Opioid substitution treatment services assessment in Moldova

2016

The evaluation of opioid substitution treatment services in Moldova was conducted under the program "Strengthening the HIV control in Moldova, 2015 - 2017", financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and implemented by the Centre for Health Policies and Studies in collaboration with the Republican Narcological Dispensary.

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Acknowledgment:

The author would like to express his gratitude to Ms. Liliana Caraulan and Ms. Tatiana Cotelnic (PAS Centre) for their efforts and valuable support during the preparation and conduct of the assessment mission. The author was truly pleased with professionalism, competence and commitment of Mss. Caraulan and Cotelnic.

The author wishes to express sincere appreciation to all individuals who participated in individual interviews and focus group discussions, and who contributed their time and efforts to this evaluation.

CONTENTS

ACRONYMS

AIDS	-	Acquired immunodeficiency syndrome
ARV	-	Anti-retroviral treatment
FSW	-	Female sex workers
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	-	General practitioner
HCV		Hepatitis c virus
HIV	-	Human immunodeficiency virus
IBBS	-	Integrated bio-behavioural surveillance
M & E	-	Monitoring and evaluation
MSM	-	Man having sex with man
NGO	-	Non-governmental organization
NSP	-	Needle and syringe program
PAS	-	Centre for Health Policies and Studies
PWID	-	People who inject drugs
RND	-	Republican Narcological Dispensary
OST	-	Opioid substitution treatment
TB	-	Tuberculosis
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNODC	-	United Nations Office on Drugs and Crime
WHO	-	World Health Organization

EXECUTIVE SUMMARY

This evaluation was commissioned by the Centre for Health Policies and Studies (PAS) and aimed at assessing opioid substitution therapy program in Moldova (in community and prison) and developing recommendations for improving effectiveness, quality and coverage of OST, including program coordination, program M&E, accessibility, availability and sustainability of OST. The evaluation methodology comprised a mix of site visits, face-to-face interviews, focus group discussions, desk-based research and review of existing reports and secondary data. Consultant's approach to the evaluation was issue-driven with a high degree of participation by all key stakeholders. Methodological and data source triangulation was utilized for data analysis. Site visits were conducted in July 2016.

There has been remarkable development with OST provision in Moldova over the last two years. Six new OST sites were opened in 2015-2016 in civic sector and two in penitentiary system. For the time of evaluation substitution treatment with methadone was provided through 9 sites in 7 cities in general setting, and in 13 penitentiary establishments (out of 17 existing in the country). The major advancement has been the revision of the national clinical protocol on Pharmacological Treatment of Opioid Dependence with Methadone. The protocol includes algorithm for the initiation and provision of methadone, describes staffing requirements for the provision of treatment, and supports integration of psychosocial component into the treatment.

Evaluation findings indicate that OST results in visible reduction in injection drug use, reduction in injection risk behaviour, reduction in drug related and other criminal behaviour, and contributes to improved social functioning, increased employment, and overall higher quality of life of many patients enrolled in this treatment in Moldova. However, due to low coverage (less than 3% of estimated people who inject drugs) this intervention has had so far limited impact on both, prevalence of injection drug use and rates of blood born infections among drug injectors and in general population in the country.

Recommendations proposed as a result of this evaluation aim for creating an environment that should allow for scaling up the coverage of OST in Moldova, improving its quality, and for making this treatment accessible and attractive for those who should ultimately benefit from it. However, the critical part of the reforms should aim for broader systematic changes in the field of narcology (addiction medicine) in Moldova.

- Ministry of Health and Republican Narcological Dispensary should consider abandoning the system of narcological registration. The system as it stands for now does not serve any public health purpose and is unjustified waste of financial and human resources. Most importantly, narological registration is a

major barrier that prevents people with substance use related problems from seeking assistance and applying for narcology services, including for opioid substitution treatment.

- Ministry of Health, RND, National Health Insurance Fund and Centre PAS should consider expanding OST to new locations. In small cities and remote places where there are no narcologists to engage with OST on a daily bases, the OST may be integrated into the existing infrastructure of primary health care centers. In addition, one of the options for OST expansion and coverage of patients in remote locations could be implementation of a mobile methadone dispensing unite. New clients can be admitted to OST through the main site and then could be served via mobile unite that could also provide harm reduction services (needle exchange, rapid HIV testing, counselling).

- RND should encourage doctor-narcologists to utilize take-home dosing more actively. This would allow for expanding the coverage of program and would attract patients that currently restrain from entering OST due to distant location from treatment sites and/or those who might be employed and do not wish treatment to interfere with their work schedule. In addition, more active implementation of home dispensing will lessen the workload of medical staff.

- RND should encourage doctor-narcologists to consider revising current policy on "non prescribing" any symptomatic psychotropic and/or pain relieving medication to support patients who might experience negative symptoms during the maintenance phase or, even more importantly, during the tapering and early post-methadone period. This obviously needs to be implemented with certain caution and careful monitoring of patient's conditions to avoid potential abuse of psychotropic medications or prevent development of dependence. However, there is no rationale for complete rejection of such symptomatic therapy for methadone maintained patients.

- HIV prevention services need to be integrated into narcological services. To ensure delivery of integrated services to individuals with substance use problems at narcology facilities these should include screening, counselling, diagnostics, referral, but also treatment and care related to HIV, TB and STI. If OST coverage significantly increased, and integration of services effectively implemented and sustained, it is likely that they will result in reduced HIV among PWID, reduced TB rates in this group, and overall reduction in morbidity and mortality.

- Republican Narcological Dispensary should revise and introduce Indicators for evaluating and monitoring the effectiveness of opioid substitution treatment. These would include and specify indicators currently proposed in the clinical protocol (retention in treatment, rates of infections, overdose death), but also

would introduce other important measures, such as use of illicit substances, early identification of HIV, viral hepatitis, TB and STI and successful referral to specialized services, changes in injection and sex related risk behaviour, changes in criminal activity, employment and the overall quality of life.

- Ministry of Health, RND and administration of regional hospital (that host narcological services) should revise the current system of financial remuneration for health personnel involved in OST delivery, and should introduce changes that would provide reasonable incentives for health workers to be engaged in opioid substitution treatment.

- Given the inevitable diversity in a settings and treatment provision infrastructure it is hard to propose any single uniform model of OST delivery in Moldova. In terms of funding mechanism financing OST through the National Health Insurance Fund (per day/visit funding) seems to be a feasible and convenient option. It is also necessary to agree upon and introduce a minimal obligatory package of services to be provided to every OST patient, regardless of the setting through which the treatment is delivered. This minimal package would integrate psychosocial component and screening, testing and referral for co-morbid conditions.

- Ministry of Health and RND should consider introducing substitution treatment with opioid agonist/antagonist buprenorphine. This would allow for expanding OST and attracting those PWID who are reluctant to start on methadone.

- Ministry of Health, Republican Narcological Dispensary and State Medical University should support implementation of new addiction-related curricula for medical students, residents and doctor-narcologists, and should maintain lasting efforts to update these curricula to reflect the best evidence-based and up to date content. In addition, there is a need to develop and implement addiction-focused education programs for other specialities that are involved with addictology service provision – psychologists, social workers, nurses, and general practitioners.

- All involved parties should consider working together on improving the image of OST among professionals, PWID and the general population. The poor image of OST among different groups may be related to the suboptimal quality of OST and persistence of myths. In addition, in some cases an abstinence-oriented treatment is traditionally more common and valued and OST is not accepted by health specialists as a valid treatment option.

- As an established and credible leader in the field of addiction medicine in the country the Republican Narcological Dispensary should assume a leading role

in the process of scaling up OST programs in Moldova. This would include support for and coordination of introduction of integrated services into the narcology facilities, and methodological support and supervision to ensure high quality of care. The RND is best positioned to play a critical role in the process of monitoring and evaluation of opioid substitution treatment as well.

