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“Bureaucracy & Beliefs”: Assessing the Barriers to Accessing Opioid Substitution Therapy by People Who Inject Drugs in Ukraine

Martha J. Bojko¹, Alyona Mazhnaya², Iuliia Makarenko³, Ruthanne Marcus¹, Sergii Dvoriak³, Zahedul Islam², and Frederick L. Altice^{1,4}

¹Yale University School of Medicine, Section of Infectious Diseases, AIDS Program, New Haven, Connecticut, USA

²ICF International HIV/AIDS Alliance in Ukraine, Kyiv, Ukraine

³Ukrainian Institute for Public Health Policy, Kyiv, Ukraine

⁴Yale University School of Public Health, Division of Epidemiology of Microbial Diseases, New Haven, Connecticut, USA

Abstract

Aims—Opioid substitution therapy (OST) is an evidence-based HIV prevention strategy for people who inject drugs (PWIDs). Yet, only 2.7% of Ukraine’s estimated 310,000 PWIDs receive it despite free treatment since 2004. The multi-level barriers to entering OST among opioid dependent PWIDs have not been examined in Ukraine.

Methods—A multi-year mixed methods implementation science project included focus group discussions with 199 PWIDs in 5 major Ukrainian cities in 2013 covering drug treatment attitudes and beliefs and knowledge of and experiences with OST. Data were transcribed, translated into English and coded. Coded segments related to OST access, entry, knowledge, beliefs and attitudes were analyzed among 41 PWIDs who were eligible for but had never received OST.

Findings—A number of programmatic and structural barriers were mentioned by participants as barriers to entry to OST, including compulsory drug user registration, waiting lists, and limited number of treatment slots. Participants also voiced strong negative attitudes and beliefs about OST, especially methadone. Their perceptions about methadone’s side effects as well as the stigma of being a methadone client were expressed as obstacles to treatment.

Conclusions—Despite expressed interest in treatment, Ukrainian OST-naïve PWIDs evade OST for reasons that can be addressed through changes in program-level and governmental policies and social-marketing campaigns. Voiced OST barriers can effectively inform public health and policy directives related to HIV prevention and treatment in Ukraine to improve evidence-based treatment access and availability.

Correspondence: Martha J Bojko, PhD, Yale University School of Medicine, Department of Internal Medicine, Section of Infectious Diseases - AIDS Program, 135 College St., Suite 323, New Haven, CT 06510-2483, Mobile (U.S.): +1 (860) 729 04 80, Mobile (Ukraine): +38 (050) 723 15 53, martha.bojko@yale.edu.

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Keywords

Substance abuse; opioid substitution therapy; people who inject drugs; methadone; buprenorphine; treatment barriers; qualitative research; Ukraine; health beliefs

INTRODUCTION

Ukraine is home to Europe's most volatile HIV epidemic and among the worst globally, with an adult prevalence of 1.1% (UNAIDS, 2013). Although sexual transmission is increasing in Ukraine, the epidemic continues to be fueled by drug injection, primarily of opioids (Burruano & Kruglov, 2009; Nieburg, 2012; UNAIDS, 2014). Among Ukraine's estimated 290,000–360,000 people who inject drugs (PWIDs), HIV prevalence ranges from 21.3%–41.8% (Balakiryeva, 2012; Mathers et al., 2008).

Ukraine is one of the few countries in Eastern Europe and Central Asia that has implemented relatively progressive evidence-informed HIV prevention and treatment services for PWIDs (UNAIDS, 2014). However, the effectiveness of harm reduction programs and policies, including outreach and peer education, condom distribution, voluntary HIV testing, provision of antiretroviral therapy (ART) and needle/syringe exchange programs (NSEPs), have been inadequately scaled-to-need to meet HIV prevention and treatment efforts (Degenhardt et al., 2014; Wolfe, Carrieri, & Shepard, 2010).

