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Building Integrated Care Services for Injection Drug Users in Ukraine

By Matt Curtis

ABSTRACT

WHO commissioned this report to examine the development of IC services for people with a history of injection drug use in Ukraine, as part of the country's ongoing response to the HIV epidemic.

Following a WHO evaluation of Ukrainian IC programmes earlier in 2009, three sites in Dnipropetrovsk, Kriviy Rig and Simferopol were identified as embodying a high standard of practice from which other programmes may learn. While far from perfect, each has made important progress in IC. The goal of this publication, therefore, is to present these programmes as practical, real world models for other Ukrainian government and nongovernmental agencies that are considering taking on IC services.

The author gathered information for this report through interviews with clients and staff of the three IC programmes during site visits in October 2009, and through review of evaluations, project reports and other available materials.

Keywords

DELIVERY OF HEALTH CARE, INTEGRATED - organization and administration
SUBSTANCE ABUSE, INTRAVENOUS - therapy
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1. Introduction

People were standing around a campfire on a wooded mountainside in Bakhchisirai, in the early fall chill, cooking shashlik and talking. Zhenya, a 55-year-old woman with a crippled leg but a bright gleam in her eye, said, “the worst thing about my life is that I have no children, no family. But I’ve found a family among the patients and staff of the narcodispensary.” She was speaking about the relationships she has developed and the care she has received through the Simferopol Republican Narcological Dispensary, one of several sites in Ukraine where innovative integrated medical and social services are being built to treat the intertwined HIV, tuberculosis and drug dependency epidemics.

The concept of integrated care (IC) for HIV, tuberculosis (TB) and drug dependency is built on a larger movement to reform primary health care that has increasingly gained traction in Europe and North America, especially for people experiencing or at high risk of complex, chronic medical problems. By co-locating health and social services and creating multidisciplinary teams that comprehensively respond to a person’s needs, the IC model seeks to improve access to care, health outcomes and patient satisfaction while reducing costs that result from duplication in the health care system and loss of patients who need care.

Perhaps the most comprehensive definition of IC is provided by Kodner and Spreeuwenberg: “Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings. The result of such multipronged efforts to promote integration for the benefit of these special patient groups is called ‘integrated care.’”¹

Although still relatively new in Ukraine, IC is already having a positive impact on patients. As Tatyana, a patient in Simferopol, says, “Having all these services in one place makes it so much easier to get health care. Since [IC services] started six months ago, there’s been a big change, AIDS, TB and the narcodispensary are cooperating perfectly.” Vitaly, a patient in Kriviy Rig, concurs: “The main services here are all routine, so we know when doctors are here and we can meet anyone we need to. We feel like there are people who really care about us here.” Health care providers have had a similar experience. “As an administrator, I can say that integrated care is the most progressive approach we have at the moment,” says Aleksandr Vladimirovich Nemykin, chief of the Simferopol Republican Narcological Dispensary. “During the last six months, the multidisciplinary team diagnosed 37 TB cases among our narcological patients, including 16 active cases. In my opinion, integrated care really helps us solve the TB problem among drug users – we diagnose, treat, and track them. Without integrated care, many cases would go undetected, and people would be infecting many others.”



*Dr Nemykin, Chief Doctor, Crimean
Republican Narcological Dispensary*

¹ Kodner D, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications. *International Journal of Integrated Care*, v. 2, 2002.

2. HIV and illegal drug use in Ukraine: the case for integrated care services

Since 1987, Ukraine has experienced a growing HIV epidemic that remains largely concentrated among injection drug users (IDU), and which has created significant new challenges for the country's medical and public health systems. By the end of 2007, it was thought that some 440 000 had been infected, representing roughly 1.6% of the adult population.² That year also saw 17 669 (38 per 100 000 population) officially reported new infections, the largest number to date.³ The proportion of new infections attributed to sexual contact continues to spread HIV beyond groups at highest risk, with the number of sexual partners of IDU estimated at as many as 552 000.⁴

IDU in Ukraine, as in many other countries, are dealing with a host of issues that increase their risk of HIV infection, or the chances that they will pass the virus on to others or fail in treatment if they are already infected. Alongside HIV, Ukraine has a major tuberculosis (TB) epidemic – including multidrug-resistant (MDR) TB – that disproportionately affects IDU people living with HIV (PLWH) and complicates medical care for a range of conditions. For many, drug dependency treatment is inaccessible altogether or unavailable at in-patient HIV or TB hospitals. IDU suffer greater rates of mental illness than the general population, and are often undiagnosed and untreated for such disorders. Criminalization of drug users and intense social stigma of drug use force people to adopt more dangerous injection practices and keep people away from HIV prevention, care and treatment services, and has led to increasing rates of HIV infection in the prison system.

None of this is news to anyone seeking to respond to Ukraine's HIV crisis. The challenge is that an appropriate, effective response requires action by a wide range of government and nongovernmental medical, public health and social service agencies. Like most of the rest of the former Soviet countries, Ukraine is saddled with a highly vertical health system. Cross-training and institutional collaboration between medical disciplines is rare, which too often leaves patients with multiple health problems on their own to find the care they need. Many do not succeed, leading to unnecessary death, a greater burden of disease, and greater economic and social costs to society than would be the case under a more rational system. Dealing with these issues is complicated by a host of other problems, ranging from an aging population to high rates of cardiovascular disease, child mortality and alcohol and tobacco-related disease, all of which strain an underresourced health system.⁵

Ukraine has, however, been a leader in HIV prevention, especially in the development of harm reduction services through which IDU exchange clean syringes for used ones, and receive other health and social services. In 2007, the International HIV/AIDS Alliance in Ukraine reported that more than 124 000 IDU were reached by such services, through 645 needle exchange points, the largest such network in eastern Europe.⁶ Recent

² *Epidemiological Fact Sheet on HIV/AIDS, Ukraine, 2008 Update*. Geneva, World Health Organization, The Joint United Nations Programme on HIV/AIDS, The United Nations Children's Fund, 2008.

