGOs, d/Republican and Osh Oblast Centers of Narcology (MMT programmes). Focus group discussions and one to one interviews were conducted with: a/patients of MMT programmes, Injecting Drug Users (IDU), family members; b/staff working in MMT and harm reduction programmes, and c/social workers. In total, international consultants met with 71 representatives of 27 organizations and with 52 beneficiaries from the target group (IDU).

Most of the information obtained through the meetings with policymakers, stakeholders, and IDUs is of a qualitative nature. However, wherever possible, actual numbers of beneficiaries /IDU/MMT patients were obtained. Interviews/focus group discussions were semi-structured in nature, allowing the international consultants and/or the respondents also to pursue issues of relevance or of local importance.

Tentative findings and recommendations were presented to the Country Multisectoral Coordination Committee on HIV/AIDS. Inputs received in this meeting are included in the present report.

The main findings and recommendations are summarized below:

By November 1, 2006 there were 145 patients (19 women) in Bishkek and Osh MMT programmes. There were 29 HIV positive IDU in MMT or four percent from the total number of 717 officially registered (Kyrgyz nationals) HIV positive IDU. There were 10 persons, receiving the

combined MMT and ARV therapy or 22% from all number (46) of people receiving ARV therapy. Due to the low coverage of IDU by MMT, there could be hardly and impact of MMT to HIV in the country so far.

MMT programmes in Kyrgyzstan are implemented in comprehensive way, with integrated medical treatment, psychosocial and legal support, provided by MMT programmes itself and NGOs. HIV positive IDU are admitted to MMT without delay and restrictions. HIV testing and ARV therapy are available free of charge.

At the same time, certain gaps still exist. There is a lack of professional standards and service protocols, lack of sufficiently trained personnel. Accessibility of treatment services is a problem due to limited in-patient facilities and capacities, and there is a lack of monitoring and evaluation mechanisms for quality control and to measure effectiveness of the treatment. There have been breaks in provision of methadone supply into the country.

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

- At this stage to expand MMT programmes in the governmental health care institutions with capacity building of existing staff;
- To implement MMT in geographically decentralized way with appropriate control. MMT should be provided with the whole range of medical services, such as ARV therapy, TB, and STI treatment/care. Psycho-social and legal support for patients should be available in health care institutions and through cooperation with NGOs. Self help groups should be supported in all areas where MMT programmes will be implemented.
- To conduct studies among IDU living with HIV/AIDS in order to enhance their entry into MMT and ARV therapy.
- Information on MMT dissemination strategy should include close consultation with all stakeholders involved in the MMT programmes including IDU networks, outreach programmes/networks, professional groups including medical, law enforcement, media etc.

- Capacity building of the MMT staff should include development of the training programme based on the lessons learned in the line with international standards. The ongoing continuous training system should be established;
- National standards/protocols of MMT should be adopted, based on existing international practice;
- A comprehensive monitoring and evaluation plan to monitor the quality of services and treatment outcomes should be established in the country and should be an integral and continuous part of each MMT programme. Ready available methodologies as recommended by WHO could be considered;
- To expand MMT into penitentiary system by establishing a pilot MMT programme in one or more penitentiary institutions. To evaluate the pilot MMT programme in prison settings. Based on the results of pilot MMT, to consider the expansion of MMT in penitentiary system;
- Specific strategies should be considered in penitentiary system in order to minimize the risks related with introduction of MMT, including safety and control measures, training of the staff, defining eligibility criteria for MMT and providing realistic information to staff and prison population. Training of the staff should be provided by the local experts on continuous and systematic basis.

1. Background and objectives

Methadone maintenance treatment (MMT) has been recognized as an effective tool to prevent HIV among injecting drug users (IDU) and to increase the adherence of eligible people with HIV/AIDS to anti-retroviral (ARV) treatment (UNAIDS, WHO, UNODC, 2004; WHO, 1998; WHO, 2005a). Methadone and buprenorphine has proven highly effective in the treatment of opioid dependence and HIV prevention and have been included recently into WHO XIV Edition of the Model List of Essential Medicines (WHO, 2005b). There are growing number of studies and recommendations that methadone and buprenorphine maintenance treatment should be a part of HIV prevention strategies in prisons as important and highly effective public health intervention (WHO, 2005c; Dolan K et al. 2003; EMCDDA, 2003). Substitution treatment with methadone or buprenorphine has been increasingly used in prisons in European Union countries and by the beginning of 2004 was used in six from the 15 EU countries (Stöver H, Hennebel LC, and Casselman J. 2004).

The Kyrgyz Republic was the first country of Central Asia having initiated a pilot methadone programme in 2002. MMT programmes cover low number of IDU, 145 out of 4975 (2.9%) of officially registered IDU by the Republican Center of Narcology (Esenamanova, 2006). By November 1, 2006 only 29 HIV positive IDU (4.0%) are enrolled into MMT from the total number of 717 officially registered (Kyrgyz citizens) HIV positive IDU. Seven HIV positive IDU are participating in MMT in Bishkek and 22 in Osh (Esenamanova, 2006).

Bishkek, the capital of the country and Osh, one of is provincial centers are the only sites where methadone maintenance treatment is available to a total of 145 injectors. Although about 100 injecting drug users living with HIV are eligible to ARV therapy only four percent are enrolled to combined ARV therapy plus methadone programmes. The overall involvement of eligible drug dependent people with HIV to ARV therapy in the country is lower than of eligible non-drug dependent people with HIV.

