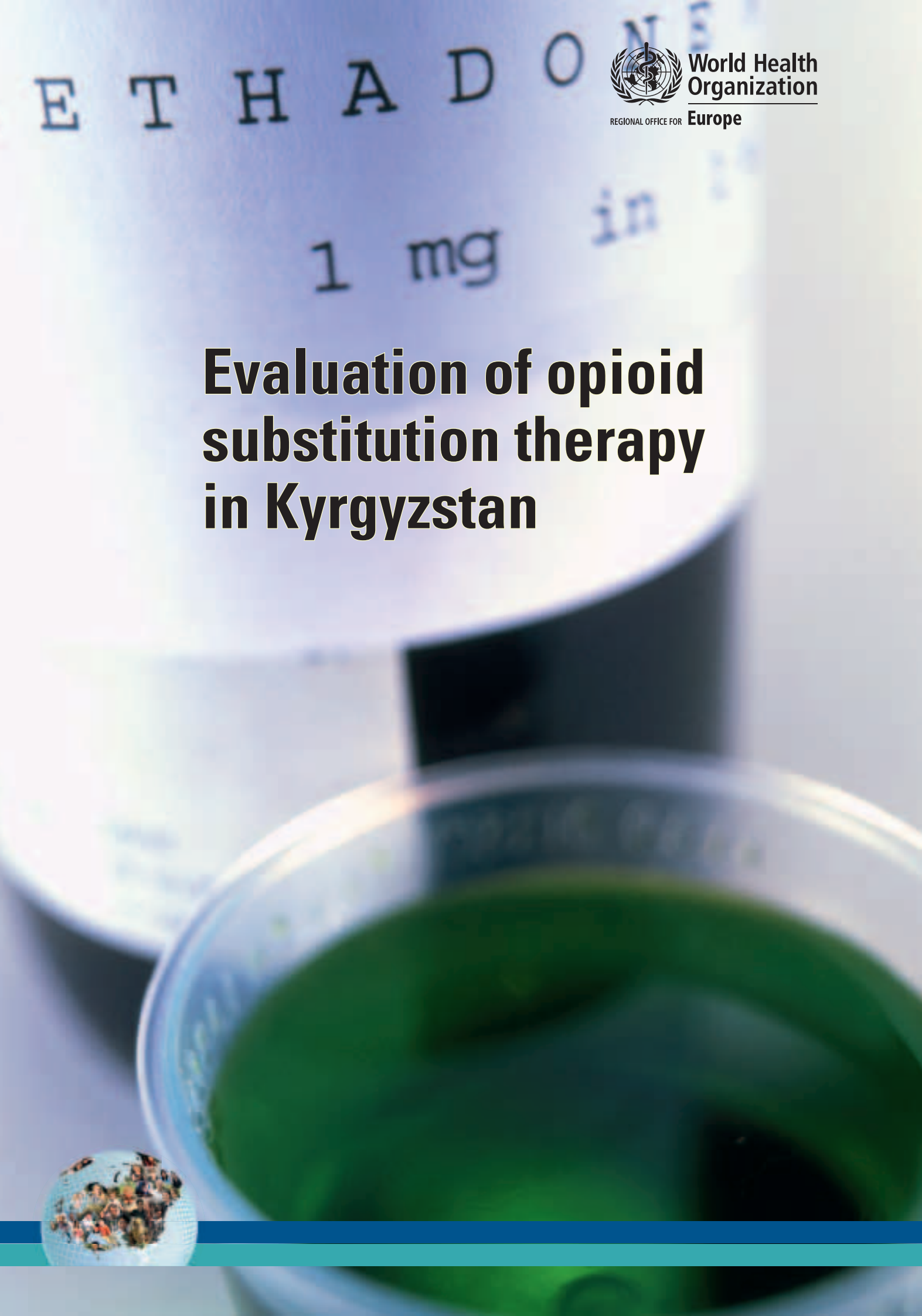

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Evaluation of opioid substitution therapy in Kyrgyzstan

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2016

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ABSTRACT
An evaluation of the opioid substitution therapy (OST) programme in Kyrgyzstan took place from 15 to 19 June 2015. This evaluation was a follow up of the previous one by a World Health Organization (WHO) mission in 2008. A delegation from the WHO Regional Office for Europe met with representatives of the Government, Drug Control Agency, Ministry of Health, Ministry of Justice, United Nations agencies, international nongovernmental organizations (NGOs), staff of drug treatment services and NGOs. Mission members conducted focus group discussions and one-on-one interviews with injecting drug users at several OST sites.