Opioid substitution therapy (OST) in Ukraine was first introduced using buprenorphine maintenance (BMT) in 2004 (Bruce, Dvoryak, Sylla, & Altice, 2007; Lawrinson et al., 2008) and followed by methadone maintenance treatment (MMT) in 2008 (Schaub, Chtenguelov, Subata, Weiler, & Uchtenhagen, 2010) to address HIV prevention and treatment challenges including risky drug injecting practices and poor access to and retention in ART. OST is internationally recognized as one of the most effective harm reduction and HIV prevention and treatment strategies for opioid-dependent PWIDs (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010; Dutta et al., 2013; Kerr, Wodak, Elliott, Montaner, & Wood, 2004). It enhances quality-of-life, improves employment and social functioning (De Maeyer, van Nieuwenhuizen, Bongers, Broekaert, & Vanderplasschen, 2013; Korthuis et al., 2011; Nosyk, 2011), and reduces injection-related transmission of HIV and viral hepatitis (Gowing, Farrell, Bornemann, Sullivan, & Ali, 2008), crime, overdoses and health-related co-morbidity (Dennis et al., 2014; Fingleton, Matheson, & Jaffray, 2014; Michels, Stover, & Gerlach, 2007). For HIV-infected patients, it improves ART access, retention in care (Altice et al., 2011; Uhlmann et al., 2010) and adherence (Malta, 2010). Mathematical modeling studies suggest that increasing OST coverage is the most cost-effective HIV prevention strategy for Ukraine's HIV epidemic (Alistar, Owens, & Brandeau, 2011; Vickerman et al., 2014).

Despite OST's many documented benefits, scale-up efforts to enroll 20,000 PWIDs into OST in Ukraine by year-end 2013 have been thwarted by numerous obstacles; only 8,600 PWIDs were on OST at 156 sites, representing only 2.7% of Ukraine's estimated 310,000 PWIDs (Degenhardt et al., 2013; Ukrainian Ministry of Health, 2013). The problematic scale-up of OST and poor treatment retention impair HIV prevention efforts (Alistar, et al.,

2011; Schaub, et al., 2010) despite free treatment available through national and external Global Fund monetary support.

In an effort to examine the challenges of expanding OST in Ukraine, we initiated a comprehensive research study to better understand the barriers and facilitators of OST scale-up in Ukraine. In this article, we identify the most salient barriers to OST access and entry through qualitative data collection with PWIDs who have never been on OST, since this group is the largest reservoir of PWIDs in Ukraine who have never successfully entered treatment.

METHODS

To better understand OST barriers and facilitators in Ukraine, extensive semi-structured focus group (FG) discussions were conducted from February–April 2013 with 199 opioid dependent PWIDs in five Ukrainian cities (Donetsk, L'viv, Odesa, Mykolaiv, Kyiv), which represent the main geographic regions in Ukraine (East, West, South and Central) and were selected in order to examine local and regional contextual factors related to OST; cities were selected for having the largest number of PWIDs in their region and two Southern cities (Mykolaiv, Odesa) were selected due to diverse OST entry dynamics.

Local research assistants in each area who were familiar with PWIDs and OST recruited a convenience sample of PWIDs. To comprehensively understand the different experiences of OST access, entry and retention, three distinct groups of PWIDs were targeted, recognizing that each group would differentially contribute to understanding access, entry and retention factors. The three target groups included those: CURRENTLY on OST (retention facilitators and barriers; access facilitators); PREVIOUSLY on OST (access facilitators, retention barriers); and PWIDs eligible for OST but NEVER on OST (access and entry barriers). One MIXED group was attempted, but aborted because the research team decided that their diverse experiences were too complex to effectively handle in FG settings. Also, in recognition that retention factors may be different for those on OST longer, the CURRENTLY on OST group was further separated into those in treatment for LESS than and GREATER than one year. Finally, a WOMEN'S only group was recruited in each city to further explore gender differences with OST. Five FGs were conducted in each of the 5 cities for a total of 25 client-centered FGs with 5–11 participants per FG (see Table 1). This represents the largest systematic qualitative data collection study conducted with opioid-dependent PWIDs in Ukraine.