Therefore formal implementation of methadone maintenance treatment in the Kyrgyz Republic could hardly provide any impact on HIV spread or saving of lives of IDU with HIV by their involvement to ARV therapy. At the same time this is financially possible because the Kyrgyz Republic has raised substantial financial resources to respond to AIDS epidemic including those specified to fund methadone programmes. Meanwhile the government of the Kyrgyz Republic remains clearly committed to expand methadone projects both for prevention of HIV transmission and ARV therapy purposes.

The objective of the joint UNAIDS evaluation of the pilot methadone maintenance treatment programme in the Kyrgyz Republic is to provide the Government of the Kyrgyz Republic (namely Ministries of Health and Justice) with evaluation and recommendations on how to scale up the provision of methadone maintenance treatment programme.

The evaluation looked at whether the programme had been effective in contributing to the reversing of AIDS epidemic. The evaluation lead to recommendations that can improve the implementation of methadone programmes in the Kyrgyz Republic and advise on the necessity of further expansion of the existing pilot methadone maintenance treatment programme.

2. Methodology

International consultants work started with a desk review of the documents produced by UNDP, UNAIDS, Government of the Kyrgyz Republic, multilateral and bilateral donors (from the 26th October to the 10th November 2006). In addition, international consultants undertook a field mission to the Kyrgyz Republic from the 1st to the 17th November 2006 - including field trips to Osh and Bishkek. These cities were selected because a/ there are the only sites where methadone maintenance treatment is available in the Kyrgyz Republic, b/the majority of IDU reside there, c/ there is a high incidence of registered HIV cases in these cities. Representatives of the following institutions were interviewed: a/Ministries/departments/agencies; b/UN agencies; c/INGOs and NGOs. Focus group discussions, and one to one interviews were conducted with a/IDU, b/family members of IDU, and

c/social/outreach workers. A complete schedule of the mission and the list of persons met are attached in annex 2 (see table 1 and 2). The field schedule of the international consultants was established in consultation with UNDP office in the Kyrgyz Republic. In total, the international consultants met with 71 representatives of 27 organizations and with 52 beneficiaries (for details see tables 1 and 2).

Most of the information obtained through the meetings with policymakers, stakeholders, and IDU is of a qualitative nature. However, wherever possible, actual numbers of beneficiaries / IDU / social workers were obtained. Interviews/focus group discussions were semi-structured in nature, allowing the international consultants and/or the respondents also to pursue issues of relevance or of local importance.

Table 1. IDU, MMT patients, family member of the IDU and social workers interviewed through one to one discussion or Focus Group Discussions

	Individual interviews	Focus Group Discussions/persons
IDU/MMT patient	4 (2 female/2 male)	29 (7 female / 22 male)
Social/outreach workers/ family members	3 (2 female / 1 male)	16 (8 female / 8male)
Total	7 (4 female / 3male)	45 (15 female / 30 male)
Grand total	***52 persons (19 female/ 33 male)***	

Meetings with policymakers and stakeholders offered not only a venue for information gathering but also an opportunity for the international consultants to validate their findings, discuss initial observations, and check whether areas of importance had been overlooked. Before leaving the country the international consultants presented their tentative findings and recommendations to the Country Multisectoral Coordination Committee on HIV/AIDS (CMCC). Inputs received in this meeting are included in the present report. The final report includes inputs and comments from the Unit for Coordination and Monitoring in

HIV/AIDS area, UNDP, UNAIDS, UNODC and was completed on 15th November 2006.

Table 2. Number of organizations / representatives interviewed during the field mission in the Kyrgyz Republic

	Bishkek (organizations / representatives)	**Osh (organizations / representatives)**	**Total (organizations / representatives)**
UN agencies, International NGOs	7/21(11female/10male)	1/1 (1female)	8/22(12female/10male)
Government officials / medical institutions	6/17(9female/8male)	2/17(9female/8male)	8/34(18female/16male)
Local NGOs	6/6(1female/5male)	5/9(9female)	11/15(10female/5male)
Total	**19/44 (21female/23male)**	**8/27(19female/8male)**	**27/71(40female/31male)**

3. Challenges and Limitations

Overall, the methodological approach was in line with the purposes of this mission. The field visits, while tightly scheduled, allowed the international consultants to interact with many people in a relatively short period of time. It should be recognized, however, that it was not possible for the International Consultants to visit all stakeholders. In particular, the international consultants could not interact with IDU in the prisons.

Several meetings were attended by a large number of people. This caused some complications in communication and may have affected the scope

and the reliability of information provided by the respondents. The international consultants tried to have separate one to one complementary sessions with the respondents when they felt the information provided was somehow biased because of the presence of an audience.

Gender, age and geographical distribution of direct beneficiaries, direct recipients and indirect beneficiaries of methadone maintenance treatment programme prevention, care and support projects were not systematically available. Reporting formats of implementing organizations differ and some projects were still in their early stages of implementation. Not all organizations in the Kyrgyz Republic adequately respond to the "Three One" concept[1] (UNAIDS, 2005) and the need for a common Monitoring and Evaluation (M&E) framework.

The legal and policy framework on methadone maintenance treatment programme would deserve a more thorough review by a legal expert. During the short term of the mission, and with no provision for translation costs, the international consultants were able to review only the documents that had been translated in Russian or English.

