PMCTC AND IMPROVING NEONATAL OUTCOMES AMONG DRUG-DEPENDANT PREGNANT WOMEN AND CHILDREN BORN TO THEM IN THREE CITIES OF UKRAINE PILOT PROJECT

Final Report

Assessment of the Pilot Project
Acknowledgement

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It is believed that recommendations provided in the report are helpful and will contribute to the further improvement and strengthening of the Integrated Care Model designed to serve drug dependent pregnant women in Ukraine.
# Table of Contents

Acknowledgement ............................................................................................................. 1  

Abbreviations .................................................................................................................... 3  

Executive Summary ............................................................................................................ 4  

Chapter I: Introduction ..................................................................................................... 16  
  Background and context of the project ........................................................................... 16  
  Project design ................................................................................................................. 16  
  Purpose, objective and scope of assessment .................................................................. 18  
  Methodology .................................................................................................................... 19  
  Assessment Limitations ................................................................................................. 22  

Chapter II: Summary of Assessment findings ................................................................. 24  
  Project Achievements and Strength .............................................................................. 24  
  Weaknesses and Shortcomings ...................................................................................... 25  
  Remaining Barriers ....................................................................................................... 28  

Chapter III: Lessons Learned .......................................................................................... 30  

Chapter IV: Recommendations ........................................................................................ 31  

ANNEXES .......................................................................................................................... 38  
  ANNEX 1: List of Documents Reviewed ........................................................................ 38  
  ANNEX 2: List of Key Informants ................................................................................... 39  
  ANNEX 3: Assessment Framework .................................................................................. 41  
  Annex 4: Semi-structured Interview guide (sample) ..................................................... 47  
  Annex 5: Focused Group discussion Guides ................................................................... 48  
  Annex 5.1 Guide for Service Providers ........................................................................... 48  
  Annex 5.2 FGD Guide for drug-dependent women who received services .................... 50  
  Annex 5.3 FGD Guide for drug-dependent women who have not received services .......... 51  
  Annex 5.4 FGD Guide for social workers ...................................................................... 52
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Clinic</td>
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<td>AP</td>
<td>Action Plan</td>
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<td>Centres for the Integrated Care of Pregnant</td>
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<td>Case Management Center</td>
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<td>Integrated Care Model</td>
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<td>Integrated Care Perinatal Center</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>Multi Disciplinary Team</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>OST</td>
<td>Opioid Substitution Therapy</td>
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<td>PMTCT</td>
<td>Prevention mother to child transmission</td>
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<td>RH/FP</td>
<td>Reproductive Health/Family Planning</td>
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Executive Summary

BACKGROUND

Ukraine has the highest adult HIV prevalence in all of Europe and Central Asia, with an estimated HIV prevalence rate of 1.1% among the adult population. This prevalence is significantly higher than any other European or CIS country. The HIV epidemic is predominantly driven by injecting drug use and is increasingly affecting women. In fact, Ukraine is facing a dual epidemic of HIV and drug use.

While injecting drug use remains the primary route of transmission of HIV, heterosexual transmission in Ukraine is growing. Women are more prone to infection due to their biological and social vulnerability. They now represent 45% of all adults living with HIV in Ukraine, and most of them are of reproductive age. In 2011, more than 5,000 pregnancies were registered among HIV-positive women. The HIV prevalence among pregnant women in Ukraine is the highest in Europe. The absolute number of children infected with HIV through mother-to-child transmission (MTCT) continues to increase, as there is a yearly 20-30% increase in HIV-infected pregnant women. According to Ministry of Health statistics, 32,504 children were born to HIV-positive mothers between 1995 and 2012: 21,916 with negative HIV status; 6,735 children awaiting confirmation of their HIV status; 2,814 with HIV-positive status; and 752 having AIDS and 287 children having died of AIDS.

Although important progress in prevention of mother-to-child HIV transmission (PMTCT) programmes that has led to a decrease of HIV transmission to babies from 20% in 2000 to 4.9% in 2009, serious issues and challenges remain.

PROJECT DESIGN

OBJECTIVE: The overall objective of this project is to maintain and improve gender responsive, comprehensive, and integrated services that address the needs of 100 drug-dependent pregnant women and the children born to them in Kyiv, Dnipropetrovs’k, and Poltava cities in Ukraine during April to December 2012.

EXPECTED RESULTS:

- Supportive, enabling environment strengthened at national and municipal levels enabling provision of integrated service to drug-dependent women and the children born to them; Linkages between PMTCT and harm reduction services, including Medication Assisted Treatment (MAT), family planning and STI prevention services for pregnant drug addicted women and social services for children born to them established and strengthened;
- Gender responsive comprehensive services that address the needs of drug dependent pregnant women at the Centres for the Integrated Care of Pregnant Women (CICP), established during the pilot project in 2011, extended and maintained in three pilot sites. Neonatal outcomes in children born to these women improved, social services for mothers and children provided;
- Service providers, including obstetricians, gynecologists, neonatologists, drug-dependence treatment professionals, and social workers in three pilots have appropriate knowledge and skills to provide integrated services to drug-dependent pregnant women and the children born to them.

INTENDED BENEFICIARIES:
Clients: Close to 100 drug-dependent pregnant women, children born to them and their families will benefit from receiving comprehensive services in a friendly, supportive environment. The estimated number of clients is 50 women in Kyiv, 20 women in Dnipropetrovsk’s, and 30 women in Poltava.