PWIDs were recruited from several OST sites and harm reduction programs operating in different parts of each city to ensure diverse participant experiences with OST access, entry and retention. Eligibility criteria for all FG participants included: age ≥ 18 years, residing within the target city and reporting either being treated for opioid dependence with OST (currently or previously) or chronically using opioids confirmed by participants' responses to type and frequency of opioid use. Local research assistants were also instructed to look for recent track marks for those participants not on OST.

The study protocol and FG guide were approved by the Institutional Review Boards at Yale University (USA) and at the Ukrainian Institute for Public Health Policy (Ukraine). Verbal assent was requested after a written informed consent form was reviewed and discussed with participants, followed by completion of a brief demographic survey (socio-demographic information, questions about previous and current opioid dependence treatment, substance use, and imprisonment information), which was used to determine eligibility and assignment to the appropriate FG.

The FG topic guide covered knowledge about OST, experiences accessing and receiving OST, attitudes and beliefs about OST and drug treatment and recommendations for improving OST. Focus groups lasted ~90 minutes and took place at neutral venues, most often community/social centers run by NGOs, where OST clients and PWIDs felt comfortable and which were easily accessible by public transportation. Participants received 80 UAH (app US\$10) for completing the short demographic survey and participating in FG discussions.

A grounded theory inductive approach utilizing a constant comparative analysis method was used that allowed researchers to simultaneously code, analyze and recode the FG data in order to identify and develop concepts and constantly refine these concepts into descriptive and explanatory categories. (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Strauss & Corbin, 1998; Taylor & Bogdan, 1985). This process began with open coding to develop initial core categories with further rounds of data reduction allowing for common themes or patterns to emerge from the data. A codebook was developed based on identified domains. Data were transcribed and translated from Ukrainian/Russian into English to create a qualitative dataset that could be analyzed by researchers not fluent in Ukrainian/Russian. Written transcripts were reviewed while listening to the original audio-recordings and back-translated to ensure interpretation (Brislin, 1970). Each English transcript was coded independently by two of the authors (MJB, AM, RM, JM) using MAXQDA, a qualitative data analysis software package designed for text and content analysis (VERBI Software – Consult – Sozialforschung GmbH, 1989–2014). Any discrepancies or disagreements in coding were discussed by the research team and then coded based on team consensus.

Since we were interested in examining the barriers to treatment access and entry into OST, we focused this analysis on the subset of 41 PWIDs who were eligible for, but NEVER enrolled in OST (OST-naïve). The codes related to OST access, entry attempts, knowledge of OST, beliefs and attitudes about OST were extracted for this subset of FG participants. The names used here are pseudonyms chosen by the participants.

RESULTS

The demographics of OST-naïve FG participants are shown in Table 2. As compared to the total FG sample, the OST-naïve group was younger (35 vs 38 years), predominantly male (88%) with the majority (83%) having reported being arrested.

In assessing the discussions of the 41 OST-naïve PWIDs, two distinct groups emerged: 1) those who had attempted OST enrollment but were unsuccessful; and 2) those who indicated

that they had no interest in treatment using OST. The first group mostly focused on bureaucratic barriers to OST entry while the discourse of the second group revolved heavily around negative attitudes and beliefs toward OST.

BARRIERS: BUREAUCRATIC AND STRUCTURAL

“Official” Registration

To receive OST in Ukraine, PWIDs are required to officially register as a drug user with the national narcology service (a medical specialty common in former Soviet countries that deals with chemical addictions). The national registry requirement deters PWIDs from not only seeking OST, but also other drug treatment, because of imposed restrictions, including exclusion from certain kinds of jobs, loss of their driver’s license and becoming targets by the police (Izenberg et al., 2013; Mimiaga et al., 2010). Some FG participants describe opting for private, paid drug treatment services to avoid registering as a drug user: *“It was anonymous and paid. That is, not to be registered... in my situation I would rather not be registered, as I worked as a driver, so I had to do it to not be registered”* (Oleg, age 25, L’viv).

The fear and stigma associated with being registered with the narcology service was voiced by Andrey (age 27, L’viv):

What do I say about this registration, I mean in general, I am almost sure that police has access to it. They know that you are a drug user, which means that you are not honest, which means something worse, and it concerns me.