4. HIV situation in the Kyrgyz Republic

The Kyrgyz Republic's estimated population is 5,264,000 people (UNAIDS, 2006). The population growth rate (PGR)[2] in the country is 1.2% (UNAIDS, 2006). Life expectancy at birth in the country is 67 years for women and 59 years for men (UNAIDS, 2006). The Kyrgyz Human Development Index (HDI) is 0.702, and the country is ranked 109th (while Uzbekistan is ranked 111th, Tajikistan 122nd and Kazakhstan 80th).

[1] "Three one" concept: One agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one single country-level monitoring and evaluation system.

[2] The average annual percent change in the population, resulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving a country. The rate may be positive or negative.

The Kyrgyz Republic is a low HIV prevalence country with a concentrated epidemic[3]. From 1987 to the 1st November 2006, 1031 HIV-positive cases were registered in the Kyrgyz Republic by the unit for coordination and monitoring in HIV/AIDS area, 932 of them citizens of the Kyrgyz Republic. Of these (N=932), the majority (N=751, 80.6%) were male. The total number of HIV cases in the Kyrgyz Republic is estimated at about 4,0000 (UNAIDS, 2006). 85.3% of registered HIV cases belong to the 20-39 age groups (WHO, 2006).

As in other countries of the region, the HIV epidemic in the Kyrgyz Republic is driven mostly by injecting drug use (IDU) – approximately 80% of registered cases (UNAIDS, 2006). Among drug users were 6.2% HIV positive persons (UNGASS, 2006). In 2002 the HIV prevalence among prisoners in the Kyrgyz Republic was 2.7% (WHO, 2006; UNGASS, 2006). HIV prevalence among vulnerable groups[4] is as follow: 6.2% for IDUs, less than two percent (1.7%) for FSWs, around three percent (2.7%) among inmates of the prisons and less than one percent (0.5%) among STI patients (UNGASS, 2006).

In recent years, a considerable increase in the number of cases of HIV infection through IDU has been observed. So far, all the individuals infected via IDU have been men. The majority of them temporarily lived in the Russian Federation. Migration is often linked to the spread of HIV pandemic for a number of social reasons (Pkhakadze, 2002).

5. The status of the methadone substitution therapy to the date in the Kyrgyz Republic

The Kyrgyz Republic was the first country of Central Asia (CA) and Commonwealth of Independent States (CIS) having initiated a pilot MMT programme since 2002. The pilot MMT programme was

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

[4] Major vulnerable groups include injecting drug users, female sex workers, men who have sex with men, prisoners, migrants and refugees and certain groups of young people (WHO. 2005. www.who.int/hiv).

implemented in the Republican Center of Narcology (Bishkek) and Osh Oblast Center of Narcology.

Since 2002 to November 1, 2006 there were altogether 406 cases (47 women) of MMT (including repeated inclusions and transfers between Bishkek and Osh). By November 1, 2006 there were 145 patients (19 women) altogether in MMT in the Kyrgyz Republic, 78 patients in Bishkek and 67 in Osh (Esenamanova, 2006).

By November 1, 2006 there were 29 HIV positive patients altogether (seven in Bishkek and 22 in Osh). Ten patients received ARV therapy (three in Bishkek) (Esenamanova, 2006).

The evaluation of the MMT pilot programme in 2002-2004 was done by T. Asanov (Asanov, 2005) and reviewed by WHO Office for Europe (WHO, 2005e). The report indicated the success rate of the MMT in more than 60% of the patients (retention in MMT or transition to abstinence from opioids). As shown in the report the significant improvement included the reduced prevalence of heroin use among patients (up to 22%) and the increased rate of employment (from 34% to 84%) (WHO, 2005e).

At present MMT is fully funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The current programme plan in the course of one year includes the expansion of MMT to five more sites in the country (Esenamanova, 2006):

- two sites in Bishkek in the primary health care centers - 50 patients capacity each with total 100 patients, and
- three sites in the north of the Kyrgyz Republic (Tokmok, Kara-Balta and Kant) - 50 patients each with total 150 patients.

6. The impact of methadone treatment on HIV prevention among injecting drug users in the Kyrgyz Republic

MMT programmes cover low number of IDU, 145 out of 4975 (2.9%) of officially registered IDU by the Republican Center of Narcology

(Esenamanova, 2006). By November 1, 2006 only 29 HIV positive IDU (4.0%) are enrolled into MMT from the total number of 717 officially registered (Kyrgyz citizens) HIV positive IDU. Seven HIV positive IDU are participating in MMT in Bishkek and 22 in Osh (Esenamanova, 2006).

The ARV therapy is available in the Kyrgyz Republic since March 2005 and is funded by the GFAMT. Up to November 1, 2006 the total number of 96 persons was enrolled into ARV therapy in Kyrgyz Republic, mainly IDU.

By November 1, 2006 46 persons continued to receive ARV therapy. Adherence to ARV therapy among IDU constituted a challenge and 32 persons refused ARV therapy. Involvement of IDU into MMT has considerably increased adherence to ARV therapy (Esenamanova, 2006).

According to National Center "AIDS" by November 1, 2006 ten IDU living with HIV/AIDS participated in combined ARV therapy plus MMT programmes. The total number of eligible persons for ARV therapy was 78 (mainly IDU), as 18 persons have died mainly because of the late initiation of ARV therapy.

The obtained data indicates that in the past years existing MMT programmes could not attract greater numbers of HIV positive IDU in spite the clear priority for this group. ARV-therapy combined with MMT programmes were able to attracte only the minority of eligible IDU.

The evaluation of 2002-2004 MMT programme didn't examine the influence of MMT on injecting risk behavior, such like needle sharing (WHO, 2005e).

