EVALUATION OF OPIOID SUBSTITUTION THERAPY IN THE REPUBLIC OF MOLDOVA

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**Acronyms**

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral (drug/therapy)</td>
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<td>CIS</td>
<td>Commonwealth of Independent States</td>
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<td>EMCDDA</td>
<td>European Monitoring Centre for Drugs and Drug Addiction</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDU</td>
<td>Injecting Drug Use / User</td>
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<td>MMT</td>
<td>Methadone Maintenance Treatment</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<td>PCC</td>
<td>Physician consultative commission at OST programme</td>
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<td>PI</td>
<td>Penitentiary Institution</td>
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<td>RND</td>
<td>Republican Narcological Dispensary</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Acknowledgments

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Deep gratitude is extended to patients of opioid substitution therapy programmes in health care facilities and penitentiary institutions who openly shared their experiences.

Dr. Emilis Subata
July 4, 2008
Executive summary

This short mission June 18-19, 2008 was initiated by Soros Foundation Moldova as a follow-up of the mission of the international consultant which took place in July 2007. During the mission July 2007, which was aimed to evaluate opioid substitution therapy (OST) in the Republic of Moldova, the international consultant had a possibility to meet with relatively high number of different stakeholders, active in the development of OST in the Republic of Moldova: representatives of different of government agencies, treatment facilities, Penitentiary Department and penitentiary institutions, UN and other international organizations, NGOs, IDU and their family members. The extensive mission report has been produced (Subata E., 2007). Mission results and recommendations were presented in the mission report and at the meeting in the Ministry of Health July 13, 2007.

International consultant’s mission June 18-19, 2008 in the Republic of Moldova included visits to existing OST programmes at Republican narcological dispensary (RND) and Balti Municipal Hospital narcological unit. Staff and OST patients in these health care institutions were interviewed June 18, 2008. Representatives from Penitentiary Department of the Ministry of Justice were interviewed the next day, June 19, 2008. The same day the consultant visited OST programs in Republican Clinical Hospital “Pruncul” penitentiary Institution (PI) Nr. 16, PI Nr. 7 (for women) and PI Nr. 15.

Mission results showed that if compared with the status of OST in July 2007 in health care and penitentiary institutions, due to efforts of many stakeholders involved, especially of the Republican Narcological Dispensary (RND) and the Penitentiary Department of the Ministry of Justice, significant positive changes in provision of OST were observed:

- Increased simplicity and decentralization of the access of IDU to OST programmes in Chisinau;
- Marked increase of patients in OST in one year period (from 17 to around 140 IDU);
- Increased quality of OST programmes with better trained staff, more adequate methadone dosing and increased acknowledgment of patients’ needs in Chisinau and Balti;
- Improved psychosocial support services for OST patients in some programmes;
- Established cooperation links between health care and penitentiary institutions;
- Possibility to continue OST for patients in arrest houses;
- Increased geographical access of OST in penitentiary institutions with the decentralized initiation of OST;
- Increased quality of OST with adequate dosing and increased individualized approach to the patients’ needs and duration of OST in penitentiary institutions;
- Increased positive attitudes to OST among medical professionals and staff in health care and penitentiary institutions, law enforcement agencies, IDU and inmates of PI.

At the same time by June 2008 there were some areas for potential improvement of OST in the Republic of Moldova:
Overall OST coverage in the country and impact of OST to HIV epidemic remained very low (OST coverage less than 1% of estimated number of IDU);

Geographically accessibility of the OST in the country was still low, with OST programmes available only in Chisinau and Balti;

In Balti the accessibility of IDU to OST was still limited by the obligatory hospitalization of patients in Chisinau in order to start OST;

OST in health care facilities still lacked full multidisciplinary approach with the employment of professional social workers in the staff;

Existing practices of OST still interfered with the full social reintegration of IDU due to the requirement of daily attendance of health care facility;

The coverage of IDU by OST in penitentiary institutions was still low.

While the previous June 2007 report included comprehensive and longer-term recommendations for different stakeholders on the development of OST in the Republic of Moldova, this short mission aimed to assess changes in the provision of OST in health care and penitentiary institutions. Based on the findings of the mission following recommendations were suggested:

1. Efforts should be continued to increase the accessibility to OST to IDU in the Republic of Moldova, including other cities. Where possible, the existent network and infrastructure of narcological and psychiatry care system should be used.