Service providers: About 100 professionals, including obstetricians, gynecologists, neonatologists, drug-dependence treatment professionals (narcologists), and social workers from NGOs and state social services, working at the national and regional levels will be benefited from acquiring new knowledge and skills in drug dependency management during pregnancy, the pre- and post-natal care and treatment of the infants of drug-dependent mothers and social support for mothers and children to prevent abandonment.

Institutions: The health facility selected as supplementary project’s site based in Dnipropetrovsk’s Clinical Hospital #9 will upgrade its technical capacities to provide services through receiving of the appropriate equipment. Necessity to create other potential sites will be determined during the project implementation.

PROJECT STRATEGIES:

Strategy 1. Targeted advocacy and communication strategy aimed at promotion of gender sensitive and right-based approaches is implemented; gender-sensitive advocacy and communication materials developed and disseminated among various target groups, including local policy makers, programme managers, services providers, etc.

Strategy 2. Gender-responsive comprehensive services addressing female IDUs (family planning, pregnancy and parenting) made available.

Strategy 3. Capacity building: Selected governmental and civil society service providers at national and provincial levels are trained in provision of services to pregnant women using drugs

Strategy 4. Monitoring, evaluation and documentation of lessons learned at pilot sites for further development of scale up approach

PURPOSE, OBJECTIVE AND SCOPE OF ASSESSMENT

The purpose of the assignment was to carry out the interim assessment of the pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’ (hereinafter Project) in order to develop the recommendations on how to achieve the goal of a project and formulation of the future interventions in a context beyond the medical.

The current assessment report documents results and the lessons learned specifically on “what worked” and “what did not work” and answer the question of how to strengthen social services enabling it to identify women vulnerabilities at early stages as an entry point to the system of integrated treatment and care for them and their children.

The assessment immensely benefited from collective contributions by concerned stakeholders, the project staff, decision makers, donors and project beneficiaries. It looked at project’s a) achievements, strengths, shortcomings and weaknesses; b) outlined remaining key bottlenecks, including policies, practices and other structural barriers in medical and social areas for the Project implementation.

Based on the findings the report provides strategic, policy and implementation recommendations of how to strengthen the on-going Project in order to guarantee achievement of its key outcome as well as ensure the model’s efficiency and sustainability in future.

ASSESSMENT METHODOLOGY
In order to meet assessment objective and results the Assessment Framework was developed structuring the issues and questions as indicators that can be measured or assessed during the assessment. The key questions were structured per each project strategy and allow the consultant to identify achievements, strength and weaknesses as well as remaining bottlenecks. The Assessment Framework also identified the sources of information and the methods the consultant applied, the range of documents reviewed and key informants interviewed for each question. The framework was seen as being part of a process rather than simply an end product to ensure there is clarity and agreement about what is required and how the assessment structure and methodology is derived from that.

**METHODOLOGY:** The assessment methodology comprised of a mix of site visits and observation, face-to-face semi structured interviews of key informants, focus group discussions, desk-based research and review of existing reports, documents and secondary data. Summary of Methods are outlined below:

**Desk Review** - Review of documents was a major part of the assessment.

**Semi-structured Interviews** - Semi-structured Interview tool have been used for the key informants on the national, regional and municipal levels, policy makers and relevant public institutions/entities, UNICEF and project staff, administrative staff of service provider institutions, NGOs etc. Prior to visiting key informants, semi-structured interview topic guides were developed based on the Assessment Framework to help ensure systematic coverage of questions and issues. The interview topics have been selected around the evaluation questions, but grouped and targeted according to the organization and/or individual being interviewed.

**Appreciative enquiry** - An approach was used to explore successes and positive experiences in dialogue with individuals and groups of people and have been applied in order to strengthen understanding of why something worked well, and how success could be replicated.

**Field Analysis** - A useful and quick visual tool used to gain an overview of the different forces driving or resisting change that the project is trying to bring. Using Force Field Analysis helped to analyze the forces working for and against a policy and its realization.

**Focused Group Discussions (FGDs)** - The assessment also used the FGD method to obtain qualitative information. Three FGD were planned for each pilot site and comprise of: i) drug-dependent pregnant women who used the services; ii) Drug-dependent pregnant women who did not use the services; iii) Integrated service provision teams and iv) Public sector social workers. For each FDG the group specific FGD guide have been designed.

**Triangulation of findings** - Finally the examination of data from the above sources were carried out to arrive at conclusions and formulate recommendations.

**Ethical Issues** - While designing the assessment methodology, the ethical issues were considered and the following approaches were applied: i) Kept assessment procedures (FGD and Semi-structured interviews) as brief and convenient as possible to minimize disruptions in respondents work process; ii) To ensure that potential participants can make an informed decision the information was provided about the purpose of assessment and final outcome as well as on the process and duration of interview and/or FGD. The consultant also assured respondents about the confidentiality of the source for obtained information and allowed to retain from answering the questions posed in case they felt uncomfortable to respond; iii) Key informants were interviewed face to face. As for the FGD, the group was encouraged for open discussion around the assessment questions by avoiding presence of their superiors; iv) The consultant collected and analyzed information as well as reported findings accurately and impartially.
DATA SOURCES - The four major sources of data: people, site visits to a sample of oblasts supported by the INCHS program, documents and information system were used during the evaluation. People - Individuals were consulted through individual interviews and focus groups; Site visits – the consultant visited all three project sites and carried assessment following proposed methodologies; Documents - reviewed all related documents; Quantitative Analysis - The consultant utilized quantitative analysis to examine changes in selected but comparable indicators from available data.