Therefore, low implementation coverage of the MMT programmes in the Kyrgyz Republic from 2002 to 2005 could hardly provide any impact on HIV/AIDS spread or saving of lives of IDU with HIV/AIDS by their involvement to ARV therapy.

7. The results and shortcomings of methadone substitution therapy programme in the Kyrgyz Republic

There are positive results of the implementation of MMT in the Kyrgyz Republic. Certainly, the staff of both centers in Bishkek and Osh has gained a lot of practical experience in implementing MMT which was shared internationally with professionals from other countries (Belorussia, Georgia, Kazakhstan, Uzbekistan, etc.).

The multi-disciplinary staff (physicians, psychologists, nurses, and social workers) of the Republican Centers of Narcology in Bishkek and Osh Oblast Center of Narcology identifies and implements measures to meet multiple needs of the MMT patients. They developed a human attitude towards their patients. They established close cooperation with NGOs which provide additional services to the MMT patients and their families. These services include legal counseling, representation in the court cases, support in obtaining personal ID, information on job opportunities, and available social services.

In Bishkek self-help group of MMT patients gives opportunity to communicate with other MMT patients in secure environment and learn "new" life style. It gives opportunity to members of the group to communicate and exchange their view and positive experience. The self help group provides additional support to MMT patients in Bishkek.

In Osh, NGOs employ MMT patients and their family members as social workers in harm reduction programmes. This approach is an adequate way to provide information about MMT to the IDU in the city.

The staff of the programmes has gained considerable experience in providing MMT and mobilization of support resources from outside the treatment centers. The know-how obtained should be used in developing curriculum of training of the staff and implementation of training on systematic basis in the line with international standards.

During implementation of the MMT programme in the Kyrgyz Republic there were no registered cases of diversion of methadone in to the "black market".

Shortcomings of existing MMT programmes should be also mentioned. The MMT programmes still do not guarantee a wider access for IDU and were not able to attract higher number of people living with HIV/AIDS and direct them to ARV therapy.

Some ancillary services which are provided by NGOs (e.g. legal counseling) are accessible for MMT patients only in Bishkek, but not in Osh.

A comprehensive monitoring and evaluation plan for quality of services and treatment outcomes has not been developed and applied on continuous basis.

The Evaluation Report on the implementation of the 2nd State Programme on Prevention of AIDS, Infections Transmitted Sexually and Through Injecting Way (2001-2005) (Unit for coordination and monitoring in HIV/AIDS area 2006 (Source: www.aids.gov.kg; accessed November 7, 2006)) reviewed the outputs and gaps of the development of drug abuse treatment and rehabilitation programmes, including the development of substitution treatment. The following gaps were identified:

- Pilot MMT has not been institutionalized,
- Lack of clear national policy and strategy in developing specialized drug treatment service system,
- Lack of professional standards and normative guidelines on provision comprehensive and diversified treatment services (both inpatient and outpatient) based on client needs,
- Lack of service protocols and standards,
- Lack of sufficiently trained personnel for the drug abuse treatment services system,
- Accessibility of treatment services is a problem due to limited in-patient facilities and capacities,
- Because of the issue of co-financing the drug treatment services are less utilized, and

- Lack of monitoring and evaluation mechanisms for quality control and to measure effectiveness of the treatment interventions.

The State Programme on HIV prevention and socio-economic consequences of the epidemic in the Kyrgyz Republic for the years 2006-2010 has been approved in July 6, 2006. This programme took into account gaps identified in the Evaluation Report on the implementation of the 2nd State Programme on Prevention of AIDS, Infections Transmitted Sexually and Through Injecting Way (2001-2005) (Unit for coordination and monitoring in HIV/AIDS area 2006 (Source: www.aids.gov.kg; accessed November 7, 2006)).

8. The quality of the substitution therapy provision

The protocols and standards for MMT and other harm approaches are in the process of the development by the Working Group established by the Ministry of Health. Adherence to clinical treatment protocols and standards, after their adoption by the Ministry of Health, should ensure the quality of services.

The existing order of the Ministry of Health, February 15, 2001 N41 registered in the Ministry of Justice of the Republic of Kyrgyzstan on April 6, 2001 N55 "Order about Conditions and implementation of substitution treatment with methadone in Kyrgyz Republic" provides mainly basic legal support to MMT.

In the focus group discussions MMT patients mentioned that physicians prescribe adequate dose of methadone which varies from 20 mg to 160 mg depending of the clinical status. They indicated that MMT programmes in cooperation with NGOs provide as comprehensive services as possible including psychosocial and legal support. HIV positive IDUs are accepted in the MMT without delay and restrictions.

HIV testing is available free of charge based on the referral from the MMT programme. Confidentiality of the HIV positive IDU is respected.

For HIV positive MMT patients ARV therapy and regular laboratory investigations are also available free of charge based on the referral from the MMT programme. ARV drugs are available within MMT in Bishkek. This "one stop shop" system provides greater sustainability of the both MMT and ARV therapy programmes, improves adherence to ARV therapy and it is convenient for patients. In Osh patients who are in the ARV therapy and MMT receive medication in two institutions which are geographically distanced.

Clinical protocols for ARV therapy are available by the order of Ministry of Health June 1, 2005 N218. Protocols include a chapter of ARV therapy for IDUs, including methadone patients and detailed description of interaction between methadone and ARV drugs.

During unexpected shortage in 2005-2006 of the methadone supply in Osh patients have been forced to reduce their methadone dose to the minimum and some experienced severe withdrawal symptoms. This experience show good cooperation between MMT staff and patients to respond to challenges.