2. In Balti the access of IDU to OST should be improved by initiating OST on outpatient basis without obligatory hospitalization in Chisinau;

3. The quality of OST programs should be further improved by inclusion of social workers into staff of OST programmes.

4. Professionals working in OST programs should have access to continuous training on OST and infectious disease prevention and care. National standards/protocols of MMT should be developed based on existing international practice and in the respect of a comprehensive approach;

5. Regulations on OST should be reviewed in order to allow take-home methadone doses for stable patients and/or their relatives in order to facilitate social integration and normal work-leisure cycle of patients. At the same time necessary control measures should be in place to prevent diversion of methadone.

6. A national monitoring and evaluation plan of existing OST programmes in health care system should be developed to prove the positive impact of OST to individual patients and the society in general. Ready available methodologies as recommended by WHO/EMCDDA could be considered in the development and implementation of the monitoring and evaluation plan.

7. To increase the coverage of IDU by OST in penitentiary institutions by strengthening the capacity of medical units and further developing the competence of staff in OST and HIV prevention and care.
1. Background and objectives

Opioid substitution therapy (OST) has been recognized as an effective tool to prevent HIV among injecting drug users (IDU) and to increase the adherence of eligible people with HIV/AIDS to anti-retroviral (ARV) treatment (WHO, UNODC, UNAIDS, 2004; WHO, 1998; WHO, 2005a; WHO, 2006a). 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).

Opioid substitution therapy (OST) has been widely used to prevent HIV among IDU and improve adherence in ARV therapy in Western Europe. Most of the Western European countries granted wide access to OST. For instance, in France the coverage with substitution therapy was 58-72% of estimated problem drug users, Ireland 52-61%, Spain 41-49%, Germany 39-49%, the Netherlands 41-46%, and United Kingdom 45% (EMCDDA, 2005).

The number of drug users among prison inmates is usually higher than in general population. Most of drug users while in prisons reduce their drug use. Nevertheless, in the European Union 10-42% of inmates use illegal drugs regularly in prisons. The prevalence of injecting of drugs in prisons usually is between 15 and 50%. (EMCDDDA, 2005). Opioid substitution therapy (OST) with methadone or buprenorphine has been increasingly used in prisons in European Union countries (EMCDDA, 2003, 2005). For instance, in Spain 18% of all inmates, or 82% of opioid dependent persons receive OST (EMCDDA, 2005).

As described in the previous report (Subata E., 2007) the estimated number of IDU population in the Republic of Moldova was 77-116 000 with the midpoint of 97 000 (WHO, 2006 b). From 1987 to the 1st January 2007, 2527 HIV-positive cases were registered in the Republic of Moldova (right bank) and 873 in the Transnistrean region, the total cumulative number being 3400.

As in other countries of the region, the HIV epidemic in the Republic of Moldova is driven mostly by injecting drug use (IDU) – approximately 62% of registered cumulative cases. Republic of Moldova experienced an outbreak of HIV infection in 1997 and 1998, when respectively 404 and 408 new HIV cases were detected. The IDU constituted 87.9%, 84.8% and 85.8% of newly diagnosed HIV cases in the years of 1997, 1998 and 1999.

In recent years, the proportion of IDU among new HIV cases has been steadily decreasing (54.5% in 2003, 50.1% in 2004, 42.8% in 2005, and 38.2% in 2006). There was a constant increase of the incidence of HIV cases contracted through a sexual route. Nevertheless, the number of new HIV cases among IDU in absolute numbers during the last years had a tendency to increase (179 in 2004, 228 in 2005 and 236 in 2006). At the same time the total number of new HIV cases has been steadily and rapidly increasing: 357 in 2004, 533 in 2005 and 618 in 2006 (National Centre of Scientific and Practical Preventive Medicine, 2006).
The Republic of Moldova initiated MMT in October 2004 (Ministry of Health and Social Protection, 2006). By July 10, 2007 there were 16 persons in MMT at Republican Narcological Dispensary (RND) and 20 in Penitentiary Institutions. With the 36 patients in MMT in 2007 the estimated coverage of IDU by OST was less than 1%.