This evaluation explored how the country had implemented the recommendations from the earlier evaluation in 2008. The WHO mission developed further recommendations on the sustainability of OST, how to increase its accessibility, and improve its quality in the civil and penitentiary sectors.

Keywords
OPIOID SUBSTITUTION THERAPY
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August 2016

Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
Global Fund	Global Fund to fight AIDS, TB and Malaria
GSIN	Government Service for Implementation of Penalties
HCV	hepatitis C virus
ICAP	International Center for AIDS Care and Treatment Programs
MDR-TB	multidrug-resistant tuberculosis
MoH	Ministry of Health
NGO	nongovernmental organization
NSP	needle–syringe programme
OST	opioid substitution therapy
PLHIV	people living with HIV
PWID	people who inject drugs
RNC	Republican Narcological Center
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Foreword

This report is based on a mission conducted in June 2015 by the World Health Organization (WHO) to evaluate the opioid substitution therapy (OST) programme in Kyrgyzstan. The report is a follow up of the initial evaluation conducted by WHO in 2008.

The Government of Kyrgyzstan, United Nations (UN) and other international donor organizations, and local nongovernmental organizations (NGOs) have invested considerable financial and human resources in a sustained and coordinated manner to expand OST in the civil and penitentiary sectors during the period 2008–2015. The overall number of OST sites have increased more than twofold, and continues to increase. The Ministry of Health (MoH) continues to implement OST in a geographically decentralized manner. Narcological services and other health institutions have further strengthened linkages with services for the care and treatment of HIV, tuberculosis (TB) and sexually transmitted infections (STIs). The penitentiary sector has significantly increased access to OST in prisons.

There is a high risk that the achievements made by the OST programme will not be sustainable in the future. In the period 2008–2015, OST remained fully dependent on donor funding, with minimal involvement of the Government.

This report gives a number of recommendations to the MoH, the Ministry of Internal Affairs, Ministry of Justice and the State Drug Control Agency as well as for the Mandatory Health Insurance Fund in order to continue and improve OST in Kyrgyzstan.

Gauden Galea
Director, Noncommunicable Diseases and Promoting Health through the Life-course
WHO Regional Office for Europe

Executive summary

In June 2015, the World Health Organization (WHO) conducted an evaluation of the opioid substitution therapy (OST) programme in Kyrgyzstan. This was a follow up of the initial evaluation conducted by a WHO mission in 2008. It showed that the Government of Kyrgyzstan, United Nations (UN) and other international donor organizations, and local nongovernmental organizations (NGOs) had invested considerable financial and human resources in a sustained and coordinated manner to expand OST in the civil and penitentiary sectors during the period 2008–2015. The overall number of OST sites increased more than twofold, from 13 in 2008 to 31 in 2015, and continues to increase. The number of those receiving OST among people who inject drugs (PWID) increased from 729 to around 1200. The proportion of patients with HIV infection and receiving antiretroviral therapy (ART) while being on OST is continuously increasing. The MoH continues to implement OST in a geographically decentralized manner. Narcological services and other health institutions have further strengthened linkages with services for the care and treatment of HIV, tuberculosis (TB) and sexually transmitted infections (STIs). The penitentiary sector has significantly increased access to OST in prisons; OST was available in half (eight) the institutions. The Ministry of Health (MoH) has succeeded in introducing and maintaining a low-cost supply of medicines for OST.

As indicated by many stakeholders, by 2015, OST in Kyrgyzstan remained poorly integrated into the mainstream health system and existed as a donor-funded project. The coverage of PWID with OST was less than the minimum (18% as against the minimum 20%) recommended by WHO, United Nations Office on Drugs and Crime (UNODC) and Joint United Nations Programme on HIV/AIDS (UNAIDS).

There is a high risk that the achievements made by the OST programme will be not sustainable in the future. In the period 2008–2015, in spite of the recommendations by WHO, OST remained fully dependent on donor funding, with minimal involvement of the Government. Different sectors of the Government (health care, law enforcement, penitentiary) did not openly voice their knowledge and belief of the benefits of widely accessible OST and social inclusion of PWID for public health and safety.