While Andrey did not elaborate further about what “something worse” meant, Anya, a Kyiv FG participant, subsequently voiced the societal views toward PWIDs in Ukraine by stating, *“If you are a drug user in our country – it means that you are a thief, a rapist and a killer.”*

Frustrating and time-consuming entry process

Once PWIDs accept the requirement to officially register, they are then faced with a time-consuming, complicated, bureaucratic process to initiate OST. Potential OST clients in Kyiv and Odesa lamented about the effort required and the bureaucratic frustrations they experienced trying to register for OST. The exchange between two participants in the Odesa FG highlights this frustration

Misha What kind of certificate do they need from narcological dispensary?

Sergey That you have been registered (*as a drug user*) for so many years.

Misha But that is in narcological dispensary, so you should bring the certificate from the narcological dispensary to the narcological dispensary?! Can’t they make a call and ask by themselves?

Sergey You must make an effort.

Limited slots: Waiting lists and payments

In all cities, participants talk about being put on waiting lists and told that they will be called when a spot opens up. But most never receive a call-back:

Taras And what's the sense? He's been waiting for two years already under the number of one hundred and something. And what's the sense for me to be registered on the waiting list and wait?...And he was told that nobody knew how long he had to wait. He was told to wait until someone dies and his turn would come...or someone will be thrown out for sneaking out the medication.

Other participants describe that treatment slots that become available are usually given to PWIDs who pay a bribe:

Alexey Well, they tell you there are no places, and what are you supposed to do? Tell him, wait, dude, let's settle this question? You do this and I do that... (*laughing*)

Seryozha Why won't he understand? They know it all...They take cash, that's how they know it.

The importance of time was a common theme discussed. PWIDs felt frustrated about the time involved to register and become eligible for OST and then the endless waiting times for a space to become available. Perhaps the biggest frustration expressed by those wanting OST, but subsequently turned away, stems from lack of slots and interminable waiting lists. For many, there is no waiting time: in their minds, starting OST is a matter of life or death since most will continue their illegal drug use, and then, as noted by Oleg (age 25) from L'viv: "*One would get either to the grave, or to the prison.*"

Serhiy (age 52), a participant from Odesa who had tried unsuccessfully to access OST concisely stated:

It looks like under the Soviet government...it reminds me of the soviet red tape, and even more, we have such a developed bureaucracy, you can't imagine, you aren't local...it's terrible, all is corrupted, you have to pay for every certificate, you have to go far to access, you have to collect lots of the certificates, all of this is so exhausting.

Uncertainty if OST will remain available

Another reason stated for not registering or seeking OST, specifically going through the complex regulatory process, is concerns that after international funding for OST runs out, the national program will end. While international donors (mainly the Global Fund to fight AIDS, Malaria, and Tuberculosis: GFAMT) and Ukraine's Ministry of Health have been negotiating to increase the number of OST slots in Ukraine to 20,300 by 2018 and gradually shift the program's cost from international donors to the Ukrainian Ministry of Health (2013), many clients who might benefit from OST don't believe that will happen and fear that the corruption that has plagued Ukraine will result in closing the OST program.

Besides, you can't be sure of anything in our country...today there is antiretroviral therapy for HIV, and tomorrow there is not. Today there is the medicine for ill children, tomorrow, there isn't. And the same situation is with methadone. You can't be sure that you are taking the methadone today and everything will be OK tomorrow. I don't want to be dependent on a dude, who drives a Lexus, and decides what treatment I should take (Vasya, age 48, Odesa)

BARRIERS: OST ATTITUDES AND BELIEFS

Option of “Last Resort”

A second group of PWIDs eligible for, but never prescribed OST, are those who expressed no interest in taking it or had major concerns about starting because of personal beliefs and attitudes about treatment delivery services and medications, especially methadoneⁱ. The perception of OST-naïve PWIDs is that “*it's unrealistic to get enrolled there*” and “*to get enrolled there is impossible anyway*.” Some, like Taras, a Kyiv participant, were convinced that he would not be accepted into OST because he was not “sick” enough: “*Well, but the people who can be enrolled are in such a condition that they are hardly able to walk. They will not accept me there, I know for sure about it.*”