STAKEHOLDER INVOLVEMENT - The consultant ensured active participation of key stakeholders in the assessment process. Moreover, initial draft of the report was shared and commented and latter were reflected and incorporated in the final report accordingly.

ASSESSMENT LIMITATIONS - The assessment experienced the following limitations: i) Due to the annual leave season some of the key informants being directly involved in the project were not available for semi-structured interviews though required information was collected by involvement of their colleagues in the assessment; ii) Due to the project’s low enrollment rates of drug dependent pregnant women organization of the FGD with 8-10 participants did not materialized, instead the FGDs were conducted with fewer numbers of participants. The latter limited the consultant to apply sampling for FGD participants.

ASSessment Findings

ACHIEVEMENTS AND STRENGTH

HIGH RELEVANCE - The Intervention is highly relevant in advocating and facilitating achievement of the National HIV/AIDS strategy goals as well as contributes to the prevention of mother to child transmission and ensures quality MCH service provision to the target beneficiaries. The integrated care service model designed and implemented in Poltava and Dnepropetrovsk meet selected medical needs of drug dependent pregnant women.

OWNERSHIP - The demonstrated ownership from MOH, local health authorities and medical staff and NGOs is observed. The MOH and local health authorities established supportive legal environment that regulates delivery of medical services to the beneficiaries through integrated care model. Additional services, such as shelter for homeless drug dependent women, is financed by the local health budget are offered to target beneficiaries in Poltava.

ENABLING ENVIRONMENT - The introduction and institutionalization of the western model of integrated care in conservative environment and assurance of its effectiveness was approached with caution by UNICEF. In order to avoid discrimination of the model at early stage of its introduction as well as fear of the decision makers associated with innovative service delivery modality, the focus was made on introduction and implementation of medical service integration in the first year of the project. Results achieved so far demonstrates success of the project and calls for move to the next stage of development. Basic enabling environment set by the project supported the introduction of integrated care model. Trainings supported by the project equipped medical staff with necessary knowledge and basic skills for provision of quality medical services as well as stimulated change of their behavior, attitude and practice towards drug dependent women.

Enrollment and High Beneficiary Satisfaction - Numbers of drug dependent women who benefited from the project since the project initiation is yet low and account for only 41, though high satisfaction with integrated medical services are observed. They are clear about the harmful consequences for children of their drug use problems. The experience of being treated as human being free of charge first time in their lives, inspired drug dependent women to share experience to their former community
members and spread the information about available services. Thus project beneficiaries become the most powerful mechanism to rich out and improve enrollment rates at integrated care sites.

**Public and Civil Society Partnership** - The project is a successful demonstration of close partnership between public and civil society organizations. Strong NGO presence is a prerequisite of initial results achieved. Besides it stimulated government contracting out of selected social services to NGOs, being innovative in Ukraine’s history.

**Noticeable Improvement of Attitude Towards Beneficiaries** - The introduction of the integrated care model facilitated the recognition of pregnant drug-addicted women as a target group for integrated services by the health and social sector authorities. Trainings supported by the project led to noticeable change of medical staff behavior, attitude and practice at ICPC sites in Poltava and Dnepropetrovsk.

**Prospects of Sustainability** - The first positive results empowered the local authorities’ to finance additional services, in order to satisfy unmet social needs of target beneficiaries. Moreover, the positive experience generated stimulates local governments to replicate the model to other cities. These developments demonstrate effectiveness of the pilot and ensure sustainability of project achievements. Moreover, the integrated care model in itself and a need for service package expansion and strengthening social services, breeds discussions and facilitates close inter-sectoral cooperation and collaboration of health and social sector partners.

**Weaknesses and Shortcomings**

**Low Enrollment Rates** - The number of women who benefited from the project is yet low. While this raises concerns of project effectiveness and efficiency, there are certain objective reasons contributing to this result. Namely, proactive outreach to ensure client flow to the ICPC has been postponed until the integrated medical services were fully operational and ready to provide quality services to beneficiaries. Establishment of the regulatory framework enabling ICM operations had a slow uptake at start.

Another contributing factor for a given result was difficulties in reaching target beneficiaries. The criminalization of drug use in Ukraine forces the community to hide and frequently change their location. Their style of life makes it difficult to reach them out. The given situation was further complicated by the project choice to reach out to too narrow target group, mainly pregnant drug dependent women, without approaching and/or involving their partners and family members. The latter served as a barrier not only for he enrollment, but also influenced OST treatment of target beneficiaries already engaged in the project.

As the project is on early stages of implementation, each pilot tested their own mechanism for identification of pregnant women. The assessment showed that mechanisms tested so far bear the passive character which in its term donates to low enrollment rates. It is also remarkable that pilots where the NGO social workers are former drug users, apply better mechanisms and have better performance rates. Apart from fear the target group has towards the general society that impedes the targeting, the lack of information about available ICM services is also evident.