The 2015 WHO mission made the following recommendations:

For the Ministry of Health

1. Together with the law enforcement sector, develop the legal frameworks that will allow the law enforcement sector to refer PWID arrested for minor drug offences for treatment rather than imprisonment.
2. Revise job descriptions of the staff engaged in providing narcological services and integrate OST into their everyday functions.
3. Further strengthen linkages between programmes and services for OST and HIV, TB, viral hepatitis C, and STI treatment and care, and integrate OST services into existing family medicine centres, TB and HIV care institutions, and infectious disease "hospitals"
4. Improve the quality of OST services by ensuring adequate dosage, assessing individual patient needs and planning treatment, adopting a multidisciplinary approach, and coordinating services to individual patients through case management. Continue monitoring the effectiveness at the programme level, and ensure the availability of a system of continuing education for staff.
5. Replace the "narcological registration system", which is a great barrier for PWID to enter treatment, with a national case-based statistical database for multifunctional purposes: to monitor trends in drug use, and the demand for and effectiveness of drug treatment.

For the Ministry of Internal Affairs, State Drug Control Agency, and Ministry of Justice

6. Develop consistent policies that will make it easier for PWID to access effective drug treatment and experience social inclusion. Adopt legal acts that will allow stable OST patients to use methadone at home on a routine basis in order to ensure their better social integration.
7. Initiate OST for temporary imprisoned OST clients in detentions centres based on Agreement between Ministry of Internal Affairs and the MoH.

For the Mandatory Health Insurance Fund

8. In cooperation with the Ministry of Finance, develop a model of funding for OST services from the Mandatory Health Insurance Fund. Given that work with PWID is time consuming and stigmatized for many specialists and medical institutions, the model of funding should motivate health-care institutions (AIDS and TB centres, infectious disease hospitals, family medicine centres, etc.) to enroll and provide effective medical and social services to as many

patients as possible.

For the Government Service for Implementation of Penalties (GSIN)

9. Continue efforts to make OST accessible to PWID in all prisons; ensure as wide a spectrum as possible of effective drug interventions in prisons, such as needle–syringe programmes, detoxification and psychosocial treatment and rehabilitation.
10. Continue to provide integrated services to PWID with HIV and TB in all prisons.
11. Develop funding models from the Government budget.
12. Introduce OST into the routine work of prison medical staff.

For WHO and other UN and international/donor organizations

13. Support the MoH and GSIN in developing effective funding models for OST from the national budget; models that would motivate health-care institutions to provide not only OST but also HIV and TB care in an integrated way, and provide necessary psychosocial support.
14. Continue to work with different governmental sectors and advocate for financial commitment by the Government to existing OST programmes.
15. Carry out an independent and objective evaluation of the estimated number of PWID and compare it with the overall trend of PWID in the region/subregion to support the OST effectiveness study in Kyrgyzstan.

For Nongovernmental organizations and communities

16. Enhance collaboration with OST programme and relatives of OST clients, provide psychosocial and outreach support.

Background and objectives

The World Health Organization (WHO) recognizes opioid substitution therapy (OST) as an effective pharmacological treatment for opioid dependence. In 2009, WHO published global guidelines on OST *(1)*.

OST is also an effective tool for preventing HIV among people who inject drugs (PWID). In addition, it is effective in increasing the adherence of PWID with HIV/AIDS to antiretroviral therapy (ART). WHO, the United Nations Office on Drugs and Crime (UNODC) and Joint United Nations Programme on HIV/AIDS (UNAIDS) have thus included OST as one of the key components of the comprehensive package of HIV prevention, care and treatment among PWID *(2)*.

Kyrgyzstan was the first country in Central Asia to initiate a pilot OST programme in 2002. By 2006, the country had implemented pilot OST programmes in two centres (Bishkek and Osh), with less than 150 patients. The evaluation mission conducted by the United Nations Development Programme (UNDP) in 2006 *(3)* concluded that during the pilot phase of the OST programme from 2002 to 2006, the Ministry of Health (MoH) with partners implemented OST with methadone in a comprehensive way, in cooperation with different medical institutions and nongovernmental organizations (NGOs). The report recommended further decentralized expansion and specifically the introduction of OST in the penitentiary system.

From 2006, the MoH began expanding the OST programme geographically and decentralizing it to the civil sector by introducing OST sites at family medicine centres at the primary health-care level, as well as at AIDS and tuberculosis (TB) treatment facilities. In 2008, the Ministry of Justice introduced a pilot OST project in prison No. 47. From 2008 to 2011, the WHO Regional Office for Europe did an outcome evaluation study on the OST pilot project in prison. The study demonstrated the effectiveness of OST in reducing drug use in prisons, reducing the risk of HIV transmission through injecting practices, and improving the quality of life of inmates *(4)*. The positive findings from the evaluation paved the way for the Ministry of Justice and subsequently the Government Service for Implementation of Penalties (GSIN) to expand OST in prisons.