³ *Ukraine: National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS*. Kyiv, Ministry of Health of Ukraine, 2008.

⁴ *AIDS Epidemic Update 2009*. Geneva, The Joint United Nations Programme on HIV/AIDS, The Joint United Nations Programme on HIV/AIDS, 2009.

⁵ *Health Care Systems in Transition: Ukraine*. Copenhagen, WHO Regional Office for Europe, 2004.

⁶ *Harm Reduction Developments, 2008*. New York, Open Society Institute, 2008.

innovations have included providing pharmacy-based needle exchange, overdose prevention services, new programmes targeting stimulant users, and improved case management services. Similarly, with support from the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and a cadre of dedicated nongovernmental organization (NGO) and government health professionals, Ukraine has made strides towards universal access to HIV care and treatment, which has improved on several indicators in recent years.

Drawing a lesson from the history of Ukraine's response to HIV, health policy officials, medical staff and social workers with support from the international donor community began creating the first IC programmes targeting IDU in the mid-2000s. But how has IC affected health in other countries?

As a model of health care delivery, IC has been applied to a variety of chronic conditions requiring multidisciplinary treatment approaches, including HIV/AIDS, heart disease, and psychiatric disorders to name only a few.

Though research on IC with regard to drug dependency and HIV is still emerging, several studies have examined the matter. On-site linkages between primary care and long-term methadone treatment have, for example, shown improved health outcomes, reduced inpatient and emergency department visits, and equal or reduced overall health care costs. For example, a recent study of 423 patients in the United States found that although people receiving methadone with integrated primary care had a greater number of outpatient care appointments, they had 72% fewer emergency department visits, and 67.5% fewer hospitalizations – both of which are considerably more expensive to the health system and more dangerous for patients than primary care.⁷

Similarly, a recent “review of systematic reviews” of IC programmes for various chronic illnesses found that they consistently “have positive effects on the quality of care.” The authors noted the most common elements of IC as: “self-management support and patient education, often combined with structured clinical follow-up and case management; a multidisciplinary patient care team; multidisciplinary clinical pathways and feedback, reminders, and education for professionals.”⁸

Community-based harm reduction programmes have long operated on IC principles in many countries, aiming to provide a one-stop shop for IDU health needs. The Lower East Side Harm Reduction Center in New York, for example, serves several thousand individual clients each year with a range of services: case management, substance use counseling, syringe exchange, on-site buprenorphine prescription and hepatitis vaccination, housing services, peer support and group counseling programmes, overdose prevention, and specific programmes for PLWH, people living with hepatitis C, women, transgendered people, and youth. As Allan Clear, executive director of the Harm Reduction Coalition in the United States of America has said, “Harm reduction is about inclusion. It's about being client-centered and client-driven, looking at the needs of the person in front of you, listening to them and then delivering those services.”⁹

⁷ Gourevitch MN et al. On-site medical care in methadone maintenance: associations with health care use and expenditures. *Journal of Substance Abuse Treatment*, 2007, 32(2):143-151.

⁸ Ouwens M et al. Integrated care programmes for chronically ill patients: a review of systematic reviews. *International Journal for Quality in Health Care*, 2005, 17(2):141-146.

⁹ Clear A. *What is harm reduction?* [web video]

(http://www.youtube.com/watch?v=2UQ_cZBYnnQ, accessed on November 15, 2009)

The WHO Regional Office for Europe has explicitly supported efforts to build IC through its European Office for Integrated Health Care Services, the purpose of which has been “to encourage and facilitate changes in health care services in order to promote health and improve management and patient satisfaction by working for quality, accessibility, cost-effectiveness and participation” through the integration of services.¹⁰ The case for emphasizing IC as a means of improving health care is made at length in *The world health report – Health systems: improving performance*.¹¹

¹⁰ Grone O, Garcia-Barbero M. Integrated Care: A position paper of the WHO European office for integrated health care services. *International Journal of Integrated Care*, 2001, 1.

¹¹ *The world health report – Health systems: – improving performance*. Geneva, World Health Organization, 2000.

3. A short history of integrated care in Ukraine

Although creative medical and harm reduction staff have sought out innovative ways to serve their clients for many years, formal efforts to create, evaluate and expand IC services for people who use drugs and PLWH in Ukraine began more recently alongside the introduction of buprenorphine therapy for opioid dependency in 2004. Some of the first psychosocial support projects, supported by the Alliance under GFATM Round 1, incorporated a range of additional medical and social services for OST patients. Other programmes, funded and organized by the Open Society Institute in 2005, were mainly focused on bridging HIV treatment literacy and adherence support into harm reduction settings, and harm reduction services into HIV treatment. Reflecting on the experience, Konstantin Lezhentsev of the All-Ukrainian Network of People Living with HIV notes that “I think the key outcome is actually the model site in Kazan, which showed great results in case management of active IDU and their retention on HIV treatment even in a country with no access to methadone or buprenorphine treatment. We also managed to form a pool of harm reduction experts, including outreach workers, working in treatment literacy for IDU and who want to be involved in treatment adherence projects.”