**Underutilized Capabilities and Resources** - The Government initiated primary health care reforms, limited the project to heavily rely on the active participation of the newly introduced family physicians (FP) and general practitioners (GP) at the outset of the project. The latter in its turn contributed towards low level of identification of risk groups at early stage of pregnancy and consequent referral to the integrated service model. As the country already generated critical mass of trained FP and GPs, a main challenge ahead is to ensure that identification and service provision to target beneficiaries are initiated at the PHC, first contact level, and referred to the integrated care center.
Trentment of children born to drug dependent pregnant women in Pediatric clinics deserves attention. As no intervention was undertaken by the project for inclusion of such services in integrated medical service model, the beneficiaries interviewed complained about unfair treatment and attitude of medical staff, non-availability and high risk of dropping out from OST treatment in such institutions.

Furthermore, the assessment revealed that beneficiaries are identified and enrolled into the project in late stages of their pregnancy, therefore the ICM is limited to offer preventive care and information/education services such as family planning, education on safe pregnancy, breastfeeding, healthy lifestyle and newborn care to the target group. Should identification mechanisms been more effective, these services would have been readily available for the beneficiaries which is so lacking according to their information.

Moreover, the project missed the opportunity to target women undergoing in-patient treatment at narcology centers due to the weak coordination between project and and such centers. These group of women could have been targeted for preventive, education and information sharing activities.

Ukraine has well developed civil society sector. There are many NGOs targeting children, youth, women, drug users, etc., but their capacity is not utilized by the project that could resulted in better information sharing about available services to target groups. This is a lost opportunity for the project to improve enrollment levels as well as expand information base through using NGOs for reach out activities.

**Limited Social Services Offered As Part of ICM** - Although initial strategy chosen by the project to focus mostly on offering integrated medical services as part of the ICM, attempts were made to provide limited social services as well. In the environment, where the public social workers’ role in relation to the project beneficiaries as well as eligibility of this group for public offered safety nets is not clear, the project mainly relied on NGO social wokers to accompany beneficiaries and assist in finding ways to resolve social problems. Nonetheless, it is notable that NGO SWs do not possess adequate knowledge and skill set to work closely with public CWs as well as have limited information about available social services and procedures. The latter confines effectiveness of project’s efforts in provision of adequate and quality social services.

**Lack of Coordination** - For coordination purposes the multi disciplinary teams (MDT) have been established by health departments of local administration in each pilot cities. The special decree regulates composition of the MDT. The MDT meets on regular bases to discuss project implementation status as well as individual cases of beneficiaries. However, effectiveness of this mechanism was difficult to justify during the assessment. The lack of coordination has also been revealed in legislation that governs provision of OST services. There are legislative collisions which creates barriers for access to OST and requires urgent resolution.

**Deficiency of Knowledge and State Support** - Physicians at ICM as well as drug dependent women who delivered at ICM, noted poor methods of treatment for child withdrawal syndrome. As treatment guidelines and protocols are not yet developed and approved by the MOH, physicians use symptomatic treatment for child withdrawal syndrome. Moreover, the child dose of morphine is not registered in the country, thus physicians use other medicines instead. Importantly as the state defined list of medicines for the given treatment is lacking, there are cases when the beneficiaries are asked to purchase medicines. Another area where the assessment revealed insufficient knowledge is NGO Social workers as they are mostly former beneficiaries and/or former drug users who have better access to target groups and are accepted by them, though have limited knowledge and information and standardized procedures for utilization of available social services.

**Risks To Sustainability** - The funding of the integrated medical service provision to targeted beneficiaries is fragmented. Health service budgeting is mainly input based and financed from different, Oblast and local municipal funding sources. According to the new reform municipal budgets finance primary health care level facilities, while oblast budgets finance facilities of the secondary level and tertiary level is
financed from the central budget. This reform is yet piloted only in three oblasts of Ukraine, out of which two are project pilot cites, Kiev and Dnepropetrovs. Furthermore, apart from change in funding principles, the reform also entails restructuring of the health sector by redistributing service providers from one level of care to another. Regardless of the reforms and source of financing, budgets allocated to health facilities are deficient which raises concerns. Although some pilots manage to spare medicines and other medical consumables for the project target patients, in case of increased enrollment ICPCs no longer will be able to ensure complete and free of charge services to drug dependent women.

Absence of social rehabilitation and protection services in the ICM raises risks of enrolled women not being able to integrate into society, abandon their child and return to their previous lifestyle.

POOR MONITORING AND LACK OF EVIDENCE FOR ADVOCACY - The project lacks well formulated results framework with measurable indicators, baseline, targets and potential sources of progress verification. Reporting is mainly focused on outputs produced, however less emphasises problems encountered, risks identified and potential ways of risk mitigation. The project paid less attention to the monitoring and reporting of project results and lessons learned that could have been used for demonstration of success achieved as well as different approaches introduced and tested by local authorities in pilot regions. Well formulated evidence on the importance and potential benefits of the integrated care model could have served as powerful instrument for advocating central decision makers as well as local authorities to build a bridge between public (health and social) sector and civil society. All of the above limited UNICEF and other local partners to advocate for further expansion of the project in terms of services as well as geographically.

REMAING BARRIERS

The project shows initial results, however number of barriers still remain that restrict access to integrated care services as well as sustainment of the results. The assessment confirms that people who have drug misuse problems in many cases have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behavior, etc.. The barriers outlined above were named by the participants of FGDs.