During mission in July 2007 the international consultant had a possibility to meet with relatively high number of different stakeholders, active in the development of OST in the Republic of Moldova: representatives of different government agencies, including Ministry of Health, treatment facilities, Penitentiary Department of the Ministry of Justice and penitentiary institutions, UN and other international organizations, NGOs, IDU and their family members. The comprehensive mission report has been produced (Subata E., 2007). Results of the mission and recommendations were presented in the report and at the meetings in the Ministry of Health July 13, 2007.

The short follow-up mission June 18-19, 2008 was initiated by Soros Foundation Moldova and aimed to evaluate changes in OST provision in the Republic of Moldova

2. Methodology

Mission June 18-19, 2008 included consultant’s visits to existing OST programmes at Republican narcological dispensary (RND) and Balti Municipal Hospital narcological unit. Staff and OST patients in these health care institutions were interviewed June 18, 2008. Representatives from Penitentiary Department of the Ministry of Justice were interviewed the next day, June 19, 2008. The same day the consultant visited OST programs in Republican Clinical Hospital “Pruncul”, penitentiary Institution (PI) Nr. 16, PI Nr. 7 (for women) and PI Nr. 15, where representatives of administration, medical staff and patients were interviewed.

Most of the information obtained through the meetings with administrators, medical professionals and patients was 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 consultant and/or the respondents also to pursue issues of relevance or of local importance.

3. Challenges and Limitations

During the visit June 18-19, 2008 the international consultant was able to visit limited number of OST programmes, meet with the limited number of OST programmes’ staff, patients and other stakeholders. Due to the very limited time of the mission one-to-one meetings and focus group discussions (FGD) were limited to staff and patients. Meetings and FGD with patients’ relatives, representatives of the law enforcement sector and NGO’s were not prearranged due to the limited time.

Field visits, while tightly scheduled, allowed the international consultant to visit the majority of OST programmes, interact with many people in a relatively short period of time. 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.

4. Provision of OST in the National Health Care System

HIV situation in the Republic of Moldova and the legal context of the implementation of OST in the Republic of Moldova have been extensively covered in the international consultant's previous report (Subata E., 2007).

Since the last mission in July 2007, the main document, which regulated OST in the Republic of Moldova “The Order of the Ministry of Health on the OST” (2003) has been modified. While the previous Order established restrictive indications for IDU to enter OST (e.g. 2 years or more being in the narcological register; repeated unsuccessful attempts of drug-free treatment), in 2008 legal acts required mainly the informed consent of a patient with opioid dependence to be included into OST programme. The minimal age to qualify for OST remained 18 years. HIV, TB and hepatitis C (HCV) were additional indications for OST.

By June 2008 the procedure of enrolment of patients into OST programme was much simplified. By 2008 patients in Chisinau at RND started to receive first methadone doses on outpatient basis. Back in 2007 all OST patients were hospitalized for the determination of methadone dose for 1-2 weeks.

By June 2008 there were 3 methadone dispensing units at RND premises in Chisinau. The main outpatient department had 60 patients, the other two units had around 30 and 20 patients respectively with the total number of patients in Chisinau around 110. This allowed to avoid the grouping of patients around one health care facility and to retain a therapeutic atmosphere at units with the possibility to move “difficult” patients from one unit to another. OST patients acquired a possibility to attend health care unit, which was nearer to their living place.

Each unit had a physicians’ consultative commission (PCC), which enrolled patients into OST. The examination of patients’ records showed that patients received a consultation from a narcologist, then the approval from PCC and the first dose of methadone on the same day. Thus the enrolment of patients to OST became much more simple if compared with 2007. Back in 2007 a patient had to pass two different PCC before going to inpatient department to get the first dose of methadone.