The MoH, UN agencies and international donors might consider the overall expansion of OST services in the civil and penitentiary sectors during 2002–2015 as a "success story", especially given the harsh context of post-Soviet economic, social and political realities. Nevertheless, key stakeholders raise serious questions about the sustainability of these achievements in Kyrgyzstan in the future, especially as the main funding organization, the Global Fund to Fight AIDS, TB and Malaria (Global Fund), announced the decision to reduce its financial contribution to the region in the near future, and gradually hand over funding of HIV prevention and treatment programmes to national governments.

International and national stakeholders of the OST programme identify several important risk factors for the sustainability of OST in Kyrgyzstan. First, in 2015, OST remains funded solely by donor organizations, mainly the Global Fund. There is no political consensus at the legislative and government levels on OST as an important public health intervention that significantly reduces the rates of HIV, TB (including multidrug-resistant TB [MDR-TB]), viral hepatitis C (HCV), sexually transmitted infections (STIs) and deaths due to opioid overdose. The law enforcement sector has not yet realized the potential advantages of and opportunities for effectively suppressing the illegal heroin market by enrolment of a large proportion of opioid-using individuals to OST programmes. In developed countries in Europe, 50–70% of opioid-dependent persons are in OST programmes with methadone or other medications. Inclusion of a large proportion into OST programmes would significantly reduce the demand for illegal heroin.[1] Neither the Ministry of Interior nor Ministry of Justice has so far recognized the great potential of OST to increase public safety, and reduce general criminality and incarceration rates. The financial commitment from the Government to the implementation and expansion of OST in the civil and penitentiary sectors has been minimal over the past 13 years.

Second, many informants expressed serious concern about the future of OST in Kyrgyzstan, because the country was planning to join the Eurasian Economic Treaty. Within the Eurasian Economic Treaty, the country will develop close political and economic ties with the Russian Federation. Key stakeholders opined that this could significantly impact on national drug policy.

The objective of the present evaluation mission by the WHO Regional Office for Europe in June 2015 was to follow up on the previous WHO evaluation of the OST programme in October 2008 *(6)*. The mission's objectives were (i) to review implementation of the

recommendations of the previous mission (2008), and (ii) to assess the progress and achievements, as well the remaining gaps and challenges. The mission also aimed to develop further recommendations for the Government of Kyrgyzstan (namely, the MoH and GSIN) on increasing the sustainability of OST, as well as improving its access and quality in the civil and penitentiary sectors.

[1] *Chinese experts estimated that the rapid expansion of OST programmes in 2008–2009 reduced the turnover of illegal heroin to the value of US$ 939 million and US$ 1.24 billion per year, respectively (5).*

Methodology

The mission focused on following up implementation of the recommendations of the previous mission, which the WHO Regional Office for Europe released in 2009 *(6)*. Therefore, the present mission used the same evaluation methodology as in 2008. For consistency reasons, the present WHO mission report retained the same structure as the 2008 WHO mission report.

The evaluation team undertook a field mission to Kyrgyzstan from 15 to 19 June 2015 and met with representatives of the Government, Drug Control Agency, MoH, GSIN, UN agencies, international organizations, staff of drug treatment services and NGOs. Mission members attended focus group discussions and interviews with PWID and staff at several OST sites. Information obtained through meetings with policy-makers, stakeholders and PWID was of a qualitative nature. The report used data from the review of relevant documentary sources, particularly findings and recommendations of the WHO Regional Office for Europe report "HIV/AIDS programme in Kyrgyzstan: evaluation report 2014" *(7)*. As in the previous WHO report, limitations of the mission relate to the limited number of key informants and institutions visited during the short period of the mission.

HIV and illegal drug use situation in Kyrgyzstan

As of November 2014, health authorities of Kyrgyzstan officially registered 5642 people living with HIV (PLHIV), of which 68% were male *(7)*. In total, 1140 of all registered PLHIV had died; 681 cases had progressed to AIDS, of which 328 had died. Overall, the HIV prevalence remains low in the general adult population (estimated at 0.2% in 2013) *(7)*. However, Kyrgyzstan is one of seven countries in the world with the fastest-growing epidemics over the past 10 years, peaking in 2012 with 724 new cases of HIV reported. In 2013 alone, 504 new cases of HIV were registered (292 males, 211 females). The transmission route in 58% of cases was injection drug use in 2013 (down from 72% in 2008). Nevertheless, injection of illegal drugs remains the major route of transmission of HIV infection.