MARGINALIZATION - Drug dependant individuals, especially pregnant women still feel being marginalized and experience fear to contact public institutions other then ICM. Their friends and former community members are still hesitant to use services due to the stigma and public attitude. Furthermore, they lack information about available services.

RISK RELAPSING - Those, who managed to enroll on OST, face psychological pressure from their drug dependent partners that push them to return to their old lifestyle. These women often lack parental and/or family support to continue treatment and bring up a child, which in its term appears as a barrier to pay everyday visit to OST clinic and pushes them to return back to their society. In such cases they are at risk of losing parental right.

ABSENCE OF EMPLOYMENT OPPORTUNITIES - Being unemployed appears to be another strong barrier for bringing up a child and their social integration. FGD participants expressed willingness to receive vocational education that would help them find jobs. However, also noted about non-responsiveness of public employment agencies to their queries.

PHYSICAL ACCESS BARRIERS - Gographical access barriers to IC services and transportation costs have also brought up as access barrier by the FGD participants. Some of them have to travel from far to get to the ICM by public transport and spend around two to four hours for round trip. Those who do not have family support have to carry their babies with them.

ABSENCE OF PRESCRIPTIONS - Lack of OST prescription, take-home allowances or pharmacy dispensing has been named as another barrier. 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.

LESSONS LEARNED

It is clear that none of the pilots have yet been able to completely fulfill the goal of truly bridging different parts of the health care and social systems 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 and social systems, uncertainty with ongoing reforms in both sectors, funding issues, staffing shortages and other problems. But it is equally clear that ICM has huge potential to reshape Ukrainian health and social sectors for the better, and not only for people dealing with drug dependency. Current assessment has found that ICM is contributing to improvements in access to care and treatment and increasing cooperation across medical disciplines. At the ICM sites the majority of patients at all sites were found to have been informed about services available on-site or by referral. Core services such as narcological assistance, HIV, delivery and psychosocial consultation had consistently high uptake.

The project has 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,” said the head of maternity department at Dnepropetrovsk. Patients’ experiences have mirrored this, as in the words of Natalia, a participant in the Dnepropetrovsk ICM 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.”

RECOMMENDATIONS

Recommendations are based on the findings of the assessment and a combination of inputs from service users and service providers, key informants, the expert reference network and the project staff.

RECOMMENDATION #1: EXPANSION OF TARGET GROUP AND OUTREACH ACTIVITIES

The assessment revealed potential reasons for low enrolment rates. The project target group being too narrow and limited to only pregnant drug dependent women raises risks of justifying cost efficiency of the intervention in a long run. Targeting of the given group for IC services although produces immediate results, but is shrouded to minimize the risk of future relapse without targeting partners and family members. Moreover, focus on individuals with long history of drug dependency and ignorance of those risk groups that are vulnerable to join drug dependent’s community will only produce short-term results and will not minimize persistence of a given problem. Thus it is highly recommended to widen project target group and include youth and partners of drug dependent women. This approach will ensure that potential risks groups are identified at early stage, targeted with preventive activities and when deemed necessary are given access to treatment and social care services and support.

RECOMMENDATION #2  ENSURE TRUE SERVICE INTEGRATION

Integrated care for drug dependents’ is an approach that seeks to combine and coordinate all the services required to meet the assessed needs of the individual and requires i) treatment, care and support to be person-centered, inclusive and holistic to address the wide ranging needs of drug users; ii) the service response to be needs-led and not limited by organizational or administrative practices; iii) collaborative working between agencies and service providers at each stage in the progress of the
individual in treatment, care and support, through to rehabilitation and reintegration into the society. What is referred to as integration in pilot sites is more co-location or collaborative partnership between health service providers and NGO social workers. The assessment shows that people who have drug misuse problems in many cases have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behavior, etc. This means that a wide range of responses and support needs to be deployed to address those problems. Therefore there is emerging need for introduction of the true integrated care model which meets all service users’ needs and where both individuals and service providers work in an integrated way with other services.

The overarching aim of true ICM is to help drug dependents to overcome their drug problem and their associated health and social difficulties by providing effective, coordinated and timely treatment, care and support. The goals of ICM should be: i) Reduce illicit drug use; ii) Reduce the risk of the spread of blood-borne viruses; iii) Reduce the risk of mother to child transmission of HIV and other blood-borne diseases; iv) Improve all aspects of health; v) Reduce involvement in criminal activity; vi) Improve personal, social and family functioning; vii) Improve education and employment prospects; and viii) Improve stability of housing / accommodation.

RECOMMENDATION #2.1: Define basic package of services to be provided by ICM

In order to meet the goal and objectives of the project it is highly recommended to define basic list of services that ensures treatment, care and support and addresses the wide ranging needs of drug users. Further extension of medical and social services and support will contribute towards better quality service and care provision to the project beneficiaries and will ensure sustainment of desired outcomes.

RECOMMENDATION #2.2: Introduce effective Case Management Function as a transitional model

The key principles underpinning the ICM are planning, design and management of integrated care. Case management is the overall term that covers the elements needed to ensure a more coordinated and effective approach to services including planning, commissioning and operational management. The critical factor is that the relevant range of services is under single management. Joint management needs to happen at different levels including strategic and operational levels.