9. The effectiveness measured (number of people under methadone treatment, tendencies to increase)

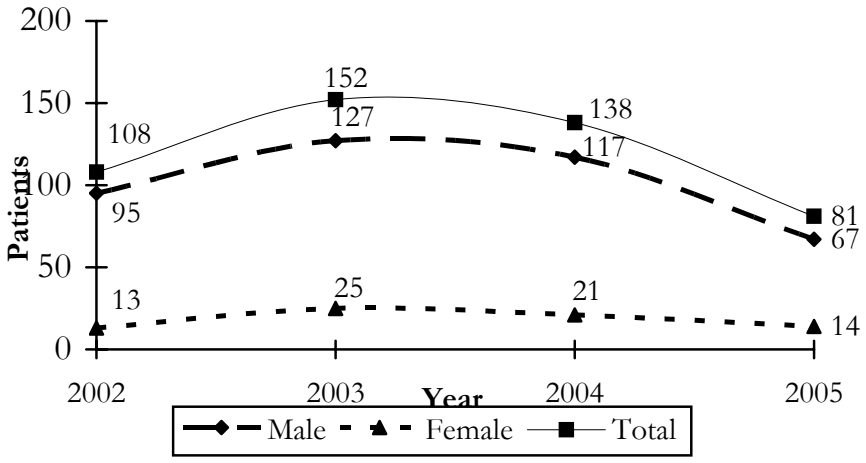
MMT has started in the Kyrgyz Republic in 2002. As indicated in the report by T. Asanov by the end of 2002 there were 108 persons (13 women) in MMT programme (Asanov, 2005). By the end of 2003 the total number of MMT patients has increased to 152 (25 women) (Asanov, 2005). In 2004 the number of patients has again decreased to 138 (21 women) see in the Chart 1 (Asanov, 2005)

In 2005 and first half of 2006 the number of MMT patients has continued to decrease. In 2005 (see Chart 1) the number of MMT patients decreased to 81 (14 women) (unpublished report of the Republic Center of Narcology, 2006). The main reason of the decrease of the number of patient in MMT since 2004 has been the shortage of methadone supply in the country. The shortage of methadone supply has been a major barrier for the expansion of MMT in the Kyrgyz Republic.

Republican and Osh Oblast Centers of Narcology could not admit new patients to MMT instead of dropouts. To continue MMT for certain patients they had to reduce methadone doses and patients suffered withdrawal symptoms. In the middle of 2006 the problem of methadone supplies was solved in the country as 9.5 kg of methadone have been received.

The current dose of methadone in Republican Center of Narcology is 63 mg (Esemanova, 2006). Based on this average dose the quantity of methadone per MMT patient per year is 23g (0.063 g x 365 days = 22,995g).

Chart 1. Number of patients in MMT from 2002 to 2005 in the Kyrgyz Republic



Source: Asanov, 2005; Republican Center of Narcology 2006.

By the end of the 2007 it is expected to have 450 patients on MMT (100 in Republican and Osh Oblast Centers of Narcology each, two primary health care centers in Bishkek with 50 patients each and three primary health care centers in provincial cities 50 patients each). The methadone supply for 450 patients for one year at the present average dose level will be 10.35 kg (23g x 450 patients = 10,350g). In case of opening new MMT programmes in Osh or neighboring oblasts and penitentiary system the necessary quantity of methadone should be adjusted.

10. Assessment of the extension possibilities of methadone substitution therapy in penitentiary system of the Kyrgyz Republic

Last several years different UN agencies and international organizations supported harm reduction/public health programmes in penitentiary system in the Kyrgyz Republic by undertaking wide range of activities:

- development of the legal background for MMT in the penitentiary system,
- study tours for the decision makers,
- capacity building of NGOs,
- training penitentiary institution staff,
- training of medical staff,
- psychosocial/legal support,
- needle exchange programmes,
- rehabilitation of drug dependent persons,
- renovation of the medical facilities, and
- provision of medical equipment.

These activities were implemented in several penitentiary institutions such as N3, 10, 16, 47, and others.

By the joint order January 17, 2006 of the Minister of Health and Minister of Justice "About the pilot programme. Substitution methadone therapy of persons with drug dependence in institutions GUIN Ministry of Justice of the Kyrgyz Republic", the pilot MMT was approved for 20 IDU in penitentiary institution N47. The order incorporated the methodological assistance from Republican Center for Narcology in the implementation of MMT as well as training of physicians and nurses.

During the meeting with GUIN the consultants were told that there is a substance dependence clinic (hospital) with ready available staff (narcologists and nurses) at the penitentiary institution N47. Few more positions for narcologists and nurses were open and not filled by specialists.

The Narcological center of penitentiary institution N47 has inpatient units for drug dependence treatment. In one of the inpatient units a rehabilitation programme "Atlantis" provides psychosocial services to IDUs. It could be used as a resource of psychosocial assistance to pilot MMT programme patients. While consultants had no opportunity to visit the penitentiary institution N47, it seems that the existing Narcological Center at this penitentiary institution could be one of the possible sites for pilot MMT programme.

"Social bureau" which provides social support and referrals to social services for the inmates has been established in the penitentiary institution N47. This service is operated by the NGO "InterDemilge and funded by the AIDS Foundation East West. This service works with inmates for six months before their release. They refer inmates after their release for further services and support in the social bureaus which are established outside prisons and operated by other NGOs.