I. INTRODUCTION

Background

The Republic of Moldova, a country with a total population of 3.5 million [National Bureau of Statistics], including a breakaway region of Transnistria with population of 0.52 million, has a concentrated HIV epidemic. As of the end of 2015, a total of 10,249 new HIV cases had been registered in the country (including Transnistria – 3,284), with about 800 newly registered HIV cases per year in 2014-2015. The breakaway region of Transnistria is the most affected region with HIV incidence of 3.5 times higher than in the rest of Moldova (48.1 per 100,000 in Transnistria region versus 16.47 per 100,000 in the rest of Moldova in 2014). People who inject drugs (PWID) are the most affected group. According to 2012/2013 Integrated Bio-Behavioral Surveillance (IBBS), the HIV prevalence among PWID was estimated to be 8.5% in Chisinau, and 41% in Balti, the second largest city. The prevalence in Transnistria was 23.9% in Tiraspol and 47.7%. in Ribnita. The Republican Narcological Dispensery (RND) has around 11,000 drug users registered in its registry. However, the estimated number of injecting drug users in Republic of Moldova is 30,200, with 19,400 of PWIDs on the right bank and 10,800 PWIDs on the left bank [Population Size Estimations of PWID, SW and MSM in Republic of Moldova, 2014].

Opioid substitution treatment (OST) with methadone has been implemented in Moldova since 2004 in civil sector and since 2005 in prisons. Since 2015 OST services have been geographically scaled up from 2 sites to 7 in general setting, and in penitentiary sector from 11 to 13 penitentiary institutions. Since its initiation OST has relied heavily on Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) funding. Since 2014, the National Health Insurance Funds has been financing 30 OST patients per year.

The OST coverage is far below the level that might impact on HIV epidemic at population level. The estimated coverage on the right bank[1] is less than 3% at the moment. The uptake of new patients in 2015 was 166, and the number of daily patients at the end of December 2015 was 468. The cumulative number of patients ever enrolled in OST since program initiation was 1,479 by the end of 2015. Geographical availability of the OST in the country is limited to those patients residing in cities (or in close locations) where OST is implemented. Despite the psychosocial support to increase adherence to OST, the dropout rates remain high - only 63% of individuals who initiated OST completed 6 months of continuous treatment [PAS, OST program data, 2015].

[1] There is no methadone substitution therapy in Transnistria region (left bank of Nistru river)

The purpose and scope of the evaluation

The overall purpose of this assignment was to undertake comprehensive assessment of opioid substitution therapy program in Moldova (in community and prison) and to develop recommendations for improving effectiveness, quality and coverage of OST, including program coordination, program M&E, accessibility, availability and sustainability of OST. The scope of the evaluation was clearly stated in the terms of reference (see Annex 1). As formulated in the terms of reference the evaluation thought answers to the following questions:

- Assess coordination of care and patient support and collaboration between NGOs and OST sites from civil and penitentiary sectors, including mechanism to ensure follow up and continuity of care and support upon incarceration or release of OST patients and recommend ways to improve.
- Assess the degree of integration of clinical and psychosocial components of OST program, address normative framework, programmatic arrangements, appropriateness and adequacy of the integrated services and recommend ways to move forward. Assess efficiency of integration models in old and new sites, and penitentiary system.
- Assess collaboration between needle exchange and OST programs, from civil and penitentiary sectors, including mechanism to ensure identification and linkage of PWID to OST services and recommend ways to improve.
- Assess scale-up opportunities of OST program in Moldova, provide recommendations and potential models for extension and quality increase. Address cost implications of OST on national budget.
- Assess costs of existing delivery model, including from National Health Insurance Fund perspectives, and recommend cost-efficiency increase for future extension of OST program. Provide recommendations for OST program financial sustainability.

Evaluation Methodology

The evaluation methodology comprised a mix of site visits, face-to-face interviews, focus group discussions, desk-based research and review of existing reports and secondary data. Consultant's approach to the evaluation was issue-driven with a high degree of participation by all key stakeholders. Methodological and data source triangulation was utilized for data analysis. A review of project and other related documents was conducted. The list of key documents reviewed is presented in Annex III. Annex IV presents the list of key informants interviewed in all cities visited. A list of potential respondents was suggested by the evaluator and was further complemented by PAS Center. Interviews were conducted with representatives of programme implementers (narcologists, psychologists, nurses) programme beneficiaries, and field stakeholders. Detailed interview guide for semi-

structured one-to-one interviews and group discussions is presented in Annex II. The topics were developed around the six evaluation questions, and were grouped and targeted according to the organization or individual being interviewed. All interviews and focus groups were conducted in Russian. The staff of project implementing sites selected participants for focus group discussions with program beneficiaries. No personal data of participants were collected and no other individuals except for evaluator and participants were present during focus group discussions. Prior to the conduct of discussions evaluator obtained verbal consent from participants. Country visit was conducted between June 4-15, 2016.

Limitations

There were few limitations to this evaluation:
During the field phase of evaluation time in each city was limited. However, it was sufficient given the review of project documents conducted by the evaluator prior to visit and intensive communication and information exchange between the evaluator and PAS staff. In addition, in some locations OST staff selected respondents for interviews and focus group discussions with program beneficiaries. It was not completely clear to what extend opinions of those respondents could have differed from the opinions of other beneficiaries. Overall, evaluator believes that these limitations had negligent impact on the findings and conclusions of this evaluation.

II. EVALUATIOIN FINDINGS

Results of the evaluation are presented in this report topic-wise and are structured in an attempt to follow the questions posed in the respective ToR and to reflect important topics that emerged during the evaluation process.

Overall context of OST provision in Moldova

Guided by the series of independent evaluations and external recommendations there has been remarkable development with OST provision in Moldova over the last two years. Six new OST sites were opened in 2015-2016 in civic sector: five sites in new locations (Comrat, Cahul, Edinet, Ungheni, Soroca), one additional (to two existing) site in Chisinau, and two in penitentiary system in P3 Leova and P4 Cricova. For the time of evaluation substitution treatment with methadone was provided through 9 sites in 7 cities in general setting, and in 13 penitentiary establishments (out of 17 existing in the country). The major advancement has been the revision of national clinical protocol on Pharmacological Treatment of Opioid Dependence with Methadone. The protocol was developed by the group of experts from the Ministry of Health of Moldova, Department of Psychiatry, Narcology and Medical Psychology of the State Medical University, the Republican Narcological Dispensary, international organizations and

national non-governmental organizations working in the field. The Ministry of Health approved the protocol in January 2015. Among other elements, the protocol includes algorithm for the initiation and provision of methadone, describes staffing requirements for the provision of treatment, and supports integration of psychosocial component into the treatment. The document also addresses the issue of continuum of treatment and describes mechanisms for provision of treatment with methadone in hospital setting (when patient is hospitalised), during the police detention, and in prison setting. Importantly, the protocol includes clear criteria and algorithm for dispensing medication for take-home doses.

Elements of monitoring and evaluation are included in the protocol and the following indicators are proposed as measures of effectiveness of treatment: number of new patients, retention of patients for 6 and 12-month period, share of patients in narcological registry infected with HIV and viral hepatitis B, C and D during the last year period, number of overdose deaths over the last year period among individuals registered with narcology registry.

In the Republic of Moldova opioid substitution treatment can be provided by any licensed health facility, however, the facility has to have doctor-narcologist employed as staff member or consultant. At the time of evaluation most of OST sites were functioning within narcological cabinets in district hospitals and in Republican Narcological Dispansery in Chisinau. The later provides methodological oversight for all narcology services in the country, but has no direct administrative role in the context of service delivery, staff employment or infrastructural support. Doctor-narcologists as a rule work as the only specialised addiction physicians in respective region and fulfil a range of tasks related to their position. This would include in- and out-patient treatment of people with alcohol and substance use disorders, routine registration/dispanserization of individuals with alcohol and substance use related problems, medical examination of individuals seeking license ("spravka") from narcologist (for example applicants for driving license, job seekers, and so on), forensic examination of individuals detained by police ("narcological expertize").

Implementation of protocol

It is not clear to what extent indicators outlined in the clinical protocol serve the purpose of evaluation of effectiveness of the treatment. Some of the indicators proposed could hardly be used as a meaningful measures to assess the effectiveness and impact of this intervention. For example, rates of HIV and HCV infections among PWID registered with narcology registry, and rates of mortality among the same group could barely be directly linked to the effects of OST. Number of newly admitted patients and the number of patients in treatment could be helpful in understanding the overall coverage of the program, however, they are not sufficient to draw any evident conclusions.

There was unified agreement among patients that narcologists are over-cautious in relation to dispensing methadone for home administration and do not utilize this approach even in cases when patient qualifies for it. Participants of focus group discussions believe that doctors do not fully trust their patients (even those who behave well) and fear for legal consequences they (doctors) might face in case patient diverts methadone. Some narcologists openly express their overall pessimism related to the provision of methadone for home administration. They do not believe they could completely trust drug dependent patients.