These early integration projects built an initial base of experience proving that NGO harm reduction and government HIV treatment programmes could be successfully bridged. They also served as models for Ukrainian pilot IC sites based on methadone maintenance therapy in Dnipropetrovsk, Mikolaiv, Kyiv and Odessa, which were established in 2008; WHO provided guidance and the Alliance and Clinton Foundation each contributed funding and technical support. When the All-Ukrainian Network of People Living with HIV was awarded a Round 6 grant from the GFATM, the pilot integration projects were expanded to include ten sites also providing primary health care and tuberculosis services, as well as sexual and reproductive health services specifically for women (including harm reduction, obstetric/gynaecological (OB/GYN) services, prevention of mother-to-child transmission, drug treatment for pregnant women, etc). The focus turned first of all to serving those patients with often the least access to health care and the highest risk of mortality: those with a dual or triple-diagnosis of injection drug use, HIV and/or TB. At the time, this involved several important advances in IC. For the first time, several TB dispensaries were licensed as providers of opioid substitution therapy (OST) with the medications methadone and buprenorphine, the ‘gold standard’ approach to treating opioid dependency. The availability of OST at AIDS centres was simultaneously expanded. Grant funding allowed for renovation of a number of sites, improving the clinical infrastructure for diagnostic and treatment services, and harm reduction services such as needle exchange and counselling were further cemented as core pieces of IC.¹²



Lezhentsev K. Organizing access to care and treatment for marginalized groups in Ukraine.”
Presentation at the International AIDS Conference, Mexico City, International AIDS Society, 2008.
(www.aids2008.org/Pag/ppt/TUSAT0704.ppt, accessed November 10, 2009).

The practice of prescribing buprenorphine and methadone for the treatment of opioid dependence deserves special attention in the development of IC. OST has clearly been a major breakthrough for people seeking to reduce or end their illegal drug use. “I used drugs for 18 years before I entered this programme,” says Oleg, a methadone patient in Kriviy Rig. “I tried many other ways to quit, going to detox, religious institutions and other methods, but nothing worked. I am convinced that methadone is the only way to help people stop taking street drugs.”



Oleg and Oxana, program participants in Kriviy Rig

Tatyana, a buprenorphine patient, concurs: “Buprenorphine changes your life. You have the ability to work and be with your family. Here in Simferopol five couples got together through the programme, and two have had children. Lots of other people have rejoined their families after many years of only being able to worry about getting drugs.”

Doctors have had a similar experience, with narcologists now able to provide a treatment backed by decades of medical

research, and infectious disease physicians able to stabilize people in need of difficult HIV or TB treatments. As Petr Anatolyevich Filolenko, a narcologist at the Crimean Republican Narcological Dispensary, says, “OST has influenced our work a lot. Previously the main goal was for patients to stop using drugs immediately and completely. But we’ve always known there are many people who won’t or can’t stop. With OST, people stop committing crimes to support buying drugs, and stop injecting which greatly reduces their risk of HIV infection. Our patients now are also much easier to link to health care. OST isn’t the perfect remedy for everyone, but it works very well for most cases.”

The concept of IC received a further boost through its adoption as a key approach within the new 2009–2013 national AIDS programme, which sets the number of IC sites as a performance indicator, and references a goal of 1200 people reached by IC by 2013 under GFATM Round 6 grants. To support action in this direction, a national IC working group was established, facilitated by WHO, and began to meet regularly throughout 2008 and 2009. The Alliance subsequently prioritized IC in Phase II of its current GFATM grant, launching new IC programmes in Poltava and Mikolaiv during summer 2009.¹³

By 2009, a number of sites had been functioning for long enough that a series of evaluations were undertaken, looking at how IC was functioning generally, as well as OST as a specific component of IC. As noted by the Ukrainian Institute on Public Health Policy (UIPHP), the on-site availability of core IC services varied considerably depending on the

¹³ Filippovich SA. Activities of the International HIV/AIDS Alliance in Ukraine for the development of integrated care centers for clients of SMT programmes funded by GFATM and USAID in Ukraine. *Presentation to the Ukrainian Institute on Public Health Policy Roundtable on Integrated Care*, October 20, 2009. (<http://www.uiphp.org.ua/ua/resursnycenterip/trening> accessed on November 8, 2009)

kind of institution hosting the IC site.¹⁴ Because of greater past investment in infrastructure and training, and medical licensing and other regulatory issues, AIDS centres are currently able to provide more on-site care (albeit only to PLWH), in large part because they often do not have to refer patients to outside clinics for treatment.

The UIPHP evaluation also found that the following.

- Multidisciplinary hospitals and AIDS centres already have an array of specialists sufficient to support high quality, cost effective IC services;
- IC is, however, a valid approach for all health care institutions, and priority should be given to staff training in this area and efforts to develop IC in a wider range of locations;
- Each element of the intended range of IC services was available in some form in Ukraine, but no one site had yet managed to offer a comprehensive package at the time of assessment. In UIPHP's view, achieving this goal will require clearer IC policy and practice guidelines, and regulatory reform to remove administrative and clinical barriers to IC;
- There is wide variation in how case management and multidisciplinary team coordination is carried out, and a need for strengthening and standardizing this aspect of IC programmes.

¹⁴ Forostyanaya E. Accessibility of comprehensive health and social care services for injecting drug users (IDUs) in integrated care centers. *Presentation to the Ukrainian Institute on Public Health Policy Roundtable on Integrated Care*, October 20, 2009. (<http://www.uiphp.org.ua/ua/resursnyicenterip/trening>, accessed online on November 8, 2009).

4. Case studies: three IC sites in Ukraine

“The biggest success of this programme is first of all the attitude towards life of our patients. Many people have started families or become employed. I know all the parents or relatives of my patients, and their lives have changed for the better.”

– Dr Elena Mukhina, Simferopol AIDS Centre



The three IC sites profiled in this report have more in common than differences. All three are located in moderately large cities, ranging in population from Dnipropetrovsk with just over 1 million people, to 710 000 in Kriviy Rig and 350 000 in Simferopol. Each suffered from the economic decline that accompanied the breakup of the Soviet Union and subsequent economic crises, in particular Dnipropetrovsk and Kriviy Rig, which were and are dependent on heavy industry. And each has experienced the rising drug use and related disease that is a feature across many similar regions of eastern Europe and central Asia: Dnipropetrovsk oblast and the Republic of Crimea are now among the Ukrainian regions with the highest HIV burden.