Considering ongoing reforms in social sector as well as capitalizing on the positive experience of public and civil society collaboration, it is recommended that case management function, as a transitional model, is delegated to the NGOs. In a given model drug dependent individuals are identified and information passed to the Case Management Center (CMC) for further planning, design and management of integrated care. The CMC assesses the case with the following objectives: i) identification of the type and level of need and the attributes and aspirations of the individual; ii) agreement jointly with the individual, and other service providers as appropriate, of an action plan for treatment, care and support; iii) agree goals and arrangements for review and reassessment; and iv) communicate the outcome of the assessment process to the appropriate providers and make arrangements of matching service provision.

From the assessment process, a profile of the individual could be created to cover: i) the type and level of needs; drug and treatment of other health problems, social support, life skills; ii) particular circumstances e.g. family problems, emotional and behavioral problems likely to create barriers to progress; iii) the aspirations and attributes, with particular attention to positive experiences in the past; iv) goals – short term and longer term.

As a result of the assessment the Action Plan (AP) is developed which draws together the outcomes of the assessment process, judgment of staff; and the profile. The AP should recognize the needs, attributes and aspirations of the individual. It should offer a systematic way
to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable service provider(s) to design and deliver the appropriate treatment, care and support “package”. The action plan should specify: a) the goals; b) the agreed treatment approach for drug use and the service provider; c) the actions to address other problems e.g. housing, family support, offending behavior, personal and social skills, education and training needs; d) what will constitute progress and how it will be measured; e) dates for reviewing progress, who will be involved and the format; and f) the main contact.

CMC should also be charged with ongoing assessment and review to measure the progress made by the individual towards goals including a) improvements in health; b) improvements in family and social functioning; c) reducing criminal behavior; d) reduction in drug use; e) improvements in self-esteem and motivation; f) movement towards employability. A planned review should take place at regular intervals to ensure that the care plan is revised to take account of changing needs and circumstances and that service providers are meeting needs appropriately and the agreed quality standards.

**RECOMMENDATION #2.3:** Develop integrated care pathways and treatment guidelines/protocols

An Integrated Care Pathway (ICP) should determine locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It should form all or part of the clinical record, documents about care given and should facilitate the evaluation of outcomes for continuous quality improvement. Particular emphasis should be given to the development of clinical guidelines and protocols, especially for “newborn withdrawal syndrome”.

**RECOMMENDATION #2.4:** Develop staffing norms and job descriptions

The effectiveness of the new ICM will require to be fully staffed with required medical and social service professionals with clear roles, competencies and responsibilities. Therefore it is recommended that staffing norms and job descriptions for each position is well thought through and approved by national and local authorities.

**RECOMMENDATION #2.5:** Design assessment tools

Difficulty in identification, reaching out drug users and provision of required services by the public structures raises need for the development of the different levels of assessment tools. Three levels of assessment may be appropriate: i) simple assessment (or screening); ii) comprehensive assessment; and iii) specialist (or in-depth) assessment.

**RECOMMENDATION #2.6:** ICM Staff Training

Staff should have access to regular training in the competencies appropriate to the level of assessment and care that they are engaged in. It is recommended to develop integrated training curricula including assessment techniques, evidence based interventions, referral systems, coordination of care and review mechanisms, training in case management and development of integrated care plans, identification of dedicated liaison positions within services to enable better feedback mechanisms and continuity of care across services.

**RECOMMENDATION #2.7:** Formulate ICM funding and incentives based reimbursement Methodologies

The ICM effectiveness is also subject to joint resourcing. The latter is the overall term that covers all aspects of resources brought together in a ‘pot’ to provide a single focus for the planning, commissioning and delivery of services. The budget can be aligned within existing powers or ‘pooled’. Moreover, provision of incentive payment schemes that enable adaptation of services to better integrate care and/or allow for stronger referral pathways for service users with complex needs has to be addressed. The Project can capitalize on the recent experience of
incentive based reimbursement of GP/FP for provision of primary health care services to the population.

**RECOMMENDATION #3  ENSURE SUSTAINABILITY OF INTEGRATED CARE MODEL**

**RECOMMENDATION #3.1  Promote rights of service users**
Service user participants in the assessment reported favorably on services that were friendly, free, and interconnected. These kinds of service provide easy access to treatment and have potential to facilitate continuity of care. The government should recognize and actively support health and social system reform that brings the inclusion of service users with drug dependence problems in line with the accepted conditions for service users in other parts of the health and social systems.

**RECOMMENDATION #3.2  PROMOTE TOP DOWN INTEGRATION**

The world wide experience of integrated care models defines two main types “bottom up” and “top down” models. The “bottom-up” integration is mainly initiated by one or more local service agencies without reference to particular federal or state initiatives or requirements and is a less formal agreement where agencies work together with a general sense of goodwill. The presence of strong local advocates for integration in this type of situation can be a major factor in initiating and maintaining an integrated service system that meets local needs. The “top down” integration is mandated by the national level, defines integration policies and funding models supporting integration across agencies. The assessments revealed that level of integration in piloted ICMs mostly bear the “bottom up” character. Additional services incorporated in the models were mostly driven by strong local advocates and supporters, and consequently resulted in different integrated care modalities. The latter is vulnerable to political and individual risks and raises concerns of sustainability. In order to mitigate these risks the government is advised to promote “top down” integration.