By 2014, 6358 opioid-dependent persons were officially registered in health-care institutions.[2] The estimated number of PWID in Kyrgyzstan was 25 000 in 2014 *(8)*. Some of the key informants said that the number of new PWID had decreased in the past years. However, the mission could not identify relevant documents to verify this assumption. Neither did the mission find evidence of a substantial increase in injecting of other substances (e.g. stimulants, etc.).

[2] *Data from the Republican Narcological Centre*

Access to opioid substitution therapy in Kyrgyzstan

As indicated by the WHO mission in 2008, by October of that year, there were a total of 13 OST sites in Kyrgyzstan, with 729 patients overall. There was no waiting list for patients to enter OST at that time.

Following the recommendations of the 2008 WHO mission, the MoH has significantly increased the number of OST sites, including opening OST sites in a geographically decentralized manner at the family medicine centres at the primary health-care level. By May 2015, the overall number of sites had more than doubled and reached 31. The overall number of OST patients was 1209 (103 women).[3] Three hundred fifty-nine or 30% of OST patients received methadone in prisons. In November 2014, the WHO mission found that the total number of OST patients was 1424[4] *(7)*. As in 2008, in 2015 too there was no waiting list and PWID could start OST within of couple of days.

In spite of the significant increase in the number of patients on OST from 2008 to 2015 (a 61% increase), the coverage of PWID with OST services is still low (18%).[5]

One group of barriers for PWID to access OST includes factors that make OST unattractive for PWID as a treatment option because of the poor service quality. Other factors include the following:

- inadequate regulation on take-home medications;
- compulsory registration at narcological centres, followed by serious limitation in finding a job or obtaining a driving license in subsequent years, risk of losing custody of one's children, and compromised confidentiality;
- lack of psychosocial support according to individual needs;
- negative attitudes of medical staff towards patients;
- inadequate doses of medication, etc. *(7)*.

Quality issues are discussed below.

Another group of barriers relates to law enforcement practices. In spite of the official regulations and recommendations, the interviews conducted in 2015 by the NGO Socium with 765 OST patients found that at some OST sites, police harass patients or even detain them without reason.[6] Interviews with OST patients, NGOs and outreach workers confirm these practices on the ground.[7] NGOs provide OST sites with video equipment to monitor and document potential harassment by the police around the premises, and provide legal aid.

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[3] *Data from the Republican Narcological Centre*

[4] *Of whom 25% received methadone in prisons*

[5] *WHO/UNODC/UNAIDS mid-level indicator is 20–40%; below 20% is a low-level indicator (2).*

[6] *Report on the survey conducted among methadone substitution therapy clients and PWID in the territory of Kyrgyzstan. Public Fund "Socium", 2015 (unpublished document).*

[7] *Smirnov P, Braga M, Boiko K. [Report on the technical support in Kyrgyzstan]. The Regional Center for Technical Support in Eastern Europe and Central Asia, 2014 (in Russian, unpublished document).*

Organization of methadone supply to drug treatment service centres and costs

The "Clinical protocol on substitution methadone maintenance therapy" (MoH, Ministry of Justice, 2008) included requirements for pharmacists to prepare methadone solution. From the start of OST in 2002, the MoH introduced production of medication in licensed pharmacies from the raw material (methadone powder). As noted by the WHO mission in 2008 *(6)*, this practice ensured possibly the lowest price of medication in Central Asia and the former Soviet Union. The daily dose of 80 mg methadone costs as little as US$ 0.10. In 2015, the MoH had maintained this exemplary model of supply and kept the cost of medication low. Other evaluations found that by 2012, 100 mg of methadone cost US$ 0.28, or only US$ 102 per patient per year *(9)*.

The low cost of medication significantly increases the potential for sustainability of the OST programme and funding of OST from the Governmental budget in Kyrgyzstan. WHO missions have recommended that the country's experience in procuring medications for OST at low cost serve as a model for other countries *(10)*.