While following the same basic model for IC, each site has also had to chart its own path to a certain extent. Without a clear directive – let alone financing – from the Ministry of Health, staff have relied on personal connections, creativity, and a willingness to listen to their patients in order to build appropriate services. What do they look like today?

Crimean Republican Narcological Dispensary, Simferopol



“We started TB testing at the narcological dispensary even before the integrated care programme was established, but there was little continuity and patients were often lost. One of the advantages of our multidisciplinary team is that it immediately identifies weaknesses and bottlenecks in the system.”

– Dr Andrey Mandybura, Crimean Republican Narcological Dispensary

Entering the Crimean Republican Narcological Dispensary in Simferopol, one almost immediately feels the presence of Andrey Mandybura, the chief doctor overseeing OST programmes and an architect of IC services. In and around the small complex of buildings that makes up the dispensary, patients constantly stop Dr Mandybura to say hello and shake his hand, trading details about how they are doing and how the programme is

going. Clinical boundaries are clear, but even so it is a relationship perhaps more familiar to frontline harm reduction staff than eminent physicians. “Every client I work with, we need to be a team. We are equals in making choices and working to improve health. It’s the only way I think this can work.”

The Narcological Dispensary was one of the first to provide buprenorphine in Ukraine, beginning in 2004. Methadone was added in August 2008, and the programme was serving 131 patients by October 2009, with roughly 5 new methadone patients added per week in pursuit of a goal of 180 patients. IC services began to coalesce around the OST programme almost from the beginning. “We noticed that about 90% of people living with HIV who came to the TB dispensary were drug users, and some two-thirds of narcology patients had a history of TB infection,” says Alla Vladimirovna Aukhadiyeva, a TB doctor who cooperates with the IC programme. “We saw a clear need to cooperate with narcology.” Elena Mukhina, an AIDS doctor, cites similar statistics, noting that “at the AIDS Center, about 75% of people living with HIV are drug users. Of those, about 40% have or have had TB, or need prophylaxis because of their HIV. It’s obvious we need IC in Simferopol, and I have no doubt that the situation is the same elsewhere in Ukraine.”

The need has indeed been there. Crimea has officially registered 800-1000 new HIV infections per year since 2005, and HIV and AIDS case burdens make it one of the more heavily affected regions of Ukraine. By international standards, for example, the Republic’s official HIV 2007 incidence rate of 48.6¹⁵ is more than twice that of the United States (2006).¹⁶ Studies of IDU in Simferopol have found HIV prevalence in excess of 50%.¹⁷ According to the Republican AIDS Center, 1250 people currently receive antiretroviral (ARV) medication for HIV in the city, one of the largest such programmes in the country.

Unlike the IC programmes in Kriviy Rig and Dnipropetrovsk, the Simferopol programme does not employ a dedicated case manager. It does, however, have an unusually strong referral system between the narcology, AIDS and TB clinics, with regular cross-recruitment of patients and weekly multidisciplinary team meetings at the Narcological Dispensary. TB testing and treatment is provided at the TB clinic located essentially across the street from the Narcological Dispensary; the AIDS Centre is located further away, but places a doctor at the IC site at least once per week, and offers some additional services (e.g. hepatitis and STI testing and care) off-site. OST dispensing is currently offered Monday-Saturday from 8:30 to 13:00, and is also available on a small scale from a total of five district narcological clinics and on an outpatient basis at both the City and Republican TB dispensaries. In-house psychiatrists at the Narcological Dispensary are also able to provide mental health care.



Nurses must observe medication consumption

¹⁵ *HIV infection in Ukraine, Informational bulletin #29*. Kyiv, Ministry of Health of Ukraine, 2008.

¹⁶ Hall H et al. Estimation of HIV Incidence in the United States. *Journal of the American Medical Association*, 2008, 300(5).

¹⁷ *HIV/AIDS surveillance in Europe: mid-year report 2007, No 76*. Saint-Maurice, Institut de Veille Sanitaire (EuroHIV), No 76, 2007.

Unfortunately, with a recent lapse in funding for the IC programme, it is not able to formally function. But the relationships it fostered between clinicians and patients have kept the system running. As Elena Mukhina of the AIDS Centre says, “Multidisciplinary teams allow us to have much more control over our patients’ care, much better and more regular follow-up. Even though I no longer work officially with the IC project, it helped me to develop very strong relationships with my clients. We trust each other, and they can reach me anytime by phone. In the end, we need a horizontal relationship between doctors and patients, a collaboration.”

Patients have responded. “I think it’s important for people to be able to get basic medical care every few months, take diagnostic tests, that sort of thing,” says Kostya, a buprenorphine client. “People in ST often have a lot of health problems after 10 or 20 years of drug use – we need to be able to access the medical system.”



Kostya, program participant in Simferopol

The IC programme’s challenges are similar to those found at other sites. Dr Aukhadiyeva places a high priority on adequate funding: “Financing is the main problem. We have specialists who understand this work and who are ready, but infectionists won’t leave their main place of work for very long just as volunteers at the integrated care site.” She and others also express frustration with the way in which Ukraine’s health care system still prevents true integration by requiring patients to leave the site for key services. “The best solution would be to have one building to cover triple pathology,” says Dr Aukhadiyeva.