Remarkable share of patients reported that they do not receive treatment for co-occurring symptoms. This was specifically indicated in relation to insomnia, anxiety and pain symptoms. Doctor-narcologists appeared to be convinced that prescription of any psychotropic and abuse-liable pain relief medications (for example tramadol) is completely contraindicated during both, methadone maintenance and post-tapering period.

In many cases patients are maintained on a low dose of methadone in ever-lasting attempt to complete the treatment. Among health professionals, but also among patients, there seem to be a widespread perception of opioid substitution treatment as a mean to drug free life with abstinence being an ultimate goal of this intervention.

In a number of cases narcologists involved with OST provision expressed concerns regarding the regulations that do not serve to ensure proper discipline among OST patients. Some health personnel perceive those rules as soft and ineffective to deal with rule-breakers. Number of respondents indicated that the process of treatment would benefit from having clear procedures allowing "not simply punish them, but to encourage to adhere to rules". As one respondent stated "we know that just getting rid of him is not a solution, what he will do then?" There was also opinion that the issue should be dealt with policeman being present at OST site and ensuring proper order.

Integration of services

Algorithm for counselling and HIV testing is provided in the "National HIV Testing Guidelines" and all health facilities, where HIV testing should be implemented, follow it. Medical personnel reported that HIV testing is done routinely every 6 months. Testing and counselling is implemented by partner NGOs within the framework of Global Fund funded project. HIV positive patients are referred to AIDS centres, and when needed receive ARV treatment there. HCV testing is not implemented at OST sites at all. When demanded, patients are referred for HCV testing to general health setting.

In the protocol (and other regulatory documents) there seem to be lack of detalization on the specific tasks of health personnel related to their involvement in the provision of OST, but even more in relation to the management of other health needs of patients. OST sites apparently do have reasonably well established collaboration with other health specialists often

asked to consult OST patients, and other health facilities that provide care and treatment for PLWA and TB clinics. However, these collaborations are of fragmented nature and lack systematization, are based on ad hoc needs of specific facility and/or particular client, and often rely on personal professional ties. The structured framework for collaboration between those facilities, and even more for provision of integrated services is lacking.

Partner non-governmental organizations provide critical support for clients at OST sites. Importance of psychosocial component of treatment and value of peer-led support is well acknowledged by medical staff, and is largely highly appreciated by patients. The role of psychosocial support in the overall treatment process and description of responsibilities of partner organizations are provided in the clinical protocol in a section "Psychosocial Rehabilitation" and in the sample agreement between narcology facility and partner NGO. However, in a number of cases representatives of partner non-governmental organizations reported that involvement of social workers and peer supporters in the overall process, their specific role in implementing treatment plan is not sufficiently formalised and structured. In a number of cases this might result in lack of clarity on their role and ambiguous expectations from the side of medical staff. In addition, the intensity and the quality of psychosocial component might differ from location to location. This apparently has to do with the fact that partner NGOs are able to provide this intervention in some distant locations only once a week (while in large cities they engage with OST clients on a daily bases), but also because the whole process might lack standardization.

Coordination and partnerships

Coordination and partnerships with non-governmental organizations providing peer support and psychosocial assistance to OST clients seem to be functioning largely within GF funded projects. The same is truth for coordination of OST services by the Republican Narcological Dispensary. RND and partner NGOs are recipients of relevant Global Fund funding to support these collaborations. It is not clear how effectively these collaborations will sustain when GF funding is over.

Continuum of treatment and provision of methadone seem to be well managed. In this regard protocol provides framework for collaboration and coordinated work between RND, other health facilities, police (when patient is detained), and penitentiary system. For example, during early detention in police department patients are escorted to OST site with guard to get methadone. When they transferred to pre-detention facility ("sizo") they get medication there. When patient hospitalized to another hospital OST staff delivers 1-2 week supply of medication and local nurse manages dispensing.

OST in prisons

OST with methadone is available in 13 out of 17 prisons in Moldova. At the time of evaluation there were 84 patients receiving this treatment in

penitentiary system. Some patients initiated treatment in prison system, but some were on OST prior to arrest and continued on methadone following the imprisonment. Prior to release OST patients are referred/transferred to sites in civic sector. If there is no OST in a location where the person resides he/she has to stop treatment following the release, or should go to the nearby OST site if distance allows. There were cases when an individual changed place of residency to be able to receive OST.

All new prisoners at the time of prison entry are routinely seen and assessed by internal medicine specialist, psychiatrist, and psychologist. Based on regulations every new prisoner is routinely tested for HIV, HCV, syphilis, and TB. If substance use related problems are reported (by prisoner) or identified (by prison doctor) staff calls for consultant-narcologist to make comprehensive assessment and to confirm substance use related diagnosis. Consultant-narcologist can initiate treatment with methadone. Prison doctor then monitors the treatment on a daily bases and consultant provides periodic oversight. When dependence is established but the person does not want to initiate OST the symptomatic treatment is provided.

In all prisons where OST is implemented the psychosocial component is supported by NGO "New Life". NGO staff visits prisons on a weekly basis. Staff of partner NGO and prison health personnel work as a multidisciplinary team – doctor, psychologist, social worker and prisoner-volunteer – and meet once a month and discuss on-going issues. Most of these activities are supported financially by the Global Fund, which also covers cost of methadone, toxicological tests, transportation, incentives for additional tasks and working hours for staff salaries, office supplies and capacity building activities.

Most prisoner patients reported that they were satisfied with the treatment and appreciated efforts by prison personnel engaged in service delivery. The same was truth in relation to the staff of "New Life". Many respondents acknowledged that doctor and prison psychologist are available and can be seen when there is a need. In some cases, patients reported that support staff was not always readily available to meet and assist patients in need. One patient reported having never seen psychologist and social worker while being on OST in prison. Many patients complained that prescriptions for medicines, other than methadone, that could help with anxiety or sleep problems were not available. As one responded stated "if you have problems while reducing dose, they do not give any medicine to help, they say it is prohibited".

Most importantly, the major problem with the provision of OST in prison system in Moldova is linked to highly biased and ideologically driven environment surrounding this intervention. Criminal ideology and criminal leaders do not approve opioid substitution treatment. In many cases OST patients abruptly quite methadone when arrested and sent to prison. Those who decide to continue on methadone, or initiate OST while in prison, are

condemned by criminal leaders and are "declassified" to the lowest category in a criminal hierarchical system. To protect safety of such prisoners they are kept in secluded wings.

Barriers to OST utilization and scale up

Narcological registry acts as a major barrier for scaling up opioid substitution treatment in the country. This has been acknowledged by the vast majority of OST patients interviewed during the assessment and majority of medical personnel. Regulations consider that personal data of a person with substance use related problems (both, voluntarily admitted for any kind of treatment, including OST, and brought to narcologists by police to be examined for drug use) will be included in the registry and will stay there for 3 years. During that time, he/she is expected to go through a number of processes (treatment, rehabilitation, monitoring by doctor with periodic visits to narcology cabinet, drug tests) and at the end of the period to pass narcological examination. Those who successfully complete the process are removed from the registry. Others will remain in the registry for unspecified period. While in the registry, an individual is deprived driving license (or is unable to get one), and is unable to get an employment for which the narcological license ("spravka") is required. Regulations do not consider provision of data from the narcological registry to police. Nevertheless, many drug users believe that policemen know the registry data. The overall agreement among people interviewed was that unwillingness to be included in the narcological registry is a major barrier that precludes potential beneficiaries from accessing substitution treatment.

Another barrier that negatively impacts on the expansion of OST is geographical availability/accessibility of this treatment. As indicated, it is available in 7 regions out of 37, and is completely absent in Transnistria (due to political considerations and the attempted alignment with Russian public health policies). Many patients indicated that they leave in districts where OST is not available and they have to travel 20-30 kilometers from their homes to OST sites on a daily basis. In this situation many patients believe that broader implementation of take-home dosing would be a sensible solution.

Finally, there seem to be a low motivation among health care providers to engage with the provision of opioid substitution treatment. OST comes as yet another (additional) duty for narcologists and can often be perceived as an extra burden for already overloaded medical personnel. In addition, opioid substitution treatment is not always perceived as a valid treatment option, if compared to abstinence-oriented treatment. It seems that the moderate top-up salaries provided to narcologists and nurses involved with OST have no real motivating effect.