Since December 2007 OST in the main outpatient unit was integrated with the short rehabilitation (day-care) program of the duration from 2 to 4 months. The rehabilitation program was paid by State Insurance Office with the rate per person in treatment to the RND. During rehabilitation period patients had to attend at least 30 days and engage in individual and group therapy and psychosocial activities, which were organized by a narcologist and a psychologist. Lunch was included into the rehabilitation package. At the time of the consultant's mission the premises of the rehabilitation programme (and OST programme) were in the process of renovation.
July 2007 there were no professional social workers in the staff of RND OST team. In June 2008 the situation remained unchanged. Thus the social needs of OST patients (lost documents, job training and finding a job, housing, health insurance, problems with the law, etc.) were not assessed professionally. Specific individual multidisciplinary treatment/social reintegration plans with specific time-lines and the involvement of patients were not developed. The effectiveness of OST for individual patients was not periodically evaluated. At RND a psychologist worked in strengthening motivation of patients to remain in treatment and improve their social and psychological status.

In all dispensing units of RND OST was provided by regular RND staff, which was additionally paid (usually modestly) from GFATM project. Thus OST was largely institutionalized in RND.

Patients attended to consume methadone every day, including weekends and holidays, under the supervision of the nurse. Methadone dispensing office was open from 8 till 14 work days and from 9.00 till 9.30 weekends and holidays. Medical records on methadone dispensed in dispensing room were kept accurate.

The pharmacy, which prepared methadone solution, under the request of the staff of RND continued to add a color to methadone solution in order to allow identification of the diverted methadone. The staff reported that there were no seizures by the law enforcement of methadone on the “black market” so far.

In the focus group discussion patients have indicated general satisfaction with OST, methadone dosing principles, relations with staff and the duration of therapy. Patients indicated that there were no waiting lists to OST and it was easy to get enrolled.

One disadvantage which patients indicated as having serious impact towards their lives was the necessity of daily attendance to RND outpatient units for methadone. It interfered with finding and maintaining jobs, leisure and spending time with family on weekends or during the holidays, traveling inside the country and internationally.

If patients were sick, e.g. had fever, they had also to come for their methadone to RND. In cases of hospitalizations (for AIDS, pneumonia, traumas, etc.), staff of RND transported methadone to health care institutions for the supervised consumption.

The advantage for patients was to continue OST if they were detained in arrest houses. The usual practice was for police officers to escort patients to RND for methadone daily intake.

HIV testing was available free of charge at OST programmes and was offered for patients approximately twice a year. CD4 counts and viral load were also free of charge. Tests for hepatitis C were not available free of charge, neither treatment for hepatitis C.

The staff and patients indicated that random urine screens were performed if decided by clinician, not on a regular basis, usually less than once per month. Positive urine screen tests were followed by discussion with the narcologist and psychologist and possible changes in therapy. Patients were not discharged from MMT upon positive urine screens.
Most of the patients indicated that their mental and physical situation has significantly improved while on OST. Patients indicated they received sufficient medication doses and there was no problem to increase or lower the dose after the communication with a physician.

Generally the atmosphere at RND seemed more relaxed if compared with back in July 2007, services at OST more “user friendly”, the staff more open for communication with patients and more competent in OST. The staff admitted than since June 2007 they were more open in communication with patients and to the methadone dose increase if needed by a patient. The average daily dose was around 70-80 mg of methadone.

At Balti municipal hospital OST programme was opened in April 2007. During consultant’s July 2007 mission there were no patients in OST programme. June 2008 there were 12 patients in OST.

The staff of OST in Balti included two narcologists, a psychologist and a nurse. Differently from RND in Chisinau, first methadone dose administration was not initiated locally in Balti. Instead, patients were sent to RND inpatient department and came back to Balti after 7-10 days with set maintenance dose. Physicians in Balti could not explain the reason for this procedure, though it was clear that this was an obstacle for IDU to be enrolled to OST in Balti.

Physicians and psychologists indicated that the image of OST among IDU in Balti was still low. In spite of great numbers of IDU and absence of waiting lists only few IDU were willing to be enrolled into OST in Balti.

In Chisinau and Balti there were several patients transferred to OST from penitentiary institutions. In penitentiary institutions patients on their release received a signed document, which indicated the duration of participation in OST programme, daily dose of methadone and the date of the last dose. With this document a patient was automatically included to continue OST programme if he lived in Chisinau or Balti. In Balti OST patients, who were detained in arrest houses were able to continue methadone intake as they were escorted by police officers to health care centre as well as in Chisinau.