Funding for OST

By June 2015, all OST sites were dependent solely on external funding, with minimal involvement of the MoH. Thus, the funding situation had not changed since 2008. The Global Fund remained the main donor. By 2015, the US Centers for Disease Control and Prevention[8] funded the establishment and functioning of four OST sites (two in the civil sector and two in prisons), including innovative sites at a TB dispensary and prison No 31. ICAP[9] is another organization that develops innovative OST projects in Kyrgyzstan.

By 2015, OST remained poorly integrated into mainstream narcological services. Provision of OST has not been included in the regular job description of physician narcologists. OST, as in 2008, remained a donor-funded project-based activity in narcological and other medical institutions. Integration into the existing health-care system and potential for sustainability were poor.

[8] *Division of Global HIV/AIDS, U.S. Centers for Disease Control and Prevention (CDC)*

[9] *International Center for AIDS Care and Treatment Programs (ICAP). Global. Health. Action. Columbia University, Mailman School of Public Health*

The quality of OST service provision

As indicated in the WHO mission report in 2008 *(6)*, the MoH approved the first clinical protocol on methadone substitution maintenance therapy (MoH, Ministry of Justice) in 2008. This clinical protocol was essential in setting minimal and equal service quality standards for health-care institutions in the civil and penitentiary sectors, including the procedure for methadone supply. Next, extensive clinical guidelines for organizations that implement OST were approved by the MoH in 2010 *(11)*. By 2015, a working group of national experts developed the draft of the new comprehensive clinical protocol based on the WHO guidelines of 2009 .

The 2008 WHO mission appreciated that medical institutions implemented OST in a comprehensive way, and made efforts to establish linkages with the HIV, TB and STI services. By 2015, linkages with the HIV, TB and STI services were further developed. It is worth mentioning specifically that HIV testing with rapid HIV tests was introduced at the Republican Narcological Center, which significantly increased the accessibility of HIV testing for OST patients and other PWID. Mobile HIV testing units at needle–syringe programme (NSP) sites were important in significantly improving the access of PWID to HIV testing.

By 2008, as the previous mission found, there were 95 HIV-infected patients (13%) on OST, and three on ART (all in Bishkek). By May 2015, there were 290 OST patients with HIV infection (24% of the total number of OST patients), of which 183 were receiving ART (15%).

During recent years, the MoH with the support of international donors, has introduced innovative integrated service delivery models at some OST sites, which include OST, HIV and TB care and treatment, and better psychosocial support. By 2015, several OST sites provided integrated services to PWID, combining and coordinating services providing OST, and HIV and TB care and treatment. These sites were at Bishkek city TB hospital, Osh city territorial clinical hospital, Bishkek city Center for prevention and fight with AIDS, prisons No. 2 and No. 31. Several other OST sites have implemented coordinated referral systems for OST patients.

Back in 2008, as indicated by the WHO mission, the administration of health-care institutions and medical staff provided methadone for home use for two or more days on a case-by-case basis. Medical institutions used to give methadone to a family member with his/her signature. There was a joint regulation approved by order 56 of 08.02.2007 of the MoH and Order 15 of 14.02.2007 term 5.2 of the State Drug Control Agency, which allowed health-care institutions to give two daily doses of OST medicines. Nevertheless, this practice was very limited and applied as an exception rather than the rule. The need to repeatedly attend OST sites, even for stable patients in remission, was one of factors that made OST less attractive to PWID. OST unavoidably but severely interfered with the normal social functioning of the individual. By 2015, the situation had not changed. OST sites still applied this practice as an exception, not

the rule. Without proper legal regulation, there was the risk to patients and their relatives of the police harassing them for illegal possession of controlled medicines. Due to the absence of a normal life and the likelihood of attending the OST site 1–3 days per week, OST remains unattractive for many PWID (especially in the earlier stages of dependence). The current model of OST delivery creates barriers to higher retention rates in therapy and patients' social integration.

The 2008 WHO mission report found that patients generally did not complain about the staff and their flexibility in increasing or decreasing the daily methadone dose. The 2014 WHO evaluation report *(7)* indicated that the average methadone dose in five OST sites was lower than 60 mg (60–120 mg is recommended by WHO as the average effective daily dose). Other evaluations (ICAP 2012) confirmed inadequate dosing practices at different sites *(9)*. The practice of suboptimal dosing had implications for common and intensive use of illegal psychoactive substances,[10] and reduced retention in therapy. Apparently, in 2015, the quality of services and dosing practices differed at OST sites, and there was potential for clinical improvement in some of the OST sites.