Tatiana, program participant in Simferopol

The still young and controversial OST programme is the source of greatest concern for both doctors and patients. Regulatory barriers and attention from the police about potential diversion of medications mean that all OST patients must attend the clinic every day, which strains both their ability to lead a normal life – the central goal of the programme – as well as the narcological system itself. “I wish we could get methadone with a doctor’s prescription. I’m an invalid, and some days it’s impossible for me to get out of bed, let alone to the narcodispensary,” says Zhenya. Elena, a buprenorphine patient, was one of many who brought up employment: “The best thing would be to be able to get my medicine by prescription at any pharmacy. The dispensing hours here are very complicated to combine with my work.” For Kostya, time is the issue: “I live 20 km outside Simferopol. I have to spend up to three hours per day coming to and from the programme to get my medication.”

“The main point is to change the approach to OST – it should be no different than prescribing antidepressants. It’s a tool for doctors to support patients,” says Dr Mandybura, the doctor overseeing the OST programme. This relatively simple distillation of the problem could be used to describe the basic philosophy of IC in

Simferopol. As Dr Aukhadiyeva says, “It’s only a matter of will and motivation to start integrated care services. Clinicians elsewhere can do it. There’s nothing overwhelming to cope with.”

Kriviy Rig City Narcological Dispensary

“When we started integrated care with OST, at first of all we were worried about the possibility of something going wrong, such as our patients overdosing. But after 1-2 months we saw that we were not harming our patients, and in fact their health was dramatically improving.”

Dr Dmitri Valentinovich Shaposhnik, Kriviy Rig City Narcological Dispensary

Stretching along a 126 km north-south band of iron ore mines and one of the largest steel mills in the world, Kriviy Rig has been a centre of Ukraine’s HIV epidemic, which has accompanied the economic disruption of the past two decades. A 2007 study of 540 IDU in Kriviy Rig found that more than 30% were HIV-positive, and roughly 45% were infected with hepatitis B or C.¹⁸ Other epidemiological surveys have found HIV prevalence among Kriviy Rig IDU as high as 89%.¹⁹ There are roughly 5 000 people registered as drug users in the city, though local harm reduction staff estimate the true figure closer to 15 000. Opium-based shirka remains the predominant injected drug in the city, but health staff estimated that more than one-third of IDU are using stimulant drugs such as vint.

The Ministry of Health made the decision to establish OST in Kriviy Rig roughly two years ago, setting the stage for what later became the IC programme. Methadone services began in 2008. “To be honest, when we first began talking about OST, I was against it, says Dmitri Valentinovich Shaposhnik, narcologist of the Kriviy Rig City Narcological



Dr Strakh, Kriviy Rig Narcological Dispensary

Dispensary. “In some ways, it was interesting to see what was used in other countries, even though we knew it was unacceptable in Ukraine. But finally, once we started actually doing it, we quickly began to see the positive impact.”

The City Narcological Dispensary, where the IC programme is centred, is located on the campus of a large psychiatric hospital. The chief administrator, Petr Andreyevich Strakh, shared Dr Shaposhnik’s

initial skepticism of OST: “At first I was very actively against methadone, even, you could say, and activist against it. I’m an Orthodox Christian, and our religion is against this method of treatment. But as a doctor, the more I witnessed, it was impossible to deny the positive effects of methadone – social functioning, better family life, employment, much better access to health care and improving health, much less participation in crime. Now, I’m leaving Kriviy Rig to go back to practice in the small town I come from, and I will do everything I can to start a methadone programme there.”

¹⁸ Smyrnov P. *Peer-driven intervention (PDI) among stimulant users in Ukraine*. International HIV/AIDS Alliance in Ukraine. Presentation at the Global Methamphetamine Conference, Prague, September 15, 2008.

¹⁹ *HIV/AIDS Health Profile, Ukraine*. Kyiv, USAID, 2008.

Currently, the narcodispensary is providing methadone to 136 clients. The IC programme, supported by funding from the Clinton Foundation, has linked OST clients to HIV care and treatment, TB services, counselling, and a variety of other services. Though some key services (e.g. dispensing medications for HIV and TB treatment) still must be provided at other sites, all care is coordinated through the IC programme's multidisciplinary team, which unites various government medical specialists. Aside from check-ins on individual client cases, the multidisciplinary team at the narcodispensary meets once per month to review how the programme is going, discuss difficult cases, and coordinate additional improvements. Some professionals, including social workers, a lawyer and a gynecologist, are provided by the local harm reduction organization Gromadskye Zdorovya.



Nadezhda Velikodnaya, case-manager, Kriviy Rig Narcological Dispensary

Overall, the IC is able to provide a full-time narcologist, narcological nursing staff, psychologist and a social worker. AIDS and TB specialists attend once per week, but are unable to dispense medication on site; the AIDS and TB centres are quite far from the narcological dispensary and do not yet provide OST for in-patient treatment, though plan to introduce a total of 80 new OST treatment slots between them in the near future.

Individual clients' first point of contact is Nadezhda Velikodnaya, a social worker and case manager. "The first goal of my job is to establish good relations with all our patients, so that when they have some problem they will be comfortable to come to me," she says. "Every client needs an individual approach. You can't press them into some preconceived idea of what care or treatment 'people like this' should receive."

As a regular feature of her work, Nadezhda provides short trainings for clients on HIV, hepatitis, treatment adherence and other topics, the goal being to create a supportive environment where clients are well educated and comfortable to deal with their issues. It seems to be working, to the point that clients have found a space in which to support one another as well. As Nadezhda says, "Many of our clients are very generous and ready to help. We have a client who lost a leg and then her husband died. Other clients recently brought her a big bag of clothes and other things for her child. It's nice to see people who have often been treated badly be so considerate."