Cost implications and options for optimization

There is common agreement and expectation among health workers and partner organizations that following the withdrawal of the Global Fund from Moldova cost of opioid substitution treatment should and will be covered by the National Health Insurance Fund. Many health professionals believe that the insurance will cover these costs regardless of whether patient has health insurance certificate or not. This has been justified by the fact that substance use related disorders are included in the list of "socially dangerous conditions" which obliges the Insurance Fund to cover these conditions regardless of the insured status of individual. However, some physicians believe that regulations consider covering the cost of "socially dangerous conditions" for only acute phase of the disease (acute intoxication, overdose, withdrawal syndrome, intoxication related psychosis), and OST would not fall into the category to be paid by the Fund in case the patient is not insured. It has also been acknowledged that the issue of many OST patients not having a health insurance certificate should be a primary target of case management and support provided by social workers. Essential part of these activities is assisting OST patients in achieving stabilization and improving social conditions. This obviously includes helping clients to get registered with health insurance system, helping with employment or, when qualified, assisting with obtaining disability status.

There seem to be a unified agreement among narcologists and other health workers interviewed for this assessment that the amount of per case funding considered for OST patients by the Insurance Fund (69 LEI per patient per day) is adequate and sufficient to cover all the elements of treatment and all indirect costs of service provision. This was obviously also truth for the amount of 52 LEI (patient/day) that is apparently paid by the Fund for 30 OST patients at the current stage (it was not completely clear why actual payment was 52 LEI given that regulations indicate 69 LEI to be paid by the Fund). Number of respondents representing partner non-governmental organizations indicated that the issue with insurance-covered OST could be the lack of standardization of services to be provided to the patient (minimal package that would clearly define the range and volume of services to be provided as a must), rather than the amount of funding itself.

In a recent year's number of economic evaluation studies attempted to assess current costs of HIV prevention and treatment interventions in Moldova and propose optimal scenarios to be considered for the future. The UNAIDS-lead cost-effectiveness analysis of HIV and HCV related interventions among PWID suggested that significant reduction in HIV and HCV prevalence over the next 5, 10, 15, and 20-year period would not be possible without scaling up all relevant interventions such as NSP, OST, HIV diagnosis and ARV treatment, and without implementing novel approach to HCV diagnosis and treatment. Expansion of NSP and OST would be a very cost-effective and would result in significant reduction in HCV cases, but to

less extent to the reduction in HIV cases. The World Bank-led study using an OPTIMA model found that the optimized allocation of resources would entail:

- Scaling up antiretroviral therapy (ART) and prevention for key populations including in the highly affected areas of east of the Nistru River
- Increasing investment in prevention programs for PWID, opiate substitution therapy (OST) and programs for FSW and MSM
- Improving geographic prioritization and introducing OST, MSM, and FSW programs on the left bank
- Reinvesting funds currently allocated to programs for the general population in the above-mentioned priority programs
- Reviewing the unit cost and technical efficiency of ART and OST programs as well as for management and other costs.

The study found that OST service in Moldova costs more than average per region ($935 vs $737) and suggested that the unite cost of this service should be reviewed and optimized. Another study commissioned by the Eurasian Harm Reduction Network (EHRN) attempted to assess the unite cost of OST in six countries – Moldova, Georgia, Kazakhstan, Tajikistan, Belarus and Lithuania. Authors presented comparative unite costs of OST where Moldova with $681 (patient/year) had unite cost somewhere in the middle of a range of unite costs estimated for other countries (range $525-1,372). In addition, authors presented OST unite cost components by countries. If compared to other countries studied in this research, Moldova had the lowest share of cost of medication (16%), and the highest share of direct staff cost (60%) in the overall cost of OST service. However, it is not clear to what extend the costs of OST components were adjusted to the differences in service packages (and respective staffing) provided in each country. For example, in Moldova the "direct cost" included cost of partner NGO staff providing psychosocial support to OST patients. In Georgia psychosocial support is a mandatory component of treatment with every OST facility being required to have psychologist and social worker in its staff.

These studies obviously provide useful information for understanding the overall context for planning and implementing an HIV prevention and treatment interventions. However, certain limitations characteristic to all these studies barely allow for drawing any definite conclusions in relation to specific models of OST service delivery and/or particular structure of unite cost of this treatment. For example, none of these studies include benefits associated with reduction in illicit drug use and reduction in criminal activity resulting from participation in OST. Nevertheless, all these studies do indicate that OST (in conjunction with other interventions) is a critical part of a complex approach to any efforts to address HIV and HCV epidemics among PWID and in general population in Moldova.

III. CONCLUSIONS

Due to low coverage of the opioid substitution treatment in Moldova (less than 3% of estimated people who inject drugs) it is reasonable to assume that this otherwise most effective treatment for opioid dependence and powerful intervention to prevent HIV and other infections among PWID has had so far limited impact on both, prevalence of injection drug use and rates of blood born infections among drug injectors and in general population in the country.

Nevertheless, data collected for this report suggest that OST results in visible reduction in injection drug use, reduction in injection risk behaviour, reduction in drug related and other criminal behaviour, and contributes to improved social functioning, increased employment, and overall higher quality of life of many patients enrolled in this treatment in Moldova. OST is well accepted by patients and perceived by many as the best (often the only) option to quite illicit drugs. Among beneficiaries there is clear appreciation of the efforts and commitment of medical personnel involved in the provision of substitution treatment.

Significant share of patients acknowledges insufficient level of utilization of take-home dose dispensing by OST doctors. Many patients, specifically those residing in distant (from OST sites) locations and those having jobs, would benefit from wider implementation of this form of administration of the medication. It is reasonable to assume, that broader application of take-home dosing will attract certain groups of new patients to treatment.

Substitution treatment with partial opiate agonist buprenorphine can be yet another option to increase the coverage of treatment and attract new patients who might perceive methadone as too "heavy" medication. Regardless of the higher unite cost for buprenorphine medication, if compared to methadone, number of studies suggest that the overall cost of service delivery can be comparable for both medications [Maas, Barton, Maskrey, Pinto, & Holland, 2013]. International narcotics control framework allows for buprenorphine treatment to be provided in general health setting by general practitioners (family doctors) and the medication to be dispensed via pharmacies [World Health Organization, 2009]. In addition, extended half-life of buprenorphine allows for every other day or every third day administration of the medication. Available formulations (ex. Suboxone, combination of buprenorphine and naloxone) can be utilised in settings where specific precautions should be taken to prevent diversion and non-medical use of the preparation.

Doctor-narcologists vastly restrain from prescribing any symptomatic psychotropic or pain relief medication alongside methadone and/or in post

methadone (following the tapering) period. International guidelines obviously advise to use any psychotropic and other abuse-liable medicines in methadone maintained patients with specific precaution. However, it is rather a common practice to provide supportive symptomatic treatment to OST patients when there is clear need for that. For example, this could be management of depressive symptoms and correction of sleep problems during the maintenance, or management of pain in early post-methadone period. Supporting patients in elevating unpleasant symptoms can prevent use of non-prescribed psychotropic substances during the methadone treatment and, most importantly can stabilize patients in post-methadone period and reduce the risk of relapse.

Narcological registry is a major barrier for attracting more patients to OST. Potential beneficiaries of the program do not wish to get registered in the system and to bear all the consequences linked to this – deprivation of certain rights, risk of disclosure, risk of losing job and so on. The existing system of narcological registration needs to be fundamentally reformed, or more correctly abandoned. As obvious heritage of soviet totalitarian system the current narcological registry serves as a form of control over the large group of population and hardly can be perceived as any useful kind of public health intervention. There is no evidence that narcological dispensarization achieves any positive results to benefit either people it is supposed to help (registered individuals) or general population at large. It can be seen as outdated and irrational waist of financial and human resources.

Another barrier for many potential beneficiaries to apply for OST was widespread negative attitude towards methadone and surrounding myths (methadone damages your liver; it is harder to quit methadone than heroin; and others). In addition, the criminal ideology that is widespread among certain groups of drug users negatively influences treatment-seeking behavior. In this setting it is believed (and reinforced by criminal leaders) that authorities hook people on methadone and can use this treatment to force patients to collaborate with police.

