



Determinants of willingness to enroll in opioid agonist treatment among opioid dependent people who inject drugs in Ukraine



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ABSTRACT

Background: Coverage with opioid agonist treatments (OAT) that include methadone and buprenorphine is low (N = 8400, 2.7%) for the 310,000 people who inject drugs (PWID) in Ukraine. In the context of widespread negative attitudes toward OAT in the region, patient-level interventions targeting the barriers and willingness to initiate OAT are urgently needed.

Methods: A sample of 1179 PWID with opioid use disorder not currently on OAT from five regions in Ukraine was assessed using multivariable logistic regression for independent factors related to willingness to initiate OAT, stratified by their past OAT experience.

Results: Overall, 421 (36%) PWID were willing to initiate OAT. Significant adjusted odds ratios (aOR) for covariates associated with the willingness to initiate OAT common for both groups included: higher injection frequency (previously on OAT: aOR = 2.7; never on OAT: aOR = 1.8), social and family support (previously on OAT: aOR = 2.0; never on OAT: aOR = 2.0), and positive attitude towards OAT (previously on OAT: aOR = 1.3; never on OAT: aOR = 1.4). Among participants previously on OAT, significant correlates also included: HIV-negative status (aOR = 2.6) and depression (aOR = 2.7). Among participants never on OAT, however, living in Kyiv (aOR = 4.8) or Lviv (aOR = 2.7), previous imprisonment (aOR = 1.5), registration at a Narcology service (aOR = 1.5) and recent overdose (aOR = 2.6) were significantly correlated with willingness to initiate OAT.

Conclusions: These findings emphasize the need for developing interventions aimed to eliminate existing negative preconceptions regarding OAT among PWID with opioid use disorder in Ukraine, which should be tailored to meet the needs of specific characteristics of PWID in geographically distinct setting based upon injection frequency, prior incarceration, and psychiatric and HIV status.

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1. Introduction

Buprenorphine (BMT) and methadone (MMT) maintenance therapies are opioid agonist treatments (OAT) that effectively reduce relapse to opioid use among persons with opioid use disorder (Gowing et al., 2008, 2011), decrease HIV and hepatitis C virus (HCV) transmission (Gibson et al., 1999; Gowing et al., 2006; Van Den Berg et al., 2007), HIV risk behaviors (Magura et al., 1998; Wong

et al., 2003), and criminal activity (Sun et al., 2015). For patients with HIV or tuberculosis (TB), it also improves health-related outcomes, retention in treatment (Kamarulzaman and Altice, 2015; Morozova et al., 2013; Tran and Nguye, 2013), and decreases mortality (Nolan et al., 2015). Globally, access to OAT is underscaled, especially in Ukraine. The majority of people who inject drugs (PWID) remain out of treatment, although PWID continue to drive the HIV epidemic in Ukraine (Bojko et al., 2013; Wolfe et al., 2010; World Health Organization, 2013) and elsewhere.

In Ukraine, BMT was first introduced as a treatment for opioid use disorder in 2004, with MMT added in 2008 (Bruce et al., 2007; Schaub et al., 2010). Currently nearly 8400 patients receive OAT, primarily MMT, through public medical facilities (Ukrainian Centers for Disease Control (UCDC), 2015). In order to receive OAT,

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persons with opioid use disorder must officially become registered at a specialty addiction treatment center operated by the Narcology Service. This name-based registration process has been documented as a barrier to treatment due to restrictions in employment and harassment by police (Bojko et al., 2015, 2016; Izenberg et al., 2013). Once registered, it is extremely challenging to be removed from these lists (Altice et al., 2016). For the past five years, the number of patients on OAT in Ukraine has not increased appreciably with OAT coverage (2.7% of the estimated 310,000 PWID in Ukraine) (Nieburg and Carty 2012; Ukrainian Centers for Disease Control (UCDC), 2015) nearly 10-fold lower than the recommended 25% needed to effectively reduce HIV transmission (Alistar et al., 2011). Despite the target of enrolling 20,000 PWID on OAT by 2015 (Verkhovna Rada of Ukraine, 2014a) and planned funding to enroll them, the majority of out-of-treatment PWID have not initiated treatment. Many individual and structural barriers to expanding OAT in Ukraine and throughout other countries of Eastern Europe and Central Asia have been described (Altice et al., 2016; Bojko et al., 2013, 2016; Cohen, 2010; Elovich and Drucker, 2008; Polonsky et al., 2015; Samet, 2011) and influenced greatly by nearby Russia where OAT remains banned mostly based on myths and prejudices against it rather than on extensive scientific evidence (Elovich and Drucker, 2008; Latypov, 2011).