"Case management is the link in the chain between patients and doctors," says Gromadske Zdorovya director Svetlana Arkadyevna Osipova. In the IC system in Kriviy Rig, the case manager works in concert with the medical team to track each client, ensure that they successfully navigate the medical system, and provide more intensive help to people dealing with multiple medical issues. "My biggest successes are those people I help start [anti-retroviral therapy]," says Nadezhda, "which even includes the personal example of my husband." Achieving this can involve numerous steps, as with the case of Viktoriya, a client who came to the narcology centre quite ill, and who was diagnosed with HIV, tuberculosis and hepatitis-related liver disease. Following an initial consultation, she had visits arranged with an AIDS physician, a surgeon, a phthisiatrist and a psychologist. Integrated care, in this instance, was as much about helping patients through a system that may be confusing or frightening as it is about simply providing services. Despite a low CD4 count and TB, Viktoriya initially refused to start ARV medication because of fears

that it would negatively affect her liver disease, a situation that needed to be talked through with the entire team coordinating her care.

This effort to truly provide integrated health care delivery based around OST and case management is the Kriviy Rig IC's chief success to date. Stating the results most succinctly, Dr Strakh says, "We feel that patients need us now. I can't say I think that was always true." Positive outcomes are often as much about social well-being as they are about managing a particular medical concern. In the view of Dr Shaposhnik, "the process of social adaptation among our patients has been very important. At first, only about 5% of them were employed; now it's one in three. And many have gotten back together with their families. Speaking as a human being, I like this very much. I'm happy to see the eyes of our patients' parents. In clinical terms the medical services now available on-site are not even usually available to the general public."



*Svetlana Osipova, Director of Gromadske Zdorovya
NGO, Kriviy Rig*

Patients echo these sentiments. About the basic IC approach, Olga says, "I like the attitude of the medical staff very much. They are always kind and supportive, and they treat us as equals, not like at other clinics." Others often focus on the intense change brought about by stopping the use of illegal drugs. "I didn't live with my family for 7 years, but now that I'm taking methadone I've been able to go back to my wife and children," says Vitaly. As a young woman named Tanya puts it, "I remember there was a time early on after I started taking methadone and I went to the place where I normally bought shirka, just out of habit. Standing there waiting to buy, I suddenly realized I didn't want it."

Many of the challenges for the future development of IC in Kriviy Rig were common to other sites visited during preparation of this report. Patients reported distress with the clinic staff's practice of crushing methadone pills, seeing it as a symptom of continued discrimination against them and widespread misunderstanding about OST. "We have big problems with disinformation about methadone," says Olga. "The local news reports say we act crazy, that the chief doctor is wrong to give us this medication, that sort of thing. Drug users too will say things like, 'Methadone is dangerous, the doctors are experimenting on you.' There is a lot of education to be done."

Staff are well aware of such problems, which can have a wider impact on their ability to work. Dr Strakh notes that, "We have a terrible shortage of narcologists here. People don't want to enter a field where there may be controversy or trouble with the police, and many still just don't support OST. In Kriviy Rig we have five narcologists when we need at least 17, but no one new has come to work here in the past 10 years." But the focus is ultimately on expanding access to high quality care.

"The only thing we really need to be doing is increasing the number of patients and the number of IC sites," says Dr Shaposhnik. "People are afraid of what they don't know, though. We must provide more information to the public about what we're trying to do here."

Dnipropetrovsk City AIDS Centre

“Integrated care services are very much needed for our patients. Most are HIV-positive or have other serious health conditions, and OST is just one tool among many for helping people be more healthy. I’m focused on drugs issues, but as I see my role now, I never forget about other health issues in my clients, and if I suspect something I make sure they are connected with my colleagues.”

– Dr Oleg Victorovich Shtengelov, Narcologist, Dnipropetrovsk City AIDS Center

Along with Odessa Oblast, Dnipropetrovsk Oblast has Ukraine’s highest official HIV infection rate, and is second only to Donetsk with the largest number of PLWH.²⁰ Eleven thousand people are registered as HIV-positive in Dnipropetrovsk city, and about 6 000 have some kind of regular contact with the AIDS Centre system. According to Alena Lesnichaya, who directs the AIDS Centre, some 80% of PLWH have a history of drug use, though sexual transmission of HIV is increasing, and is a bigger factor among young people than in the past. As elsewhere in Ukraine, the drug scene has evolved in recent years, with roughly 50% of IDU in Dnipropetrovsk using stimulants now.

Situated within the City AIDS Centre – itself on a larger campus housing a hospital – the IC site, supported by the Clinton Foundation, has by far the most resources and most developed infrastructure of the three centres visited for this report, partly due to its location, and partly to the relatively greater investment in AIDS medicine than in narcology in recent years. The IC is able to provide on-site HIV, narcological, gynecological, case management and social support essentially on demand. A psychologist and TB specialist are each present roughly once per week, and a psychiatrist (who can prescribe psychiatric medications) attends once per month. Unlike at the narcological dispensaries, TB medications are dispensed alongside OST, allowing for a more efficient directly observed therapy system.

IC clients in Dnipropetrovsk can also begin methadone induction somewhat faster than in many other cities, generally in 1-2 days. Since patients come through the AIDS system, most have already completed necessary HIV-related blood work, are often already registered with the local narcological dispensary, and the hospital has some TB equipment on site which can be used to complete diagnostics required before methadone induction. Altogether this limits the need for referrals to other clinics before a patient can begin OST.

Dr Lesnichaya views several recent developments as major advances in the AIDS Center’s ability to provide IC: “First of all, OST has been incredibly helpful. When we began we had no idea it was even possible, and it’s had a really positive effect on patients’ lives.” Improvements in OB/GYN services have been tremendously positive for HIV-positive women. And the multidisciplinary team has advanced the quality of care despite the fact that it is not institutionalized in Ukrainian medicine. As she says, “Our team – AIDS, TB, narcology, psychiatry, nurses, social workers – everything is working very well when the funding is coming in, but there are always gaps that make our work difficult.” Dmitri Chekhov, a social worker with the NGO Virtus who provides case management services within the IC programme, adds that, “We are really focused on ARV adherence. Since we began the IC programme, only two or three people have left, and we are consistently seeing people’s CD4 and viral load improve, and positive changes to their overall health.”