The Educational Center for GUIN provides training to the staff of the penitentiary system on different topics including public health. This institution can be used as a training base for the prison staff to disseminate information about MMT programme in the penitentiary system.

11. Sustainability of the achievements within the programme

Increase of the accessibility to MMT, as a part of harm reduction response to prevent HIV among IDU has been included in country's main strategic programmes, including the 3rd State Programme on HIV/AIDS for the years 2006-2010 as well as in the National Programme to counter Drug Addition and Trafficking for 2006 and 2010. These documents prove the increased strategic consensus of different governmental agencies regarding the necessity of expanding of MMT in the country.

MMT is being implemented according the order of the Ministry of Health, dated on February 15, 2001 N41 registered in the in the Ministry of Justice of the Republic of Kyrgyzstan, April 6, 2001 N55 "Order

about Conditions and implementation of substitution treatment with methadone in Kyrgyz Republic". However, during the meetings some governmental agencies and NGOs expressed opinion that MMT should be defined by the separate law to ensure its sustainability.

The order of the Minister of Health, dated on May 3, 2006 N227 and the Drug Control Agency (AKN), dated May 13, 2006 "About development of the substitution treatment programmes of opioid dependence in the Kyrgyz Republic", recognized MMT as justified treatment intervention in the Kyrgyz Republic.

By the order of the Ministry of Interior dated September 15th 2006 entitled "On realization of the state programme on HIV/AIDS for 2006-2001, and reduction of the HIV/AIDS among IDU and co-dependant" it is prohibited to arrest and conduct ungrounded search by the police of IDU participating in MMT. The order gives opportunity to form adequate relations between law enforcement agencies, MMT staff and patients.

11.1 Monitoring and evaluation

Important component for the sustainability of MMT in the Kyrgyz Republic is to retrieve on the regular basis data on the impact of MMT on HIV situation in the country and on the benefits for individuals /community.

Therefore, it is important to have the system of ongoing monitoring and evaluation both of the quality and outcome effectiveness of the MMT programmes.

The evaluation of MMT programme in the Kyrgyz Republic 2002-2004 did not include the monitoring of the quality of services, impact of MMT on general health and risk behavior (injecting and sexual), and the impact of MMT on the transmission of HIV.

The importance for the development of the ongoing monitoring and evaluation of the quality and treatment outcome of MMT programmes was well recognized in the past years by different UN agencies. In 2003

the World Health Organization has developed the General Protocol (WHO, 2003) on outcome and process evaluation in the framework of WHO Collaborative Study on Substitution Treatment of Opioid Dependence and HIV.

The WHO Collaborative study has been carried out in Central and Eastern Europe (Lithuania, Poland, and Ukraine), South-West Asia (China, Indonesia, and Thailand) and Iran. The WHO Collaborative Study has developed essential instruments for comprehensive process and outcome evaluation, which were translated into the main languages (including Russian) (WHO, 2003).

The process evaluation, as indicated in the Protocol, includes assessment of existing procedures of substitution treatment, HIV prevention services, satisfaction of programme staff as well as satisfaction of patients with services provided, and other indicators. Retention rate of patients in the substitution treatment programme and the average dose of substitution medication are also the important indicators of the quality of the substitution treatment programmes.

The outcome evaluation in the Protocol covers the impact of substitution treatment to general health and wellbeing of the patient, including the improvement of general health, changes in the illegal drug consumption, risk behavior (injecting and sexual), and changes in the quality of life. The Protocol also covers benefits of substitution treatment to the community (reduction of criminal behavior and employment of patients).

The WHO Collaborative Study Protocol (WHO, 2003) and instruments have been already tested in different regions and countries in transition (Central and Eastern Europe and South-East Asia, Iran). They might be considered to be used in the development of the monitoring and evaluation plan in the Kyrgyz Republic.

Implementation and expansion of MMT programme in Kyrgyz Republic as integral part of the government health care services creates a good basis for its sustainability.

Ownership of the MMT by the staff of the programme, NGOs, beneficiaries and increasing cooperation with AIDS/TB programmes enhance sustainability of the programme.

MMT staff gained considerable experience and lessons learned from the programme. Their knowledge and skills should be used in the training of new MMT sites' staff as well as other health professionals.

12. Risk and capacity assessment of the methadone substitution therapy scaling up, especially in penitentiary system

The current legal situation provides the possibility to extend the MMT to penitentiary system. Thus expansion of MMT to penitentiary institutions is included into the 3rd State Programme on HIV/AIDS for the years 2006-2010 as well as in the National Programme to counter Drug Abuse and Illegal Trafficking for 2006 and 2010. Joint order of the Ministry of Justice and the Ministry of Health dated 17th January 2005 "Regarding pilot programme "MMT for IDU in GUIN of the Ministry of Justice of the Kyrgyz Republic" made provisions to start MMT programme in penitentiary institutions in the Kyrgyz Republic.

The Agency of Drug Control with other governmental institutions responsible for the implementation of country's drug policy expressed their strong support for the extension of the MMT into penitentiary institutions of the Kyrgyz Republic. They see MMT as an important public health tool.