While patient-, clinic- and structural-level factors constrain OAT expansion, patient-level decisions by PWID to enter OAT are often associated with significant social, medical and psychological problems that occur as a result of illicit drug use (Stover, 2011). Globally, numerous factors have been associated with OAT initiation including: older age (Fairbairn et al., 2012; Lloyd et al., 2005; Reynoso-Vallejo et al., 2008; Shah et al., 2000; Shin et al., 2007; Yen et al., 2011), social support through marriage or living with a partner (Lloyd et al., 2005; Schutz et al., 1994), being female (Kerr et al., 2005; Schutz et al., 1994; Shah et al., 2000; Springer et al., 2015) and living with children (Lundgren et al., 2003). Other factors related to the individual's drug use also facilitate the decision to initiate OAT including a substantial duration (Schutz et al., 1994; Schwartz et al., 2008) and frequency of drug injection (Booth et al., 1998; Reynoso-Vallejo et al., 2008; Zule and Desmond, 2000), overdose experience (Callon et al., 2006), prior history of drug treatment (Booth et al., 2003, 1998; Schutz et al., 1994; Zule and Desmond, 2000) and needle/syringe program (NSP) attendance (Shah et al., 2000). In addition, having been incarcerated or homeless (Reynoso-Vallejo et al., 2008; Schutz et al., 1994; Shah et al., 2000), and being HIV-infected (Kerr et al., 2005; Zule and Desmond, 2000) influence OAT entry, and there is evidence that PWID with mental health problems are more likely to be enrolled in OAT (Amodeo et al., 2004; Reynoso-Vallejo et al., 2008).

The most commonly reported reasons for enrolling in treatment also reflect the perceived benefits of OAT by PWID. These include the desire to improve health, change social networks, avoid criminal activity, and reduce illicit drug use (Stover, 2011). Many patients are attracted to treatment as the financial burden of illicit drug use becomes too costly (Booth et al., 1998). Previous studies found that expressed interest in treatment is a significant predictor of future participation in OAT (Booth et al., 2003; Zule and Desmond, 2000). Our study aimed to assess the determinants of patients' willingness to initiate OAT among out-of-treatment PWID with opioid use disorder in Ukraine, to help guide tailored interventions to improve OAT entry and scale-up in Ukraine and throughout the region.

2. Materials and methods

2.1. Data collection

Data for this study were derived from a cross-sectional survey of 1613 opioid dependent PWID from 5 cities in Ukraine with

the highest burden of addiction and HIV that assessed the prevalence of barriers to OAT access and retention. Specifically, three groups of PWID meeting ICD-10 criteria for opioid dependence were recruited: (a) never on OAT; (b) previously on OAT; and (c) currently on OAT. Recruitment occurred sequentially (approximately 60–90 days per city) between 2014 and 2015 in Kyiv, Mykolaiv, Odesa, Dnipro (formerly Dnipropetrovsk) and Lviv. For the purpose of this analysis, we included only data on participants who were previously or never on OAT.

2.2. Sampling procedures

PWID meeting criteria for opioid dependence who had never been on OAT were recruited utilizing respondent driven sampling (RDS). Those who were previously on OAT were recruited using random sampling from pre-existing OAT patient lists. An additional 26 PWID recruited through RDS were re-classified as previously on OAT based on their baseline survey. Eligibility criteria included: ≥ 18 years; met ICD-10 criteria for opioid dependence; lived/worked in the city surveyed; able to provide informed consent; and willingness to undergo rapid HIV and HCV testing. Initial participants ("seeds") for RDS were selected from community outreach sites where PWID interface (e.g., NSP) and included for each city the following of at least one: female; age 18–25 years; and PWID with less than 2 years of injecting.

2.3. Measures

All participants completed a computer-assisted, self-administered instrument (CASI) survey using a Qualtrics® web-based platform. Results of exploratory qualitative phase analyses (Bojko et al., 2015, 2016; Mazhnaya et al., 2016) were used to develop sections of the questionnaire related to OAT experience to assess facilitators and barriers of OAT entry and retention, and attitudes of OAT-naïve study participants towards OAT. In addition to identifying OAT facilitators and barriers in qualitative focus groups, we also developed survey content areas using previously validated instruments or from previous research conducted in Ukraine. The survey domains included: demographic characteristics, addiction history and drug treatment experience, self-reported HIV status, HIV testing experience, assessment of alcohol use disorders (AUDIT; Saunders et al., 1993), depression (CES-D; Radloff 1977), addiction severity (DAST-10; Gavin et al., 1989), health-related quality of life (SF-12v2), sex and injection risk behaviors. HIV and HCV testing and post-test counseling were conducted using rapid tests (CITO TEST HIV 1/2/0 and CITO TEST HCV) by qualified and trained medical staff (i.e., nurse or doctor).

The primary outcome was defined as willingness to initiate OAT with methadone or/and buprenorphine in response to the question: "Are you interested in starting methadone or buprenorphine treatment now?" All analyses of the primary outcome were stratified by those who had previously and never been on OAT. Education was categorized by whether they had completed high school or not, while employment included full- or part-time versus not employed. Stable housing was defined as living in one's own home or renting an apartment, or living with family or friends, but not describing themselves as being homeless, living at a shelter, or any other temporary housing. Income was stratified based on the minimum poverty level (1200 UAH/150USD; Verkhovna Rada of Ukraine, 2014b) and average monthly wage (3500 UAH/437 USD; State Statistics Service of Ukraine, 2014) for Ukraine in 2014. Duration of drug injection was stratified at >5 years or ≤ 5 years and frequency of drug injection in the last 30 days was divided at 20 days. Other factors were chosen from our qualitative analysis that appeared as a barrier to OAT including official registry at a Narcology center and previous experience with drug treatment (Bojko et al., 2016).

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