The theme that OST was a “last resort” treatment was often voiced by PWIDs with some, like Oleg (age 25) from L'viv, indicating that this was also the perspective of some of the medical and psychosocial counseling staff: “*I already visited a psychologist. He says, go and ask for rehabilitation. Substitution treatment is kind of a last option. And it is the last option.*” For others, OST is a “last resort” treatment when there are no illegal drugs for them to buy. When asked what needed to change for PWIDs to consider starting OST, Sergey (age 48) from Donetsk claimed “*when they shut the oxygen off completely, then I go to this program. The police I mean. When they [drug dealers] can't sell it...when there's no illegal drug for me to buy.*”

“No way out”

Connected to the belief that OST should be taken only as a last resort are the additional fears of some OST-naïve PWIDs, like those from the Kyiv FG, that once they start taking methadone, they will have to remain in OST for a long time, or even for life:

Facilitator Have you ever thought about substitution therapy?

Andrey, Oksana (in unison) Of course, we have!

Andrey We have. We were offered it recently.

Oksana Yes, recently there was one place available.

Andrey Yes, on Methadone, but we do not want Methadone.

ⁱWhile both buprenorphine and methadone treatment are offered in government-run OST sites in Ukraine, methadone is the main treatment medication offered to new entrants since buprenorphine maintenance treatment is limited to approximately 800 OST clients.

Facilitator Why?

Andrey Well, because Methadone is something scary.

Oksana It's every day and the whole life to go there.

For others, there is the belief that once on methadone, there's no way back to a normal life: *"Everyone knows that if you go there, for you it's [life] over"* (Lyosha, age 38, Mykolaiv). There is also the belief that the dependence on methadone is greater than dependence on illegal drugs and that detoxing from methadone is difficult or impossible. According to Petro (age 54, Mykolaiv), *"The opinion is that one can somehow go off drugs, but from this one (methadone) – no way!"* (Petro, age 54, Mykolaiv)

Health risks and fears

A major concern voiced by participants in each city is that methadone is a "synthetic" drug with dangerous side effects. They feel that methadone is more harmful to their health and makes them more dependent than the illegal drugs that they can cook or buy which are made from "natural" poppy straw. Viktor (age 45) from Donetsk stated: *"That's dependence...this substitution treatment destroys liver and all, I read a lot about it."* Additionally, a recurrent description provided by study participants about PWIDs who are on OST is that they are like "zombies."

First, this is synthetic. Second, one needs to keep enhancing the dose. Because, if you inject *shirka* (homemade opioid made from poppy straw), you somehow also get some vigor (*bodryak*). And methadone... The first week you take it, you're feeling high (*tebya grebyot*), you are feeling good. But then, that's all. After the first week it makes you simply a zombie. (Petro, age 54, Mykolaiv)

Methadone = Death

Together with the health risks and synthetic nature of methadone, another belief shared by OST-naïve participants is that methadone use results in death. *"They give synthetic stuff to all, they kill people. Well, it's all the same."* (Andrei, age 39, Mykolaiv). Such beliefs were raised several times during FG discussions. Sergey (age 42) from Donetsk concisely stated, *"Methadone—it's death."* When asked why he thought that way, he replied: *"Because it's dry plastic."* Vasya (age 48) from Odesa simply stated: *"I only know that all the people whom I knew who were on that program, all of them are dead."* In Mykolaiv, Lyosha (age 38) explained that he is against OST because *"it seems to me, it's chemistry...and that after a year or two, a man simply expires...dies."* For some, this belief of methadone as a "one way ticket" was enough for them to refuse OST even if a spot were available for them:

Sergey Well, in my opinion, that's a one-way ticket...

Facilitator Why?