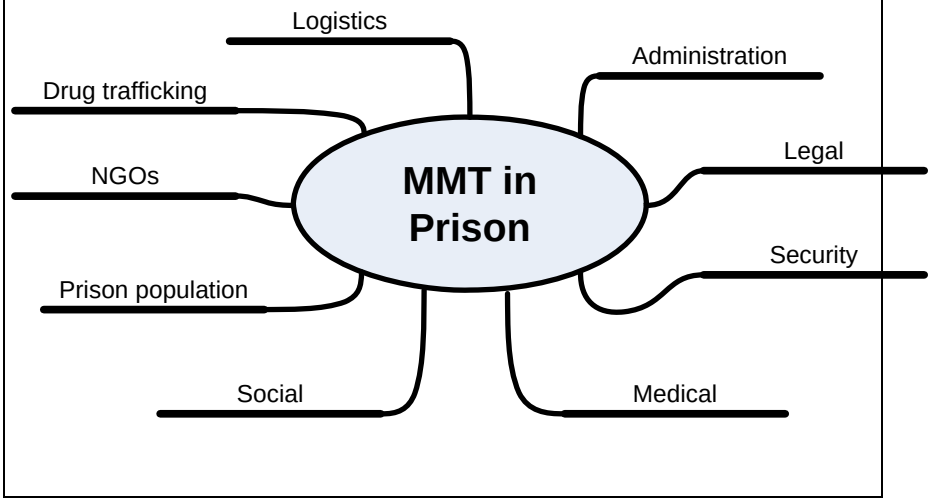
At the same time some risks/factors which will influence introduction of MMT programmes in the penitentiary system in the Kyrgyz Republic have been identified in the course of meetings with stakeholders (see Chart 2):

- *Rejection of MMT* by the penitentiary inmate population. In the beginning of MMT programme only a part of inmates in penitentiary institutions will be eligible for MMT. Thus it can be expected that some part of inmate population will be unsatisfied

being denied this service. The dissatisfaction could be instigated by inmates and potentially by prison staff.

- *Safety of medications.* There was a concern there could be attempts to break in by the inmates into the premises where the medication will be stored.
- *Potential corruption of the medical staff*. The salary of medical specialists in penitentiary institution is still low. Thus there are potential conditions for the diversion of medication through the staff of MMT programme.

Chart 2. Factors influencing introduction of MMT in the penitentiary system in the Kyrgyz Republic



There should be an adequate medical staff in the penitentiary institution, which will provide MMT. The minimal staff should include a physician/narcologist and nurses trained in MMT. The MMT programme staff should have the possibility to refer patients in MMT to essential laboratory tests, specialists of infectious diseases, general practitioner and other medial specialists according to the needs. Ancillary services should include psychosocial support provided by psychologists, social workers

by penitentiary institution staff or from outside NGOs. MMT could be initiated on out-patient or in-patient basis.

13. Recommendations on the need to scaling up provision and initiation of methadone substitution therapy in penitentiary system in the Kyrgyz Republic.

1. Efforts should be made to increase the accessibility to MMT in the Kyrgyz Republic in order to increase impact on the prevention of HIV, hepatitis B and C, TB, and STI. At this stage it recommended to expand MMT programmes in the governmental health care institutions with capacity building of existing staff.

2. Successful MMT programme should be implemented in geographically decentralized way with appropriate control. Psycho-social and legal support should be available in health care institutions and through cooperation with NGOs. Self-help groups should be supported in all areas where MMT programme will be implemented.

3. Comprehensive approach in providing the whole range of medical services to IDU such as ARV therapy, TB, and STI treatment/care should be promoted in all new and existing MMT programmes. Inclusion of the NGOs in to MMT provision such as social and legal support should be continued in all levels.

4. It is recommended to conduct studies among IDU living with HIV/AIDS in order to enhance their entry in to MMT programme and ARV therapy.

5. To avoid misconception about MMT, information dissemination strategy should include close consultation with all stakeholders involved in the MMT programme including IDU networks, outreach programmes/networks, professional groups including medical, law enforcement, media etc.

6. Capacity building of the MMT staff should include development of the training programme based on the lesson learned in the line with international standards. After the MMT starts, it is important that the ongoing continuous training system should be established

7. National standards/protocols of MMT should be adopted based on existing international practice.

8. Regular methadone supply in sufficient quantities should be considered as essential for the stability and expansion of MMT programmes in the Kyrgyz Republic.

9. A comprehensive monitoring and evaluation plan to monitor the quality of services and treatment outcomes should be established in the country. Monitoring and evaluation activities should be an integral and continuous part of each MMT programme. Ready available methodologies as recommended by WHO could be considered in the development and implementation of the monitoring and evaluation plan.

10. To expand MMT into penitentiary system by establishing a pilot MMT programme in one or more penitentiary institutions. To evaluate the pilot MMT programme in prison settings. Based on the results of pilot MMT, to consider the expansion of MMT in penitentiary system

11. Medical staff of penitentiary institutions needs to undergo a substantive basic training on opioid dependence diagnosis, withdrawal management, MMT, HIV, HBV, HCV, and ARV therapy. Training should be provided by the local experts on continuous and systematic basis.

12. To minimize risks related to the process of introduction of MMT in penitentiary institutions specific strategies should be considered:

a. providing ongoing, extensive, relevant and realistic information to inmate population and penitentiary institution staff about MMT (public health objectives, effects of medication, etc.),
b. carefully define the selection criteria of inmates for MMT (e.g. inmates which are IDU living with HIV/AIDS, TB, those who participated in MMT before incarceration, with long history of injecting drug use and multiple relapses and incarcerations because of drug use, etc.),
c. the bulk of medication could be stored outside the penitentiary institutions (e.g. in a pharmacy) with only amount needed for the 1 day to be brought,
d. to develop clear assignments and the responsibilities of the medical staff in MMT and their accountability,
e. to minimize possibilities for the corruption of the staff, and
f. ongoing internal and external inspections of the process of storage, transportation and dispensing of the medication.