5. **Provision OST in the Penitentiary Institutions of the Ministry of Justice**

The Republic of Moldova was the first country among CIS countries to introduce OST in penitentiary institutions July 2005.

Since July 2007 there was a little change in the number of patients in OST (20 in 2007 and 26 in 2008). This number is very low if compared with the total number of prison inmates 8,876 and 9.9% of them estimated as potential drug users (Ministry of Justice, 2005, Subata E., 2007).

There were positive changes in the quality of OST and geographical accessibility in penitentiary System. June 2008 OST was available continuously at PI Nr. 16 (“Pruncul”
central hospital), PI Nr. 15 and 18. The new OST program started in PI Nr. 7 for women. In the course of few months there were preparations to open OST in the city Soroki PI Nr. 9.

Differently from July 2007, by June 2008 OST patients started to receive methadone in a decentralized way, i.e. in medical units of PI and not necessarily at central hospital. The enrollment of new patients into OST was decided by the Physician Consultative Commission (PCC) usually with the participation of the specialist from the Penitentiary Department. At the same meeting of PCC the initial dose of methadone was determined, which was usually 20 mg of methadone and then gradually increased. Heads of medical units of PI had possibilities of telephone consultation with specialist at Penitentiary Department. They also increased or decreased methadone doses by 10 mg self-dependently or after the consultation with specialist of the Penitentiary Department. Through frequent visits to PI of the specialist from the Penitentiary Department of the Ministry of Justice more complex clinical and legal problems were solved in medical units.

Another major positive change was the possibility to continue OST with maintenance doses beyond 6 months. Back in June 2007 patients had to reduce gradually their methadone dose during the period of 6 months (Subata E., 2007). This was often complicated by serious withdrawal symptoms experienced by inmates. By June 2008 patients were allowed to sign 12 month contracts for the participation in OST, which could be extended according the needs of the patient without duration limit. Doses of methadone were adequate on the average 60 – 80 mg. Patients were able to receive ARV therapy if needed together with methadone.

Interviews with inmates indicated that they were satisfied with the possibility to receive OST and the possibility change the dose according their health status. As the main positive influence of OST in the long run in prison conditions, they indicted the stabilization of their mood, the reduction of impulsive behavior and increased control of negative emotions, such as anger. Some patients, while being in OST, were able to work in different workshops (e.g. women in sewing workshop in PI Nr. 7).

Some inmates were ordered by court to mandatory treatment for drug dependence in prison. They had a possibility to apply for OST and thus fulfill the requirement of court for mandatory treatment and qualify for the earlier release.

On the release from prison, inmates received a document on their participation in OST, the date and the last dose received and were referred Chisinau or Balti health care institutions to continue OST.

As one of the major reasons which limited the access of IDU to OST in penitentiary institutions, the staff indicated high criteria for the enrollment to OST: only inmates, who had high motivation for abstinence from illegal drugs and with irreproachable behavior were included into OST. The reason behind, was the continuous sensitivity of OST and existing different opinions on the importance of OST in prisons among the PI staff.

The other major reason to refuse the inclusion of IDU into OST programmes in penitentiary institutions was the limited possibility to continue OST after release (only in 2
cities: Chisinau and Balti). Thus inmates from other cities were refused to enter OST because they had no possibility to continue OST after the release.

6. Recommendations for further development of OST in the Republic of Moldova

Mission results showed that if compared with the status of OST back in July 2007 in health care and penitentiary institutions of the Republic of Moldova, significant positive changes could be observed:

- Simplified and decentralized access of IDU to OST programmes in Chisinau;
- Marked increase of patients in OST in one year period (from 17 to around 140 IDU);
- Increased quality of OST programme with better trained staff, more adequate methadone dosing and increased acknowledgment of patients needs in Chisinau and Balti;
- Increased psychosocial support services for OST patients;
- Established cooperation links between health care and penitentiary institutions;
- Possibility to continue OST in arrest houses;
- Increased geographical access of OST in penitentiary institutions with the decentralized initiation of OST;
- Increased quality of OST with adequate dosing and increased individualized approach to the patients’ needs and duration of OST in penitentiary institutions;
- Increased positive attitudes to OST among medical professionals and staff in health care and penitentiary institutions, law enforcement agencies, IDU and inmates of PI.