Remarkable share of health personnel involved with OST provision believes that the ultimate legitimate goal of this intervention is abstinence. Thus, the provision of substitution treatment is seen as preparation for drug free life. The six months' period is acknowledged as acceptable (often sufficient) time for patients to stabilize and is often followed by tapering and preparation to graduation from OST. As a result of this "preparation for abstinence", many patients are maintained on very low doses of methadone (5-15 mg/day). There were no data available on the rates of planned withdrawal from treatment and on the rates of relapse or re-initiation of OST following such withdrawal.

Health workers consider use of non-prescribed psychotropic and/or illicit substances by OST patients as a serious problem. There were polarized opinions with regard to strategies to prevent and/or address this issue. Part of narcologists saw the solution in introducing more clear and structured procedures to heighten the discipline among patients (frequent toxicological control, stricter punishment for regime violators). Others considered increase in intensity and efficacy of psychosocial component of treatment as possible solution to extra-medicinal use of psychotropics and other problems faced by OST patients.

Involvement in opioid substitution treatment comes as addition to the routine tasks of medical personnel of narcology services and often is perceived as extra burden for the staff. Due to very low utilization of take-home dosing staff members have to do medication dispensing on a daily basis, including weekends and all public holidays. Both, the salaries and moderate incentives for additional tasks and working hours, currently provided within Global Fund funded project, are not perceived as adequate. In a number of cases patient load for single narcologist is too high (up to 130 patients). As a result, there is lack of motivation from the side of health care personnel towards engagement with OST services. More broadly, there seem to be lack of motivation and incentives for young specialists to enter the field of addiction medicine.

Over the last few years' medical personnel of OST programs went through a series of education and skills building activities (trainings, seminars). This has obviously contributed to building the capacity of the staff in terms of provision of opioid agonist treatment and increasing an overall knowledge of evidence based approaches in addiction field. Nevertheless, the paradigms of "Soviet narcology" that aimed at controlling, rather than caring might still be prevalent within the narcology field. In many countries in the region of Eastern Europe and Central Asia (EECAA) the development of addiction treatment has been shaped by the school of "Soviet narcology" that operated within a highly centralized and closely regulated vertical health-care system. A focus on heavy medicalization, an emphasis on administrative duties, rather than positioning themselves as care givers, and few incentives to seek major changes in the field – all have historically been characteristics of Soviet narcologists. In Moldova, and in many other countries in the region, health professionals have been rejecting those old paradigms and successfully adopting evidence based and human rights based approaches and interventions. It is obvious that narcology field in Moldova has wealth of opportunities for relevant reforms in this regard.

Whatever beneficial ad-hoc education events might be, it is obvious that profound and sustainable changes in capacity and competence of health care personnel have

to be achieved through systematic reforms in formal education. On a positive side, UNODC supported the development of addiction-related curricula for the State Medical University. Starting from Fall 2016 new curricula will be implemented for medical students, residents in psychiatry/narcology, and for doctor-narcologists within life-long education process. Within the process of overall reforms, it is important that health professionals have permanent access to literature/information on newest research findings and the best practice. Internet now days can be a useful source of the information. However, most of OST-related information available on a global net in Russian language is negative, severely biased and/or just contains direct disinformation. It is not clear to what extend health workers in Moldova can benefit from relevant websites that present information in English (or any other language). The useful strategy here could be development and dissemination of relevant information in Moldavian language.

IV. RECOMMENDATIONS

Recommendations presented in this section aim for creating an environment that should allow for scaling up the coverage of OST in Moldova, improving its quality, and for making this treatment accessible and attractive for those who should ultimately benefit from it. It is obvious that part of the reforms should aim for broader systematic changes in the field of addiction medicine with opioid substitution treatment being just essential element of overall service provision in this field.

- Ministry of Health and Republican Narcological Dispensary should consider abandoning the system of narcological registration. The system as it stands for now does not serve any public health purpose and is unjustified waste of financial and human resources. Most importantly, narological registration is a major barrier that prevents people with substance use related problems from seeking assistance and applying for narcology services, including for opioid substitution treatment. Substance use disorders should be treated just as any other medical nosology and any kind of medical registers should only serve the purpose of providing better care to patients, and/or for monitoring the epidemiological situation.

- Ministry of Health, RND, National Health Insurance Fund and Centre PAS should consider expanding OST to new locations. In small cities and remote places where there are no narcologists to engage with OST on a daily basis, the OST may be integrated into the existing infrastructure of primary health care centers. As recommended in the WHO *Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, OST may be provided at primary health care level by a general practitioners (GPs). Therefore, it could be offered relatively inexpensively. The option can be to train local physician (general practitioner) and to have doctor-narcologist from nearby location to provide supervision and periodic oversight. OST prescribed by a GP might be considered as less stigmatizing than when offered in specialized narcology services. Treatment by a GP often implies that opioid dependence is treated just like any other chronic disease.

As outlined in the WHO *How to Improve Opioid Substitution Therapy Implementation* the involvement of GPs will require certain steps to be implemented:

- ✓ To adjust the national legal framework in order to allow any medical doctor, including GPs, to prescribe OST with methadone or buprenorphine;
- ✓ To provide technical assistance in the development of sites' internal protocols and procedures on OST, and regulations on the control of narcotic medications;
- ✓ To establish training for GPs addressing the assessment of clients with dependency problems and their treatment, including OST;

- ✓ To implement a system of continuous mentoring and supervision of the new OST site by experienced practitioners through site visits, email and telephone communication;
- ✓ To provide a possibility to GPs to refer more "difficult" clients to OST in specialized and more intensive or inpatient services.
- ✓ For psychosocial assistance GPs usually refer to psychosocial programs, which are run by NGOs or municipal services.

In addition, one of the options for OST expansion and coverage of patients in remote locations could be implementation of a mobile methadone dispensing unite. New clients can be admitted to OST through the main site and then could be served via mobile unite that could also provide harm reduction services (needle exchange, rapid HIV testing, counselling).

- RND should encourage doctor-narcologists to utilize take-home dosing more actively. This would allow for expanding the coverage of program and would attract patients that currently restrain from entering OST due to distant location from treatment sites and/or those who might be employed and do not wish treatment to interfere with their work schedule. In addition, more active implementation of home dispensing will lessen the workload of medical staff.

- RND should encourage doctor-narcologists to consider revising current policy on "non prescribing" any symptomatic psychotropic and/or pain relieving medication to support patients who might experience negative symptoms during the maintenance phase or, even more importantly, during the tapering and early post-methadone period. This obviously needs to be implemented with certain caution and careful monitoring of patient's conditions to avoid potential abuse of psychotropic medications or prevent development of dependence. However, there is no rationale for complete rejection of such symptomatic therapy for methadone maintained patients.

- HIV prevention services need to be integrated into narcological services. To ensure delivery of integrated services to individuals with substance use problems at narcology facilities these should include screening, counselling, diagnostics, referral, but also treatment and care related to HIV, TB and STI. In ideal case the integration of services would include at least the implementation of following procedures at narcology facilities:
  - ✓ Pre- and post-test counselling and rapid onsite screening for HIV and HCV
  - ✓ Consultations by infectious disease specialist
  - ✓ Referral and escorting to health facilities that provide care and treatment for PLWA for those tested positive for HIV
  - ✓ Provision of ARV treatment at narcology facilities
  - ✓ Screening for TB and referral/escorting to TB clinics
  - ✓ Provision of tuberculosis treatment
  - ✓ Screening for STI and referral to STI clinic

In preparation for the departure of Global Fund narcology facilities should consider developing job descriptions and introducing positions of psychologist and social worker at every site where OST is provided. Whatever the level of integration might be achieved in the near future, the system of narcology services would obviously benefit from building capacity of personnel of narcology clinics (doctors, nurses, psychologists, social workers) in following topics:

- ✓ Addiction as a Bio-Psychosocial model
- ✓ HIV testing and counselling
- ✓ HIV treatment and care
- ✓ Screening and counselling for blood born infections
- ✓ Screening and counselling for TB
- ✓ Continuum of care

Close collaboration (referral) with relevant health facilities and harm reduction programs is highly relevant to the needs and priorities identified in the field of illicit substance use and associated health and social conditions in Moldova. If OST coverage significantly increased, these collaborations are enhanced and integration of services effectively implemented and sustained, it is likely that they will result in reduced HIV among PWID, reduced TB and STI rates in this group, and overall reduction in morbidity and mortality. This will be accomplished through increased access to and utilization of HIV testing and counselling, early initiation of and improved adherence to antiretroviral treatment, improved identification and early diagnosis of tuberculosis and sexually transmitted infections, and subsequent increase in rates of specific treatments for these conditions.