**RECOMMENDATION #3.3  Integration of the ICM model in the new five year National AIDS strategy**

Inclusion of the new ICM model in the new five year National AIDS strategy will demonstrate government commitment towards achievement of the strategy goals including the PMTCT.

**RECOMMENDATION #3.4  Develop National legislation regulating ICM**

Development of enabling legal environment is another recommended action required by the national and local governments to ensure effective integration of health and social services and its operations. New legal documents have to be developed that regulates basic package of integrated care services, ICM structure, staffing, functions, care pathways and treatment guidelines and protocols, accountability forms and rules, performance monitoring and evaluation requirements as well as funding and incentives based reimbursement modalities.

**RECOMMENDATION #3.5  Harmonization of existing legislation**

The assessment revealed legislative collisions to be an access barrier for the appropriate services. Therefore, it is essential that thorough review and harmonization of existing legislation is given a priority.

**RECOMMENDATION #4  INTENSIFY ADVOCACY EFFORTS**

Implementation of above recommendations will necessitate strong advocacy efforts from UNICEF and will require active engagement with the policy makers in the social and health sector reform agenda formulation.
RECOMMENDATION #5   ENHANCE INFORMATION/COMMUNICATION ACTIVITIES

It is highly recommended to intensify and re-align education campaigns to address the stigma of illicit drug use. Seek to change public perceptions of illicit drug use so that these issues are recognized as legitimate and integral parts of health and social care. Develop and distribute information brochures on availability, location and procedures to receive IC services as well as use innovative distribution channels (NGOs, SWs, GP/FPs, Diagnostic and consultancy centers, RH/FP centers, AIDS centers, TB centers, Youth clinics, narcology centers, etc.). Based on assessment findings project beneficiaries have willingness and can play a pivotal role in dissemination of information. To improve access to information they suggested placing information posters in common location of drug users, public transport etc.

RECOMMENDATION #6   DEVELOPMENT OF COMPREHENSIVE M&E FRAMEWORK AND SYSTEM

The Government should recognize the need for M&E that focuses on the establishment of national indicators detailing the target population, treatments, care provided and outcomes. The project is advised to commission the design of M&E framework that measures quantitative and qualitative indicators required for national statistics and project performance evaluation. Introduction of anonymous patient surveys that measure knowledge, attitudes and practice as well as satisfaction with quality of service provision and level of social assistance and support is recommended to be considered in the M&E framework. UNICEF is advised to commission technical assistance and support of M&E framework and system development as well as finance training of all involved parties in accurate data collection and analysis.
Chapter I: Introduction

Background and context of the project

Ukraine has the highest adult HIV prevalence in all of Europe and Central Asia, with an estimated HIV prevalence rate of 1.1% among the adult population. This prevalence is significantly higher than any other European or CIS country. The HIV epidemic is predominantly driven by injecting drug use and is increasingly affecting women. In fact, Ukraine is facing a dual epidemic of HIV and drug use.

While injecting drug use remains the primary route of transmission of HIV, heterosexual transmission in Ukraine is growing. Women are more prone to infection due to their biological and social vulnerability. They now represent 45% of all adults living with HIV in Ukraine, and most of them are of reproductive age. In 2011, more than 5,000 pregnancies were registered among HIV-positive women. The HIV prevalence among pregnant women in Ukraine is the highest in Europe. The absolute number of children infected with HIV through mother-to-child transmission (MTCT) continues to increase, as there is a yearly 20-30% increase in HIV-infected pregnant women. According to Ministry of Health statistics, 32,504 children were born to HIV-positive mothers between 1995 and 2012: 21,916 with negative HIV status; 6,735 children awaiting confirmation of their HIV status; 2,814 with HIV-positive status; and 752 having AIDS and 287 children having died of AIDS.

Although important progress in prevention of mother-to-child HIV transmission (PMTCT) programmes that has led to a decrease of HIV transmission to babies from 20% in 2000 to 4.9% in 2009, serious issues and challenges remain.

Project design

Project Objective

The overall objective of this project is to maintain and improve gender responsive, comprehensive, and integrated services that address the needs of 100 drug-dependent pregnant women and the children born to them in Kyiv, Dnipropetrov’sk, and Poltava cities in Ukraine during April to December 2012.

Expected results

- Supportive, enabling environment strengthened at national and municipal levels enabling provision of integrated service to drug-dependent women and the children born to them; Linkages between PMTCT and harm reduction services, including Medication Assisted Treatment (MAT), family planning and STI prevention services for pregnant drug addicted women and social services for children born to them established and strengthened;
- Gender responsive comprehensive services that address the needs of drug dependent pregnant women at the Centres for the Integrated Care of Pregnant Women (CICP), established during the pilot project in 2011, extended and maintained in three pilot sites. Neonatal outcomes in children born to these women improved, social services for mothers and children provided;
- Service providers, including obstetricians, gynecologists, neonatologists, drug-dependence treatment professionals, and social workers in three pilots have appropriate knowledge and skills to provide integrated services to drug-dependent pregnant women and the children born to them.
**Intended beneficiaries**

**Clients:** Close to 100 drug-dependent pregnant women, children born to them and their families will benefit from receiving comprehensive services in a friendly, supportive environment. The estimated number of clients is 50 women in Kyiv, 20 women in Dnipropetrovsk’sk, and 30 women in Poltava.