Sergey Cause I know many of those who died due to this methadone and I wouldn't like to take their place. (Donetsk)

Going one step further, another belief among some PWIDs was that methadone was manufactured with the intent to control and eliminate the entire drug-using population. Viktor (age 45) from Donetsk stated: *“This thing [methadone] is really bad...it doesn’t help anyone, it’s just to put everybody under control so they can keep you chained all the time...and send you to your grave faster.”* Perhaps the strongest words spoken about this were by Lyosha (age 38) from Mykolaiv:

I am sorry...this entire program has been created in order to exterminate us! Drug addicts! From the face of the planet! Simply “methadonize” them all totally (*zametadoni’t vsiekh nafig*)! And so that all of them die out. That’s what this program is for, in my opinion.

DISCUSSION

The international literature is extensive about barriers to OST and the attitudes and beliefs about OST, which are highly variable among opioid dependent PWIDs. To our knowledge, barriers to OST entry have not been assessed through such extensive targeting of PWIDs with specific (lack of) experiences with OST and include such extensive geographic diversity across an entire country. For this analysis, we specifically excluded anyone who had ever been on OST because they would have clearly been motivated differently than those who were OST-naïve. Moreover, those currently or previously on OST would be able to provide facilitators (or motivators) for accessing OST and provide even better information about retention. Given the low OST coverage (2.7%), an overwhelming majority of PWIDs have never accessed it and are an important target to increase access and entry. Unlike the international experience with buprenorphine (~20 years) and methadone (~50 years), OST is relatively new in Ukraine, about 9 and 5 years, respectively. In this country with a nascent OST program that responded to an explosive HIV crisis, barriers specific to individuals, healthcare systems, and regulatory structures were identified through focus groups. Many of these stated barriers, however, are amenable to intervention, especially in a country where OST is relatively new.

The group who wanted to enroll in OST, yet had never succeeded, provided valuable insights into bureaucratic (organizational and structural) impediments since they had indeed “tried” to receive treatment. Importantly, official “registration” as a drug dependent person was a major obstacle since those who are registered may lose a number of privileges in civil society, including loss of driver’s license, discrimination in some employment opportunities, and being targeted by the police to fill arrest quotas (Bojko, Dvoriak, & Altice, 2013; Izenberg & Altice, 2010; Izenberg, et al., 2013; Mimiaga, et al., 2010). A recent study in China (Lin, Wu, & Detels, 2011) confirmed that such bureaucratic and structural barriers including complex application and registration procedures and police harassment were the strongest barriers to accessing OST and which hinder scale up efforts. Simply removing this registration requirement would greatly enhance access to treatment, or in the absence of removing it completely, creation of unique identifiers that maintain anonymity and is restricted from review by police, employers and governmental agencies would be an important step. Though addressing the problems of bribery may prove more challenging, the complicated bureaucratic process of pulling together documents could easily be overcome

by setting up integrated systems of care (Altice, et al., 2010; Bachiredy et al., 2014; Basu, Smith-Rohrberg, Bruce, & Altice, 2006; Sylla, Bruce, Kamarulzaman, & Altice, 2007; Weiss et al., 2011) where patients can complete the entire eligibility process at a one-stop site.

Addiction treatment organizational obstacles were voiced by PWID respondents, which are also amenable to intervention. Addressing waiting lists, negative attitudes toward OST by providers, and the perceived ineffective quality of OST is an important step. One such evidence-based intervention is the NIATx (Network to Improve Addiction Treatment) Modelⁱⁱ, which uses change teams to improve the healthcare delivery setting and effectively reduces waiting times to treatment and improves treatment retention. This rapid-cycling testing intervention involves both the potential client but also the staff at the OST site and fixes key problems in the way the OST program operates (McCarty et al., 2007).