- Republican Narcological Dispensary should revise and introduce Indicators for evaluating and monitoring the effectiveness of opioid substitution treatment. These would include and specify indicators currently proposed in the clinical protocol (retention in treatment, rates of infections, overdose death), but also would introduce other important measures, such as use of illicit substances, early identification of HIV, viral hepatitis, TB and STI and successful referral to specialized services, changes in injection and sex related risk behaviour, changes in criminal activity, employment and the overall quality of life. Adequate attention to the quality of service is specifically important within the process of scaling up of OST - one would not wish to sacrifice the quality for the sake of increased coverage. Continuous monitoring of the effectiveness of OST using comprehensive set of indicators is critical and will allow for timely identification of possible flaws and bottlenecks in program management and/or service delivery models, and to propose and implement relevant improvements. In addition, this will ensure that there is sufficient evidence on the impact of this intervention to be presented to decision makers and to the general audience.

- Ministry of Health, RND and administration of regional hospital (that host narcological services) should revise the current system of financial remuneration for health personnel involved in OST delivery, and should introduce changes that would provide reasonable incentives for health workers to be engaged in opioid substitution treatment. Part of the solution can be related to the new, to-be-introduced overall system of remuneration in Moldavian health system (performance based). However, effectiveness of this new system has to be seen when it is introduced. It is expected that following the departure of the Global Fund the National Health Insurance Fund will take over the funding for OST. Rate of per case funding (amount per OST patient) currently provided for about 30 OST patients from this Fund is considered as well reasonable and adequate by health workers. It is reasonable to expect that if this system of funding is applied to all OST patients in post-Global Fund period it will allow for increase in health personnel salaries as well.

- Given the inevitable diversity in a settings and treatment provision infrastructure it is hard to propose any single uniform model of OST delivery in Moldova. In terms of funding mechanism financing OST through the National Health Insurance Fund (per day/visit funding) seems to be a feasible and convenient option. It is also necessary to agree upon and introduce a minimal obligatory package of services to be provided to every OST patient, regardless of the setting through which the treatment is delivered. This minimal package would integrate psychosocial component and screening, testing and referral for co-morbid conditions. However, the actual models of delivery and staffing of OST programs would differ from place to place. Some options to be considered might include examples outlined in the table below. However, these options should be seen as just indicative and elaboration of optimal models should result from the joint efforts of all stakeholders involved with OST planning and delivery. In addition, part of indirect costs covered by the per case funding from the Insurance Fund should be used to improve treatment infrastructure and create a descent and comfortable environment that would both reinforce the motivation of health personnel and be attractive and rewarding for patients.

	50-150 patients (in narcology service)	**20-50 patients (in narcology service)**	**Up to 20 patients (in narcology service)**	**Up to 20 patients (in primary health setting)**
Doctor-narcologist	x	x	x	
Doctor – GP				X (+ supervising narcolgist)
Nurse	x	x	x	x
Psychologist	x	x	Provided by partner organization	Provided by partner organization

Social worker	x	x	Provided by partner organization	Provided by partner organization
Peer educator	Provided by partner organization	Provided by partner organization	Provided by partner organization	Provided by partner organization

- The overall system of OST provision would benefit from introducing detailed job descriptions for all staff involved in this treatment. This would include clear division of tasks and responsibilities and algorithms of actions for medical personnel in relation to both, provision of substitution treatment itself and collaboration with partner organizations when addressing various needs of beneficiaries. At the current stage, job descriptions as minimum would enhance partnerships with non-governmental organizations providing psychosocial support to OST patients.

- Ministry of Health and RND should consider introducing substitution treatment with opioid agonist/antagonist buprenorphine. This would allow for expanding OST and attracting those PWID who are reluctant to start on methadone. Moreover, some patients currently maintained on methadone might find it more acceptable to continue treatment using this alternative substitution medication. Importantly, buprenorphine is considered as effective medication for detoxification of opioid dependent patients when the ultimate goal of treatment is complete abstinence [World Health Organization, 2009]. Therefore, it can be widely applied for outpatient abstinence-oriented treatment and can remarkably reduce the cost of treatment if compared to traditional in-patient detoxification.

- Ministry of Health, Republican Narcological Dispensary and State Medical University should support implementation of new addiction-related curricula for medical students, residents and doctor-narcologists, and should maintain lasting efforts to update these curricula to reflect the best evidence-based and up to date content. In addition, there is a need to develop and implement addiction-focused education programs for other specialities that are involved with addictology service provision – psychologists, social workers, nurses, and general practitioners. Ideally, these would include both development of short-term life-long education trainings (for in-service professionals) and specific subject courses for formal education (pre-service education).

- All involved parties should consider working together on improving the image of OST among professionals, PWID and the general population. The poor image of OST among different groups may be related to the suboptimal quality of OST and persistence of myths. In addition, as indicated earlier, in some cases an abstinence-oriented treatment is traditionally more common and valued and OST is not accepted by health specialists as a valid treatment option. There are

number of steps that can help to improve the image of and attitude towards OST, and ultimately contribute to its better acceptance and utilization. Strategies, that would help to reduce grouping of patients near OST site with a large number of clients can prevent complaints from close neighbourhood residents and can reduce the risk of peer-triggered extra-medicinal use of psychotropic substances on top of methadone. Decentralization via integration of OST into the existing primary health care system and utilization of mobile dispensing units could be useful options. Developing and making widely available (to health professionals and general public) fact-sheets that would address prevalent myths and misconceptions would be another strategy in improving image of OST. Developing an effective strategy for communication with mass media should complement this. Finally, there is a need to diminish an ideological gap between supporters and opponents of OST through a continuous dialogue between them that would also include patients' groups and communities.

- As an established and credible leader in the field of addiction medicine in the country the Republican Narcological Dispensary should assume a leading role in the process of scaling up OST programs in Moldova. This would include support for and coordination of introduction of integrated services into the narcology facilities, and methodological support and supervision to ensure high quality of care. The RND will need to play a critical role in the process of monitoring and evaluation of opioid substitution treatment as well.

ANNEX I. TERMS OF REFFERENCE OF THE EVALUATION

INTERNATIONAL CONSULTANT[2] TO UNDERTAKE ASSESSMENT OF OPIOID SUBSTITUTION TREATMENT SERVICES IN MOLDOVA

Location:	Republic of Moldova
Application Deadline:	April 18, 2016
Type of Contract:	Individual Contract
Languages Required:	English, Russian or Romanian an asset
Duration of Contract:	3 month (April – June 2016)
Expected Duration of Assignment:	up to 25 days
Starting Date:(date when the selected candidate is expected to start)	May 2016

1. General Background

The Republic of Moldova, a country with a total population of 4.1 million, including a breakaway region of Transnistria with population of 0.52 million, has a concentrated HIV epidemic, with people who inject drugs (PWIDs) being the main affected group and an increasing prevalence among men who have sex with men (MSM). As of the end of 2015, a total of 10,249 new HIV cases had been registered in the country (including Transnistria – 3,284), with about 800 newly registered HIV cases per year in 2014-2015. Incidence and prevalence are estimated to be stable, with overall prevalence below 1%. The breakaway region of Transnistria is the most affected region with HIV incidence of 3.5 times higher than in the rest of Moldova (48.1 per 100,000 in Transnistria region versus 16.47 per 100,000 in the rest of Moldova in 2014). The PWID is the most affected group. According to 2012/2013 Integrated Bio-Behavioral Surveillance (IBBS), the HIV prevalence among PWID was estimated to be 8.5% in Chisinau, the country capital, compared to 16.4% in 2009, and 41% in Balti, the second largest city, compared to 39.8% in 2009. The estimation number of injecting drug users in Republic of Moldova is 30,200[3], 19,400 of PWIDs on the right bank and 10,800 PWIDs on the left bank.

The HIV response is guided by the National Program on Prevention and Control of HIV/AIDS and STIs (NAP). HIV prevention in MARPs is one of the two NAP key strategies and the focus of Government interventions as a response to the epidemic. Since 2003, the national HIV response has been

[2] Or a team of consultants if the consultant chooses to associate with other to enhance qualifications.