²⁰ HIV infection in Ukraine, Informational bulletin #29. Kyiv, Ministry of Health of Ukraine, 2008.



Multidisciplinary team at Dnipropetrovsk City AIDS Center

Broadly speaking, services at the AIDS Center are grounded on a commitment to harm reduction. Referring to the approach of the narcological services that he oversees within the IC programme, Oleg Victorovich Shtengelov says, “Harm reduction needs to be a concern at every turn. Addiction requires long term treatment, and there is a need to pay attention to times when people are struggling.” As Tatyana Sadirina, a nurse, says simply, “medical staff need to be patient – change takes time.”

Virtus also introduced additional harm reduction services into the IC programme. Every new OST patient, for example, receives training on overdose prevention and receives a kit with naloxone, an opioid overdose antidote. Although no one in the programme has reported using naloxone yet, providing the medication has calmed fears among some clinicians and is appreciated by patients, many of whom have experienced overdose in the past.

The IC programme does continue to face certain problems that threaten its longer-term viability to some extent. Though less dependent on funding for outside specialists than the narcological dispensaries, AIDS Centre staff nonetheless must be concerned about money on a regular basis. Staff reported interference with and pressure from local police and OBNON on the programme, including a recent incident in which police entered the AIDS Centre premises to arrest a participant, affecting participation in life-saving services and clinicians’ ability to provide the highest quality of care. The multidisciplinary model at the AIDS Centre has its limits as well: it cannot provide every conceivable kind of health care, and, as Dr Lesnichaya notes, outside institutions still frequently discriminate against HIV patients and drugs users. The AIDS Centre frequently comes into conflict with district health clinics that turn down patients.

Among patients, although there is widespread appreciation for the scope of services offered at the IC programme, concerns remain in particular about the highly restrictive nature of OST. Many cited the lack of take-home prescription of methadone, or alternative

dispensing options (e.g. pharmacy-based) as a major barrier to employment and normal living. As one said, “It takes a lot of money for transportation and a lot of time. It would be a great help if methadone could be given out at the district health clinics, closer to home for most of us.” The crushing of methadone pills as a result of police pressure to reduce the chance of diversion is seen as insulting, and many expressed concern over possible clinical problems with doing so (“Every time I take crushed pills I feel nauseous and the effect is much shorter”). Several people also cited potential police interference with their treatment, for example the threat of losing a driver’s licence because of participation in methadone therapy.

In the end, the IC programme in Dnipropetrovsk delivers a sense of pushing toward a new, better way of offering health care to people with a history of illegal drug use. Patient retention has been high and the clinical team is tightly organized. As with any endeavor in the vanguard of a field, there is an emotional element as well. As Dr Lesnichaya said, “It’s very important for people who work in this area to love their patients. Without real love, it’s not possible to do this kind of work.”

5. Lessons learned

What can be said about the development of IC programmes in Ukraine? It is clear that no programme has yet been able to completely fulfill the goal of truly bridging different parts of the health care system in order to improve the continuity of care and outcomes for patients. Much of the reason for this has to do with the legal and regulatory structure of Ukraine's medical system, funding issues, staffing shortages and other problems. But it is equally clear that IC has huge potential to reshape Ukrainian medicine for the better, and not only for people dealing with drug dependency, HIV or TB. Recent evaluations by the WHO Country Office, Ukraine, UIPHP and international experts have found that IC is contributing to improvements in access to care and treatment and increasing cooperation across medical disciplines. At the IC sites evaluated by UIPHP,²¹ the majority of patients (often a large majority) at all sites were found to have been informed about more than 40 different services available on-site or by referral. Core services such as narcological assistance, HIV and TB diagnostics, and psychosocial consultation had consistently high uptake, with AIDS centre-based IC programmes having slightly more success in connecting patients to a wider array of health care.

The programmes have had other positive, but less tangible, results as well. Many staff cited feelings that they are now better able to serve their clients, and consequently more fulfilled in their work, under the IC model. "We got used to our patients, learned to trust each other under this system, and now we see them, I'd say, almost like relatives," says Tatyana Sadirina, a nurse at the Dnipropetrovsk AIDS Centre. Patients' experiences have mirrored this, as in the words of Olga, a participant in the Kriviy Rig programme: "I like the attitude of the medical staff very much. They are kind and supportive, and they treat us as equals. It's the furthest thing from many other clinics."

Essential elements of IC in Ukraine

"First, you must believe in the therapy. Second, make a team that consists of people you can trust and rely on. Next, don't set big, complicated targets that will immediately frustrate you. It takes time and commitment to help people change."

Dmitri Valentinovich Shaposhnik, Chief Doctor, Kriviy Rig Narcological Dispensary)

Among the three IC sites visited for this publication, there was consensus among staff and patients that the most successful features of the programmes developed to date include:

- **a basic package of essential services**, including for drug dependency, HIV and TB infection, mental illness and psychosocial assistance;
- **a multidisciplinary team model linked through individual patient case management** that meets regularly and actively works to reduce barriers to health care and promote cross-training between disciplines (new programmes should consider that "training of IC specialists is crucial," says Svetlana Osipova from the Kriviy Rig team. "Not merely theoretical training – people need to see IC in practice at existing model sites");
- **efforts to build trust with patients, and a collaborative approach to their health care** (Lyudmilla Kibovskaya, nurse in Dnipropetrovsk, advises that patients should be

²¹ *Report on assessment of integrated care implementation progress in 7 sites in Ukraine*. Kyiv, Ukrainian Institute on Public Health Policy, 2009.