Among this group of OST-naïve PWIDs, their voices provide nuanced information that can be leveraged to directly target national OST policies (structural interventions) or healthcare delivery sites. Moreover, given the misinformation and markedly negative attitudes and beliefs about OST, it argues for progressive social marketing. Social marketing can be especially effective to provide information where the beliefs are not based in facts. Among the factors that impeded provision of OST were numerous accounts of negative beliefs and fears surrounding OST and methadone, including fear of methadone withdrawal, adverse side effects and harmful health risks. For example, the perception that methadone resulted in death may have stemmed from real observations by PWIDs in Ukraine when the first OST patients, who were HIV-infected, died not from methadone but from complications of HIV/AIDS. Others believed that the goal of OST was to keep them high and that they would have to keep increasing their methadone dose in order to achieve this high, suggesting a lack of correct information about how methadone is supposed to work, specifically to reduce cravings and not cause euphoria. These types of concerns have been raised in other international settings by both PWIDs who are not in treatment (Lin, et al., 2011; Notley, Maskrey, & Holland, 2012) as well as PWIDs who are in OST programs (De Maeyer, et al., 2013; Notley, Blyth, Maskrey, Craig, & Holland, 2013). Such fears and myths can be addressed through mechanisms targeting both patients and their providers who continue to believe that OST is only something to be used for those at the “end-stage” of their addiction. One approach that would target such information is social marketing campaigns that are broad-based and attempt to address stigma and provide accurate information about OST and methadone. A review by Gordon et al. (2006) provided evidence that social marketing interventions can be effective in improving diet, increasing exercise, and tackling the misuse of substances like alcohol, tobacco, and illicit drugs and that social marketing provides a promising framework for improving health both at the individual level and at the wider community and policy levels.

Social marketing campaigns utilize strategies with the intent to influence behaviors that benefit individuals and communities for the greater social good. Generally, they integrate research findings, best practices, theory, and the target audience to inform the delivery of

ⁱⁱFor more information about the NIATx Model, see <http://www.niatx.net/Content/ContentPage.aspx?PNID=1&NID=8>

sensitive and segmented social change programs that are effective, efficient, equitable and sustainable. In other words, it is created and put forth by those seeking a change (Ministry of Health – the change agent) in an attempt to persuade others (PWIDs, addiction specialists, family – the target adopters) to accept, modify, or abandon certain ideas, attitudes, practices or behavior (Kotler, Roberto, & Lee, 2002). Social marketing may work well in the Ukrainian context because the information technology infrastructure and mobile access are very well developed.

An alternative approach would be to better-inform PWIDs about their treatment options, through the creation of effective decision aids that provide objective information and motivation that highlight the relative risk and benefits of treatment (O'Connor et al., 2009). Decision aids that better inform patients are effective even for patients with low health literacy (Coulter & Ellins, 2007; Krahn & Naglie, 2008; Padon & Baren, 2011), but objective ones are currently not available for patients with opioid dependence. Such decision aids can actively engage patients in the decision-making process experience and empower them to improved treatment engagement. They also directly address misinformation (liver damage, more dangerous than heroin), negative and personal beliefs (killing off PWIDs, greater dependence), adverse side effects (zombie-like appearance) and issues of efficacy (ineffective at reducing injection and illegal activities). Consequently, they become more motivated to adhere to the treatment, may tolerate more side effects, inconveniences and achieve better outcomes (Brewin & Bradley, 1989; King et al., 2005; McPherson, Britton, & Wennberg, 1997; Mondloch, Cole, & Frank, 2001).

One current belief voiced by the participants and which must be addressed to allay the fears of potential OST clients is that the OST program will remain and continue to operate in Ukraine, even if international donor funding is stopped or other situations arise. The recent invasion and contested annexation of the Crimean peninsula by the Russian Federation in March 2014 presented an extraordinary example of OST services being disrupted for over 800 current OST clients and thousands of OST-eligible PWIDs living in Crimea (Holt, 2014; Kazatchkine, 2014). Ukrainian NGOs, together with the Ukrainian Ministry of Health, are actively working to ensure that services and medication are available to eligible PWIDs by offering them the opportunity to receive treatment at clinic sites on Ukraine's mainland.