[3] Population size estimation 2013.

implemented with support from Global Fund and there has been commendable progress in mobilization of resources and efforts for the scale-up of prevention programs for MARPs, including in penitentiary system. Reflecting the concentration of the HIV epidemic among key populations, mostly PWID in civilian and prison sectors, with a smaller proportion of SWs and MSM, the overall goal of current Global Fund program is to support an effective response to HIV in order to reduce prevalence among key affected populations and decrease AIDS related mortality through improving access of key affected populations to essential HIV prevention, diagnostic, treatment, care and support services. Currently HIV prevention in PWIDs, including OST, relies heavily on Global Fund Grant. Since 2014, the National Health Insurance Funds is financing 30 OST patients per year to the Republican Narcological Dispensary and there is governmental commitment to fund 2 harm reduction projects.

2. Specific background

Substitution treatment with methadone (OST), recognized as an effective tool for prevention of HIV infection among PWIDs, is implemented in Moldova since 2004 in civil sector and since 2005 in prisons and it is part of the NAP. During year 2015, the OST services have been geographically scaled up from 2 sites to 7, and in penitentiary sector from 11 to 13 penitentiary institution.

On the course of OST program implementation, a series of independent evaluations had taken place and a range of external recommendations have been implemented and improvements are in place, including alignment of OST clinical protocols to WHO recommendations, release of opioid medications at home for patients in stable remission, geographical extension of OST program to bring services closed to patients, the client-centered multidisciplinary approach to address the medical and psychosocial needs of OST patients, integration of psychosocial support services within the methadone distribution sites, continued capacity building for staff and info sessions for patients.

Even though progress has been registered in the field of OST in Moldova, there are still constraints related to availability, coverage, quality and sustainability of comprehensive OST services to PWIDs.

Nationally, OST coverage is low and not yet at levels necessary to impact HIV incidence at population level. The estimated coverage on left bank[4] is less than 3% at the moment. The uptake of new patients in 2015 was 166, and the number of daily patients at the end of December 2015 was 468. The cumulative number of patients ever enrolled in OST since program initiation in 2004 raises to 1,479. Geographical availability of the OST in the country is

[4] There is no methadone substitution therapy in Transnistria region (left bank of Nistru river)

still low, and OST access limited for PWIDs from other site, migrating OST patients or OST patients released from detention. Despite the psychosocial support to increase adherence to OST, the dropout rates remain high - only 63% of individuals who initiated OST completed 6 months of continuous treatment[5].

3. Main objectives of the assignment

With the aim to improve extension and quality of current OST services for PWIDs in Moldova, PAS Centre and Republican Narcological Dispensary (RND) issues this call for proposals for an international consultant or team of consultants to undertake comprehensive assessment of opioid substitution therapy program in Moldova (in community and prison) and to develop recommendations for improvement of effectiveness, quality and coverage with OST, including program coordination, program M&E, accessibility, availability and sustainability of OST.

As a result of the consultancy, a detailed report should be produced and findings and recommendations presented to the national authorities.

4. Duties and responsibilities of the consultant

An international consultant or team of consultants will be hired to conduct a comprehensive assessment of OST service in the Republic of Moldova. The consultancy includes both in country and out of country working days.

To conduct a comprehensive assessment, the following tasks are suggested for implementation:

1. Undertake a desk review of Moldova OST program: achievements and constraints based on desk review of documents.
2. Review overall OST normative framework (clinical protocols, internal regulations, psychosocial assistance standards, etc.) and provide recommendations for improvement;
3. Design the assessment methodology in advance to the field mission to Moldova, undertake a field mission and implement the assessment methodology in country as per preliminary agreed agenda for both civil and prison sectors.
4. Conduct interviews with key OST stakeholders, key staff of all OST treatment centres and psychosocial support centres, in both civil and penitentiary sectors, with special focus on new civil sites and penitentiary sector.
5. Conduct interviews and/or focus groups with OST patients in both civil and penitentiary sectors, with special focus on pre-trial detention.

[5] Latest evaluated cohort.

6. Assess coordination of care and patient support and collaboration between NGOs and OST sites from civil and penitentiary sectors, including mechanism to ensure follow up and continuity of care and support upon incarceration or release of OST patients and recommend ways to improve.
7. Assess the degree of integration of clinical and psychosocial components of OST program, address normative framework, programmatic arrangements, appropriateness and adequacy of the integrated services and recommend ways to move forward. Assess efficiency of integration models in old and new sites, and penitentiary system.
8. Assess collaboration between needle exchange and OST programs, from civil and penitentiary sectors, including mechanism to ensure identification and linkage of PWID to OST services and recommend ways to improve.
9. Assess scale-up opportunities of OST program in Moldova, provide recommendations and potential models for extension and quality increase. Address cost implications of OST on national budget.
10. Assess costs of existing delivery model, including from National Health Insurance Fund perspectives, and recommend cost-efficiency increase for future extension of OST program. Provide recommendations for OST program financial sustainability.
11. Present and discuss initial findings with PAS Centre and RND. Formulate preliminary conclusions and recommendations.
12. Prepare draft and final versions of the report.
13. Consult the report findings and recommendations with national counterparts and CCM HIV prevention TWG.
14. Organize an in-country two- days training for service providers on opioid substitution treatment and psychosocial support, act as main expert, facilitator and develop the action plan for OST program further development. Agree the arrangements in advance to the field mission.

5. Deliverables

The consultant or team of consultants is/are expected to produce the following outputs:

1. Design for Assessment of OST services in Moldova, including methodology, including questionnaires if applicable, data collection and analysis methods, selection of projects and plans for relevant organizations visits, as well as practical local logistical and administrative arrangements for the consultant or team of consultants.
   Assessment plan has to be discussed with PAS/RND and approved before the mission to the field.
2. Draft mission agenda presented not later than three weeks before the field visit.

3. Preliminary findings and recommendations presented at the end of in-country mission.
4. Draft and final assessment reports focused on main constraints towards ensuring coverage, accessibility and quality of services; and most important steps for achieving progress and efficiency in OST program implementation. The report should include analysis of current OST program strengths and weaknesses (SWOT), shortcomings of program implementation, analyses of existing models of delivery and recommended models for further program extension, assessment of existing costs and recommendation for efficiency gains and most efficient ways of providing integrated care to OST clients, sustainability analyses including future cost implications on national budget.

6. Monitoring and reporting requirements

The consultant will report directly to PAS/RND.

7. Client's Contribution

PAS Center in connection with RND will facilitate access to any available information, in relation to the assignment that may be needed by the consultant or team consultants and help coordinate OST implementers, national authorities and other stakeholders. The consultant or team of consultants is expected to carry out all the work in close collaboration with and report to the PAS Center/RND.

8. Experience and qualifications requirements

The consultant must meet the following qualifications:

- At least a Master's Degree or equivalent in Public Health, Sociology, Social Work, Public Administration or related field connected with HIV/AIDS;
- At least seven years of relevant experience at the national or/and international level in providing monitoring and evaluation of OST programs, and services provides' capacity and needs assessment;
- Knowledge and understanding of theories, concepts and approaches relevant to HIV prevention, including among injection drug users and in prisons, WHO/UNAIDS/UNODC guidelines provisions;
- Knowledge of the use of various research methodology and sources, including ones relevant to capacity and needs assessment;
- Knowledge of context of post-soviet countries and experience of working in post-soviet region would be an asset;
- Deep understanding and knowledge of specific of technical assistance provision to HIV and harm reduction related services, specifically opioid substitution therapy;
- Experience in conducting research, assessments, and analyses, with strong abilities in quantitative and qualitative analysis;
- Ability to work independently and take initiative;
- Excellent analytical report drafting skills;

- Knowledge of Republic of Moldova context would be an asset;
- Good knowledge of English, Russian or Romanian is asset.

9. Duration of service and terms of payment

This consultancy is expected to begin during the second quarter of 2016 and last over a period of 3 months. It is estimated that the external consultant or team of consultants will spend up to 1,5 weeks in country.
Estimated period of the services will be up to 25 man/days.
The payment for the assignment will be divided in two parts, as follows:

20% of the Contract – upon the presentation of Assessment Plan, according to the TOR, following the receipt and approval of the Plan by the PAS/RND.

80% of the Contract - upon presentation of the Visit Report and other sub-products (technical notes, memos, plans, presentations and other documents) that may be required by the Client, according to the TOR, following the receipt and approval of the Report by the PAS/RND.