At the same time by June 2008 there were some areas for potential improvement of OST in the Republic of Moldova:

- Overall OST coverage in the country and OST impact to HIV epidemic remained still very low (coverage less than 1% of estimated number of IDU)
- Geographically accessibility of the OST in the country was still low, with OST programmes available only in Chisinau and Balti; it also significantly limited the continuation of OST among IDU after release from penitentiary institutions;
- In Balti the accessibility of OST was still limited by the practice of obligatory hospitalization of patients in Chisinau in order to start OST;
- OST in health care facilities still lacked full multidisciplinary approach with the employment of professional social workers in the staff;
- Existing practices of OST still interfered with the social reintegration of IDU due to the requirement of daily attendance of health care facility;
- The coverage of IDU to OST in penitentiary institutions was still low.

The previous June 2007 mission report included extensive recommendations on the development of OST in the Republic of Moldova. The results of this short follow-up mission suggest the following recommendations on the further development of OST:
1. Efforts should be continued to increase the accessibility to OST to IDU in the Republic of Moldova, including other cities. Where possible, the existent network and infrastructure of narcological and psychiatry care system should be used.

2. In Balti the access of IDU to OST should be improved by initiating OST on outpatient basis without obligatory hospitalization in Chisinau;

3. The quality of OST programs should be further improved by inclusion of social workers into the staff of OST programmes.

4. Professionals working in OST programs should have access to continuous training on OST and infectious disease prevention and care. National standards/protocols of MMT should be developed based on existing international practice and in the respect of a comprehensive approach;

5. Regulations on OST should be reviewed in order to allow take-home methadone doses for stable patients and/or their relatives in order to facilitate social integration and normal work-leisure cycle of patients. At the same time necessary control measures should be in place to prevent diversion of methadone.

6. A national monitoring and evaluation plan of existing OST programmes in health care system should be developed to prove the positive impact of OST to individual patients and the society in general. Ready available methodologies as recommended by WHO/EMCDDA could be considered in the development and implementation of the monitoring and evaluation plan.

7. To increase further the coverage of IDU with OST in penitentiary institutions by strengthening the capacity of medical units and further developing the competence of staff in OST and HIV prevention and care.
References


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<tr>
<td>Meeting at RND</td>
<td>Balti Municipal Hospital</td>
<td>Eduard Nenescu</td>
<td>Narcologist</td>
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<td>Victor Krivoj</td>
<td>Narcologist</td>
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<td>Balti Municipal Hospital</td>
<td>Aliona Chubanu</td>
<td>Psychologist</td>
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<tr>
<td>June 19, 2008</td>
<td>Department of Penitentiary Institutions of</td>
<td>Georgi Caluian</td>
<td>General Director</td>
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<tr>
<td>the Ministry of</td>
<td>the Ministry of Justice</td>
<td>Viktor Vovk</td>
<td>Head of</td>
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<tr>
<td>Event Description</td>
<td>Location</td>
<td>Participants</td>
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<tr>
<td>Meeting at Republican Clinical Hospital “Pruncul” of the Department of Penitentiary Institutions with the staff of MMT and inmates (5 persons, 2F/3M)</td>
<td>Republican Clinical Hospital “Pruncul”</td>
<td>Oleg Istratuc (Chief Specialist, Psychiatry and Narcology Specialist), Vasile Sorocianu (Psychiatrist)</td>
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<tr>
<td>Meeting at Penitentiary Institution Nr 7, discussion with staff and patients (5 patients, all female)</td>
<td>Penitentiary Institution Nr 7</td>
<td>Lidia Marandich (Head of the Hospital)</td>
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<td>Meeting at Penitentiary Institution Nr. 15,</td>
<td>Penitentiary Institution Nr. 15</td>
<td>Natalija Chioran (Head of the Medical Unit)</td>
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<td>Interviews with inmates (10 persons, all male)</td>
<td>Penitentiary Institution Nr. 15</td>
<td>Vladimir Trofim (Director), Konstantin Byrka (Head of the Medical Unit)</td>
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