It is crucial for Ukraine to improve OST, an evidence-based treatment for opioid dependence that is associated with numerous positive outcomes, including influences on reducing drug use and risk for blood-borne viruses, improving quality of life, employment, and family reintegration, criminal activities, and improvements of other comorbid conditions (Dennis, et al., 2014). A key benefit of hearing the voices of those who had never accessed OST before, is that we are able to glean important insights (i.e., personal, programmatic and structural) into how to address scalability of OST in Ukraine, which is currently inadequate to meet the needs of PWIDs. OST has been documented as the single most effective and cost-effective strategy for reducing HIV transmission in places with a mixed HIV epidemic driven by an injection drug use component, like in Ukraine (Alistar, et al., 2011). Unless OST is scaled to need, however, its benefits will not be achieved at the population level.

LIMITATIONS

A limitation of this qualitative study is that the recruited sample cannot be considered representative nor the results generalizable. Since a local research assistant was asked to recruit PWIDs without OST experience into the study, there is a chance that those more comfortable with the recruiter and/or with previous research experience may have self-selected into the study. The use of focus group methodology may have limited individual disclosure of participants since anonymity and confidentiality, particularly within a closed group such as PWIDs, is difficult to guarantee. The researchers' presence as focus group facilitators and observers may also have affected the responses of participants. Also, while we recognize that many of the barriers and attitudes presented in this paper are embedded in broader, macro-level issues relevant to Ukrainian society (including stigma toward PWIDs, corruption, human rights) we limited our discussion on these topics primarily because we were interested in discussing more immediate interventions which in the long-term should address these broader, structural barriers.

CONCLUSIONS

The personal attitudes and beliefs combined with programmatic and structural bureaucratic barriers discussed by these PWIDs indicate the need for a comprehensive review of OST policies and procedures in Ukraine as well as a potential social marketing campaign to counter misinformation, myths and stigma associated with OST, especially methadone, in Ukraine. Improving patients' knowledge and understanding about OST through targeted education was suggested for both PWIDs and treatment providers in China (Liu et al., 2013) and the United Kingdom (Alves & Winstock, 2011). Countering the myths and misinformation about OST and methadone uncovered in the focus group discussions is an important first step to expanding OST and other medication-assisted therapies in Ukraine. The need to balance not only the risks, but also the beneficial aspects of OST, while targeting both PWIDs and medical and psychosocial staff at the OST sites, is necessary in order to influence change about the attitudes and beliefs.

Data from this qualitative analysis was used to design a culturally-relevant survey instrument which is currently being implemented among 1500 PWIDs in Ukraine to quantitatively assess the magnitude of each cited barrier. The data is also informing the next steps toward intervention, which is seeking to improve the way services are designed and provided utilizing culturally-appropriate approaches. Understanding these barriers to OST entry through the eyes of OST-eligible PWIDs in Ukraine will help inform new and revised policy and procedures and enable Ukraine to meet its continued goal of providing medication assisted therapy to over 20,000 PWIDs in 2018.

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Table 1

Focus Group Distribution by Type and City

Type of FG	Kyiv	Odesa	Mykolaiv	Donetsk	L'viv	Total FG participants
ON OST >1 year	11	11	8	14	7	51
ON OST <1 year	9	—	8	5	9	31
NEVER OST	11	5	9	10	6	41
PREVIOUS OST	9	7	8	7	2	33
WOMEN only	7	5	8	9	7	36
MIXED	—	7	—	—	—	7
Total FG participants	47	35	41	45	31	199

Table 2

Demographics of NEVER OST compared to Total Focus Group sample

Variable	NEVER OST N=41		Total N=199	
	N	%	N	%
Gender				
Male	36	88	132	66
Female	5	12	67	34
Marital Status				
Never married/single	13	32	51	26
Married/live with partner	18	44	90	45
Separated/divorced	10	24	42	21
Education				
Complete high school	13	32	90	45
Professional technical	5	12	24	12
Completed higher	4	10	22	11
Employment (official)				
Yes	8	20	39	20
Total income				
0 to < 600 UAH *	13	32	56	28
600 –1800 UAH	21	51	104	52
>1800 UAH	7	17	37	19
Ever arrested				
Yes	34	83	165	83
Mean age	35 years		38 years	

* UAH: Ukrainian hryvnia (At time of study, exchange rate was 8 UAH = US\$1)