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Annex 1. Possible Model of Methadone Maintenance Treatment in Penitentiary System

The Model of methadone maintenance treatment (MMT) in penitentiary institution should be in line with existing legal acts and follow the same standards/protocols. The requirements for the staff and safety of the premises should be the same as in the MMT programmes outside the prison.

Necessary adjustments in penitentiary institutions could be made for MMT programmes due to their specific situation. For instance, criteria for patients entering the pilot MMT could be confined to HIV positive IDU, IDU with TB, etc. There can be additional safety requirements for MMT programmes in penitentiary system.

Other decisions could be made regarding pilot MMT, related to limited number of medical staff (narcologists, nurses) and also limited number of dispensing units in penitentiary system. Therefore, inpatient pilot MMT programme in one of the penitentiary institutions could be justified.

MMT Staff

There should be an adequate medical staff in the penitentiary institution, which will provide MMT. The minimal staff should include physicians/narcologists and nurses trained in MMT.

Physician/narcologist

The main responsibility of the physician/narcologist in the MMT will include:

- take the history of the disease and do routine clinical examination,
- confirm the diagnosis of the patient,
- determine clinical indications for MMT,
- decide about the appropriateness of MMT to the patient,
- take informed consent of the patient to participate in MMT,

- prescribe methadone and other medications with proper documentation,
- do follow-up examinations of the clinical status of the patient,
- adjust methadone and other medication doses,
- refer to consultations of other specialists,
- educate patient on safer injection and sexual behavior and prevention on infectious diseases,
- request for urine screening, and
- keep medical records.

The MMT programme physician/narcologist should have the possibility to refer patients in MMT to essential laboratory tests, specialists of infectious diseases, general practitioner and other medical specialists according to their needs.

Nurse

Nurse's main responsibility is to work in the dispensing facilities and *dispense* prescribed methadone and other medications to patients. Other main responsibilities of the nurse will include:

- receive and record methadone, which is transported to him/her,
- account the dispensed methadone and other medications in medical journals,
- educate patients about risk injecting and sexual behavior and prevention of infectious diseases,
- take urine samples for urine screens if prescribed by physician, and
- screen patients for health problems and treatment progress and report clinically important findings to a physician.

Psychosocial support

Psychosocial support is the important additional component to MMT. Psychosocial support for MMT patients is aimed at:

- reduction of the risk behavior,
- development of healthier life styles,
- relapse prevention skills,
- development of social skills,
- building social support networks, including family, NGOs, self-help groups,
- vocational training, and
- integration into the society.

Psychosocial support for MMT patients in penitentiary system could be provided in wide variety of ways:

- educational activities on healthier life style,
- social and legal counseling,
- vocational training and counseling,
- social skills training,
- group and individual therapy, and
- leisure activities, such as sports, etc.

Psychosocial support would be available from the staff of penitentiary institutions and/or NGOs working in the penitentiary institutions. Experience of "Atlantis" programme (where possible) will be useful for providing psychosocial support for MMT patients.

Dispensing unit

Methadone should be dispensed in the room (or two rooms near each other), which is divided into two zones: a "nurse zone" and "patient zone" by secure glass wall/bars with the window for methadone delivery.

The "nurse zone" will contain a desk for a nurse, dispenser of methadone, safe for methadone storage, disposable cups, and medical documentation. The "nurse zone" should be safe.

A "patient zone" should contain a counter at the window for signing in the documentation.

Opening hours of the dispensing unit

Depending on the number of patients operating hours could be different. For example, for 20 patients two hours of operation will be enough (e.g. from 9 till 11 a.m.).

Methadone storage safety

For safety reasons the bulk of methadone could be stored outside the penitentiary institution, e.g. in pharmacy. The amount of methadone needed for the day, could be brought each day from the pharmacy. There could be variation in the storing of methadone supplies depending on the safety situation.

Outpatient/inpatient settings

MMT, if prescribed by the experienced medical staff, is safe to be initiated and continued in *outpatient settings*. As the heroin use in penitentiary institutions among inmates could be intermittent, there is a need to avoid overdose of methadone. Therefore the induction should start with methadone doses not exceeding 20-30 mg/day and should be increased slowly till therapeutic doses are achieved.

Outpatient MMT would be feasible in penitentiary institutions, where the following criteria are met:

- presence of trained medical staff: physician narcologists and nurses,
- dispensing premises, and
- safety measures and control of medication are ensured.

One dispensing unit can serve about 150 patients per day (150 patients x 2 min. = 300 min. or 5 hours/day).

Pilot MMT programme in penitentiary institutions

Pilot MMT programme could be considered to be carried out in outpatient as well as inpatient settings.

There is a Narcological Center of the penitentiary institution N47, which at present moment seems to be best equipped with medical staff and has inpatient ward of 50 beds. As Narcological Center is in the structure of prison hospital, the different specialists and laboratory services are available there.

Evaluation of Pilot MMT:

Pilot MMT should have the monitoring and evaluation component. Evaluation of MMT impact on different spheres of patient's life (general health, drug use, unsafe injecting and sex behavior, quality of life, etc.) is important. The methodology and package of instruments for the assessment of MMT patients and treatment process are available in Russian translation from WHO (WHO. 2003. WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV/AIDS: General Protocol. WHO. Geneva. Accessed on 10th November 2006: www.who.int/substance_abuse/activities/treatment_HIV/en/index.html).