ANNEX II. EVALUATION TOOLS: QUESTIONNAIRES AND INTERVIEW GUIDES

Questions for patients:

- For how long have you been in the program?
- What is your current dose of methadone?
- Do you enjoy take-home dosing?
- What other (than methadone) medications do you take? Who prescribed those?
- How the dose change happens? (Initiated by doctor? Patient? Together?)
- Do you have treatment plan?
- What services, other than medication, are provided (psychosocial? Testing and treatment for HIV/HCV/TB? Referral?)
- What are major benefits of OST/ what are you happy with?
- What are major shortcomings of OST/ what are you unhappy with?
- What would you do differently?
- How easy is to get into OST? (what a person needs to do to get into treatment?)
- What are the barriers to participation (if a person wants to get into OST, what might hinder the process?)
- How would you describe the attitudes of OST staff towards patients (respect/doctor-patient/neglect/judgment)?
- What kind of issues with law enforcement do OST patients encounter?
- Does your participation affect your employment opportunity/current job?
- Does your family know you are in OST? Why (yeas/no)?
- Why there are so few patients on OST?

Questions for OST personnel:

- Position, work experience in OST
- Describe your regular day
- Number of patients in contact; frequency of contacts
- Range of services provided; frequency; perceived effectiveness (what is effective OST treatment)
- Purpose and quality of partnership with other facilities; issues?
- Papers to be filled in and documentations to be maintained
- What are the regulatory issues?
- What are the management and administrative issues as seen by doctors?
- What are the funding issues?
- Knowledge of WHO guidelines;
- Knowledge of local protocols and guidelines; national/local regulations
- What is the clinic's staffing?
- Work schedule for clinic (days, hours)
- Geographical coverage and geographical distribution of clinics
- Is there movement of patients between clinics?

- Based on what (and who) decides to which clinic patient will be enrolled/ How patient makes the decision?
- Does clinic have agreement with patient? Informed consent?
- Methadone dosing policy
- What is the retention in treatment; if low – what are the reasons
- What other (than methadone) medications are most often prescribed to OST patients
- Integration of HIV/HCV/TB testing, consulting and treatment/referral
- Psychosocial component of OST
- What is that patients most often ask questions about?
- What is that you do not have answer for?
- How the effectiveness of OST measured at your clinic? What instruments are used for evaluation?
- In general – what would you do/organize differently
- Why there are so few patients (what are major barriers for patient involvement?)

Partner organization:

- Position
- What is your (organization's) main field of activities?
- Purpose and quality of collaboration with OST clinic
- Number of OST patients served
- What are major issues in this collaboration? Management? Regulations? Funding?
- What are major issues in what you do for OST patients?
- What would you do differently?
- Why there are so few patients on OST?

Decision makers/public servants:

- OST regulatory framework
- Financing
- Projected financing and scale up plans
- Opportunities for capacity building

ANNEX III. Desk review list

#	Document – name
1	Ministry of Health of the Republic of Moldova, 2015, National Clinical Protocol on Pharmacological Treatment of Opioid Dependence with Methadone.
	World Health Organization Regional Office for Europe, *How to Improve Opioid Substitution Therapy Implementation*. 2014: Copenhagen.
	Ппавительство Республики Молдова, Постановление Nr. 1208 от 27.12.2010 об утверждении Национальной стратегии по борьбе с наркотиками на 2011-2018 годы
4	The World Bank. 2015. *Optimizing Investments in Moldova's HIV Response.* Washington DC: World Bank.
5	Subata E., 2012, *Evaluation of Opioid Substitution Therapy in the Republic of Moldova*, Vilnius, Lithuania.
6	National Coordination Council, *Republic of Moldova Progress Report on HIV/AIDS*, January-December 2014. Chisinau, Moldova.
7	Приложение к национальной стратегии по борьбе с наркотиками на 2011-2018 годы, Национальный план действий по борьбе с наркотиками на 2014-2016 годы
	Eurasian Harm Reduction Network, *Road to Success:Towards Sustainable Harm Reduction Financing. First year of the Regional Program "Harm Reduction Works – Fund It!", National Report for the Republic of Moldova*. 2015, EHRN: Vilnius, Lithuania.
9	Eurasian Harm Reduction Network, *Road to Success:Towards Sustainable Harm Reduction Financing. First year of the Regional Program "Harm Reduction Works – Fund It!", Regional Report*. 2015, EHRN: Vilnius, Lithuania.
10	Polonsky, M., et al., *Accessing methadone within Moldovan prisons: Prejudice and myths amplified by peers.* International Journal of Drug Policy, 2016. 29: p. 91-95.
11	ЮНЭЙДС, 2016, *Комплексы мероприятий по противодействию ВИЧ-инфекции и вирусному гепатиту С среди потребителей инъекционных наркотиков в странах Восточной Европы и Центральной Азии: моделирование и анализ эффективности затрат, Молдова*.
	Дворяк, С., 2015, *Предоставление ОЗТ в Республике Молдова. Барьеры на пути к доступу и рекомендации по их преодолению*.
	World Health Organization. (2009). *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence,* Geneva.
	Maas, J., Barton, G., Maskrey, V., Pinto, H., & Holland, R. *Economic evaluation: A comparison of methadone versus buprenorphine for opiate substitution treatment*. *Drug & Alcohol Dependence, 133*(2), 494-501.

ANNEX IV. List of persons interviewed during the evaluation

	Name	Organisation/Role in project	City
1	Liliana Caraulan	Program Coordinator, PAS	Chisinau
2	Tatiana Cotelnic-Harea	Program Officer, PAS	Chisinau
3	Dr. Mihai Oprea	General Director, Republican Narcological Dispensary	Chisinau
4	Dr. Lilia Fiodorova	Doctor-narcologist, Republican Narcological Dispensary	Chisinau
5	PWID – **5** individuals	Project beneficiaries	Chisinau
6	Ruslan Poverga	Director, NGO New Life	Chisinau
7	Vitalie Slobozian,	Program Coordinator, Soros Foundation - Moldova	Chisinau
8	Dr.	Doctor, PI #13	Chisinau
9	Dr.	Doctor, PI #4 and #15	Cricova
10	Eugenia Roman	Deputy Chief, Medical Department of DPI	Chisinau
11	Dr. Irina Tcaciuc	Chief of medical department of the Hospital of PI	Pruncul
12	Viktor Krivoi	Chief of the Narcoloical Service, Municipal Hospital	Balti
13	Ala Latco	Director, NGO Youth for the right to Live	Balti
14	Denis Hibovschi	Social worker, NGO Youth for the right to Live	Balti
15	PWID	Program beneficiary, PI #13	
16	PWID	Program beneficiary, PI #4	
17	PWID	Program beneficiary, PI #15	
18	PWID – 7 (3 females)	Program beneficiaries	Balti

19	Dr. Ion Vieru	Chief of the Narcoloical Service, Municipal Hospital of Comrat	Comrat
20	PWID – 7 (1 female)	Program beneficiaries	Comrat
21	Dr. Andrei Krasnov	Chief of the Narcoloical Service, Municipal Hospital of Cahul	Cahul
22	Svetlana Ciobanu	Director, NGO Step by Step, Day center for psychosocial support for PWID	Cahul
23	PWID – 2 individuals	Program beneficiaries	Cahul
24	Dr. Svetlana Timuş	Doctor-narcologist, RND OST site (Grenoble)	Chisinau
25	PWID – 7 individuals	Program beneficiaries	Chisinau
26	Dr. Liliana Gausauer,	Chief of the Narcoloical Service, Municipal Hospital of Edinet	Edinet
27	PWID – 8 individuals	Program beneficiaries	Edinet
28	Victoria Cojocaru	Director, NGO "Young women Cernoleuca"	Dondusen i
29	PWID – 6 individuals	Program beneficiaries	Dondusen i
30	Dr. Ion Todireanu	Chief of the Narcoloical Service, Municipal Hospital of Soroca	Soroca
31	PWID	Program beneficiary	Soroca
32	Dr. Eugenia Andriuţa	Chief of the Narcoloical Service, Municipal Hospital of Ungheni	Ungheni
33	PWID – 8 individuals	Program beneficiaries	Ungheni
34	Svetlana Plamadeala	country manager UNAIDS Moldova	Chisinau
35	Ina Tcaci	UNODC country office	Chisinau
	Total: 77 respondents		