In the 2008 report, the WHO mission recommended implementing routine monitoring of the outcomes of OST and making it an integral part of every OST site. The WHO mission developed as an example a short data collection tool for outcome evaluation, did an evaluation and published positive results in 2009 *(12)*. Following this recommendation, the latest version of the national clinical protocol on OST contains several short tools for continuous assessment of OST outcomes in patients and measuring improvement in treatment:

1) questionnaire for assessing the risk of infection with HIV;
2) scale to determine a patient's psychological distress; and
3) questionnaire to determine the severity of addiction.

After the MoH approves of the clinical protocol, these tools would be convenient for the routine monitoring of patient improvement on OST. Some of them are already in use at different OST sites.

The WHO mission in 2008 indicated that OST staff was not always aware about the availability of naloxone for the prevention and treatment of opioid overdose. By 2015, naloxone was widely used for the prevention and treatment of opioid overdose. Naloxone was available in all OST sites, emergency services and in NSP sites. In addition, the NSP distributed naloxone on a project-to-project basis to PWID clients (in total 3000 ampules in 2012).[11]

The WHO mission in 2008 welcomed a multidisciplinary approach, where social workers worked in the team with narcologists and in collaboration with family medicine centres. From 2008 to 2015, many OST sites that opened were geographically close to family medicine centres. Nevertheless, the MoH did not organizationally integrate OST in services at the primary health-care level. OST services remained organizationally a project of the vertical and centralized narcological service with a low level of sustainability.

The WHO mission (2008) recommended that the MoH develop a training module for OST and increase the capacity of multidisciplinary health-care providers (OST staff, family physicians and infectious disease specialists) through delivering continuous training by local experts. The WHO mission in 2015 could not identify such a training module and its application in a systematic way for training of OST staff. Other evaluations (ICAP 2012) found that most narcologists thought that they needed broader training *(9)*. Narcologists were trained through different workshops in the country and abroad. Most of the nurses did not undergo formal training courses. The WHO mission appreciated that non-narcologists (e.g. TB specialists, infectious disease specialists) received good training in OST, which enabled them to diagnose opioid dependence, provide OST, and care for HIV and TB infections.[12]

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[10] *Most often heroin, sedatives and antihistamine medications*
[11] *Personal communication at the Republican Narcological Centre by the Director of the Centre, 16 June 2015*
[12] *Initiative supported by the CDC*

OST in the penitentiary system

In August 2008, prison No. 47 (central prison hospital) started the first pilot OST programme in Central Asia. The WHO mission inspected the pilot OST programme on 15 October 2008 and appreciated its organizational and clinical performance. The WHO mission in 2008 also appreciated the existence of a spectrum of services for PWID in prison No. 47, which included NSP, OST, opioid withdrawal treatment and psychosocial therapy in the residential "Atlantis" programme.

The WHO mission in its 2008 report recommended finishing the OST outcome study. If the findings were positive, it recommended considering expansion of OST into other prisons. The WHO outcome evaluation study of the pilot OST project in prison *(4)* provided solid evidence on the effectiveness of the OST programme in prison No. 47, such as decreased injecting of substances among inmates, reduced risk of HIV transmission, better quality of life and improved health status.

By June 2015, the WHO mission found that there were eight OST sites in prisons (out of 16 prisons) with nearly 400 patients or nearly one third of the overall OST patient number. In 2015, GSIN planned to open another OST site. By 2015, OST was already available for women (prison No. 2) and for patients with TB and infectious diseases (prison No. 31), including patients infected with MDR-TB. In prison No. 31, roughly half of those on OST had started OST in prison (total 88) in May 2015. Of these, 29 out of the total number of 30 HIV-infected patients, or one third, received both OST and ART.

A TB physician was in charge of diagnosing opioid dependence and prescribing methadone in this prison. She received a training course on OST. She also provided ART for HIV patients and anti-TB treatment for TB patients. For some of her patients, she prescribed high doses of methadone (higher than 200 mg) due to the interaction of anti-TB and antiretroviral (ARV) medications with methadone. Medical staff did not communicate any serious incident during the course of implementation of OST in prison for patients with multiple and serious health conditions.

Availability of OST in remand prisons allowed continuous use of OST for inmates in different phases of detention. After release, prison staff referred patients for continuation of OST in health-care institutions in the civil sector.