“treated as equals, not as some ‘risk group.’” Staff must be recruited who subscribe to a nonjudgmental, non-discriminatory approach);

- **inclusion of harm reduction principles across care**, both in terms of concrete services and attitude within other elements of IC (“Harm reduction needs to be a concern at every turn,” says Dr Shtengelov, a narcologist in Dnipropetrovsk; individual change takes time, and patients deserve support throughout the process. “People who have been injecting drugs for many years know a lot about their health and can tell you a lot, so it’s important to have a good rapport. Addiction is complicated and we must consider the whole person – physical health, social and psychological factors. Only then can you decide on a course of treatment tailored to the individual”);
- **an appropriate location** for the site that is convenient for patients and has the basic infrastructure needed to support IC;
- **collaboration between government and nongovernmental agencies** in order to maximize the scope and quality of care.

As IC staff repeatedly pointed out, although NGOs usually lack the infrastructure to provide complex medical care, they often have both different, complimentary skill sets to clinic staff and sources of funding that are not always available to government clinics. In Kriviy Rig, for example, an NGO provides harm reduction, gynaecological, and social support services to IC patients. Similarly, in Dnipropetrovsk an NGO offers case management, counselling and overdose prevention through the IC.

Barriers to IC

Unfortunately, Ukrainian IC programmes also face a number of obstacles to their development. The majority of these are related to: Ministry of Health regulations on how health care may be delivered in Ukraine; misinformation and controversy about OST; and/or funding shortfalls. Each requires some combination of public policy reform, clinical training, improved intragovernmental cooperation, and public education if the IC model is to be sustained and expanded in a way can impact Ukraine’s HIV epidemic. Problems raised by staff or patients or otherwise observed during site visits for this report include the following.

General health care delivery issues

Inadequate cross-training between medical specialties

Even within multidisciplinary teams, there remains a tendency to avoid sharing responsibilities across disciplines (e.g. in primary care, prescribing of medication, etc.) which may result inefficiencies and substandard care. This is a result both of missed clinical training opportunities, and the current regulation of medical practice by the Ministry of Health.

Overemphasis on diagnostics

Some testing done by the IC sites may not be clinically warranted. In particular, frequent use of outdated x-ray fluorography as a primary TB diagnostic tool may put patients at risk from radiation exposure and fail to detect a significant number of cases.

Insufficient access to women’s health services

Some doctors and patients described women-centred health care as a missing piece in some programmes. Greater access to sexual and reproductive health and primary care

services for women is needed both in terms of having them available through the IC system, and in improving how women's health (especially OB/GYN) specialists work with drug-using women.

Issues related to opioid substitution therapy

Restrictive quotas on OST treatment slots

A number of medical staff saw government quotas on OST as unhelpful, and felt that the expansion of OST services would be better accomplished in a "more natural" way, in which doctors are able to induct patients based on need and with greater flexibility at experienced clinics that are capable of absorbing more patients.



Buprenorphine prescriptions

Lack of OST prescription, take-home allowances or pharmacy dispensing

With the exception of a small number of test cases in some cities, no Ukrainian OST patients are allowed to receive their medication except under the direct observation of medical personnel at the dispensing clinic. This practice is not typical of better-established OST programmes in other countries, and creates major, clinically pointless hurdles to patients' efforts to achieve a normal life free of illegal drugs.

Burdensome OST reporting requirements

Current OST formulations (i.e. multiple pill dosages, each with separate reporting) unnecessarily complicate dispensing and paperwork, thereby reducing the number of patients any one programme can serve and increasing costs.



Counting methadone tablets

Law enforcement interference and associated fear

Numerous staff and patients reported that police or OBNON were actively watching the OST programme, sometimes made direct or implied threats to doctors or patients, and could in future or have in the past intervened in ways that interrupt service delivery. Police pressure is also cited as the cause for crushing of OST tablets common at most sites, which creates distrust and antagonism between staff and patients.

Funding

Funding shortages and, in many places, weak infrastructure

Insufficient or interrupted grant funding for IC programmes puts services – and patients – at risk. In addition, the infrastructure available to the medical system is a major challenge to quality of care in many places.

Inefficient use of staff resources

The inability of medical institutions to assign staff between clinics (requiring IC programmes to hire specialists as consultants with outside funding), or of physicians to practice medicine outside of strictly defined boundaries drives up costs and reduces productivity and, most likely, quality of care.

Charting a way forward

With IC, much remains to be done, but Ukraine is largely on the right track. Several funders have made a commitment to IC, which must be extended and matched by the government. Initial efforts to create a cadre of IC experts have yielded skilled staff and innovative programmes in a number of cities, including several not profiled in this report. These need continued policy and technical support to reach a best practice standard and to become routine as the basic approach to chronic HIV and drug dependency care. With regard to OST many patients' quality of life and willingness to participate in services, some regulatory changes, deeper training of a wider variety of medical personnel, and efforts to familiarize officials outside of medicine with OST could produce numerous improvements.

Many of the problems cited above may seem insurmountable at first glance, and the result may be that positive change is unfortunately incremental. Some answers are a relatively straightforward matter of team building and training at the clinic level, while others will require legal or regulatory changes and significant shifts in peoples' beliefs and the culture of health care in Ukraine. Those working to build IC services should remember that changes that seemed impossible in recent memory have already happened. OST is only five years old in Ukraine, and is only now beginning to reach a significant number of people. The first efforts towards IC programmes are even more recent. In moving forward the debate about how to deal with drug use, making lifesaving HIV treatment more accessible, improving drug treatment, creating innovative links across the medical system, and other areas, Ukraine has exhibited far greater progress than most of its neighbours. Ukraine can win the fight for a more effective, more humane health care system.