The mission found that prison No. 31 offered a range of different services for PWID: NSP, OST, short-term residential psychosocial treatment ("Atlantis") and long-term drug-free community with social integration. The staff of prison No. 31 reported that the need for naloxone to treat opioid overdose had significantly reduced after methadone became widely available in this prison. The wide spectrum of different services in one penitentiary – integration of drug dependence, HIV and TB care and treatment – serves as a model for other prisons in Kyrgyzstan and the Central Asian region.

Conclusions and recommendations on the development of OST in Kyrgyzstan

The follow-up evaluation of OST by WHO in 2015 showed that the Government of Kyrgyzstan, UN and international donor organizations, and local NGOs had invested considerable financial and human resources on expanding OST services in the civil and penitentiary sectors during the period 2008–2015. The overall number of OST sites increased more than twofold, from 13 in 2008 to 31 in 2015, and continues to increase. The number of PWID on OST increased from 729 to around 1200 during this time. The proportion of patients with HIV infection and receiving ART while being on OST is increasing. The MoH continued to implement OST in a geographically decentralized manner. Narcological services and other health institutions further strengthened linkages with services for HIV, TB and STI care and treatment. The penitentiary sector has significantly increased access to

OST in prisons, and OST was available in half (eight) of its 16 institutions. The MoH succeeded in introducing and maintaining a low-cost supply of medicines for OST.

As indicated by many stakeholders, by 2015, in Kyrgyzstan, OST remained poorly integrated into the mainstream health system, and existed as a donor-funded project. The coverage of PWID with OST (18%) was less than the minimum (20%) recommended by WHO, UNODC and UNAIDS. There is a high risk that the tremendous achievements made in developing the OST programme will not be sustainable in the future. From 2008 to 2015, in spite of WHO recommendations, OST remained fully dependent on donor funding with minimal involvement of the Government. Different sectors of the Government (health care, law enforcement, penitentiary) did not openly voice their knowledge and belief of the benefits of widely accessible OST and social inclusion of PWID for public health and safety.

The WHO mission in 2015 made the following recommendations:

For the MoH

1. Together with the law enforcement sector, develop the legal frameworks that will allow the law enforcement sector to refer PWID arrested for minor drug offences for treatment rather than imprisonment.
2. Revise job descriptions of the staff engaged in providing narcological services and integrate OST into their everyday functions.
3. Further strengthen linkages between programmes and services for OST and HIV, TB, viral hepatitis C, and STI treatment and care, and integrate OST into existing family medicine centres, TB and HIV care institutions, and infectious disease hospitals. Improve the quality of OST services by ensuring adequate dosage, assessing individual patient needs and planning treatment, adopting a multidisciplinary approach, and coordinating services to individual patients through case management. Continue monitoring the effectiveness at the programme level, and ensure the availability of a system of continuing education for staff.
4. Replace the "narcological registration system", which is a great barrier for PWID to enter treatment, with a national case-based statistical database for multifunctional purposes: to monitor trends in drug use, and the demand for and effectiveness of drug treatment.

For the Ministry of Internal Affairs, State Drug Control Agency, and Ministry of Justice

5. Develop coherent policies that will make it easier for PWID to access effective drug treatment and social inclusion, and adopt legal acts that will allow stable OST patients to use methadone at home on a routine basis in order to ensure their better social integration.

For the Mandatory Health Insurance Fund

6. In cooperation with the Ministry of Finance, develop a model of funding for OST services from the Mandatory Health Insurance Fund. Given that work with PWID is time consuming and stigmatized, for many specialists and medical institutions, the model of funding should motivate health-care institutions (AIDS and TB centres, infectious disease hospitals, family medicine centres, etc.) to enrol and provide effective medical and social services to as many patients as possible.

For the GSIN

7. Continue efforts to make OST accessible to PWID in all prisons; ensure as wide spectrum as possible of effective drug interventions in prisons, such as NSPs, detoxification and psychosocial treatment/ rehabilitation.
8. Continue to provide integrated services to PWID with HIV and TB in all prisons.
9. Develop funding models from the Government budget.
10. Introduce OST into the routine work of prison medical staff.

For WHO and other UN and international/donor organizations

11. Support the MoH and GSIN in developing effective funding models for OST from the national budget; models that would to motivate health-care institutions to provide not only OST but also HIV and TB care in an integrated way, and provide necessary psychosocial support.
12. Continue to work with different governmental sectors and advocate for financial commitment of the Government to existing OST programmes.
13. Carry out independent and objective evaluation of the estimated number of PWID and compare with the overall trend of PWID in the region/subregion to support the OST effectiveness study in Kyrgyzstan.

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