**Service providers:** About 100 professionals, including obstetricians, gynecologists, neonatologists, drug-dependence treatment professionals (narcologists), and social workers from NGOs and state social services, working at the national and regional levels will be benefited from acquiring new knowledge and skills in drug dependency management during pregnancy, the pre- and post-natal care and treatment of the infants of drug-dependent mothers and social support for mothers and children to prevent abandonment.

**Institutions:** The health facility selected as supplementary project’s site based in Dnipropetrovsk’sk Clinical Hospital #9 will upgrade its technical capacities to provide services through receiving of the appropriate equipment. Necessity to create other potential sites will be determined during the project implementation.

**Project Strategies & Expected Outcomes and Outputs**

<table>
<thead>
<tr>
<th>Strategy 1.</th>
<th>Targeted advocacy and communication strategy aimed at promotion of gender sensitive and right-based approaches is implemented; gender-sensitive advocacy and communication materials developed and disseminated among various target groups, including local policy makers, programme managers, services providers, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1</td>
<td>Supportive, enabling environment strengthened at national and municipal level enabling provision of integrated service to drug-dependent women and the children born to them.</td>
</tr>
<tr>
<td>Output 1.1</td>
<td>Monitoring and support in implementation of the MOH, order issued in 2011, to enable continuation of piloting of integrated care model in Kyiv, Dnipropetrovsk and Poltava. Coordination between different health care services (narcological, maternity, HIV, TB, and STI)</td>
</tr>
<tr>
<td>Output 1.2</td>
<td>Monitoring and support in implementation of the Municipal orders issued by Kyiv, Dnipropetrovsk and Poltava city administrations to complement MOH order; Coordination with local responsible parties and establishing referral systems.</td>
</tr>
<tr>
<td>Output 1.3</td>
<td>Advocacy and coordination meetings, round tables, information sharing through partner network partners, ongoing consultative processes, and participation in the relevant working groups to raise awareness of national and city level decision makers about vulnerability and the needs of drug dependent pregnant women and children born to them.</td>
</tr>
<tr>
<td>Output 1.4</td>
<td>Gender-sensitive advocacy and communication materials developed and disseminated among various target groups, including local policy makers, programme managers, services providers to raise specialists, decision makers and general public awareness about the project</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategy 2.</th>
<th>Gender-responsive comprehensive services addressing female IDUs (family planning, pregnancy and parenting) made available.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2</td>
<td>Gender responsive comprehensive services that address the needs of drug dependent pregnant women at the CICP extended and maintained in pilot sites. Neonatal outcomes in children born to these women improved;</td>
</tr>
</tbody>
</table>
Purpose, objective and scope of assessment

**Purpose of the Assessment**

The purpose of the assignment was to carry out the assessment of the pilot project ‘Prevention of Mother-to-Child Transmission and Improving Neonatal Outcomes among Drug-Dependent Pregnant Women and Children Born to Them in Three Cities in Ukraine’ (hereinafter Project) in order to develop the recommendations on how to achieve the goal of a project and formulation of the future interventions in a context beyond the medical.

**Assessment Objective**

The current assessment report documents results and the lessons learned specifically on “what worked” and “what did not work” and answer the question of how to strengthen social services enabling it to
identify women vulnerabilities at early stages as an entry point to the system of integrated treatment and care for them and their children.

The assessment immensely benefited from collective contributions by concerned stakeholders, the project staff, decision makers, donors and project beneficiaries. It looked at project’s a) achievements, strengths, shortcomings and weaknesses; b) outlined remaining key bottlenecks, including policies, practices and other structural barriers in medical and social areas for the Project implementation.

Based on the findings the report provides strategic, policy and implementation recommendations of how to strengthen the on-going Project in order to guarantee achievement of its key outcome as well as ensure the model’s efficiency and sustainability in future.

**Assessment Results**

The project assessment looked at: i) The achievements, strengths, shortcomings and weaknesses; ii) Outlined remaining key bottlenecks, including policies, practices and other structural barriers in medical and social areas for the Project implementation; iii) Developed strategic, policy and implementation recommendations of how to strengthen the on-going Project in order to guarantee achievement of its key outcome as well as ensure the model’s efficiency and sustainability in future.

**Assessment Process**

In order to meet the assessment objectives the consultant applied he following processes: i) Based on the desk review of project related documentation the Project assessment design, methodology and the data collection instruments were developed; ii) Conducted in-country project assessment mission with the objective to gather project specific observational and other data, including through key informant interviews, site visits, review of available statistical, clinic or other site specific or/and other data sources; conduct meetings with relevant national, sub-national and local counterparts and if warranted, community members; and conduct debrief with UNICEF Ukraine Country Office; iii) Preparation of the report and recommendations based on the results of assessment.

**Methodology**

**Criteria**

The project assessment followed established OECD DAC evaluation criteria. Table # 2 below summarizes those criteria. These criteria were used and translated in the assessment objectives.

**Table 1: Criteria**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Questions</th>
</tr>
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</table>
| Relevance | • What is the relevance of the intervention in terms of advocating for and facilitating the national HIV/AIDS strategy?  
• To what extent is the intervention relevant in terms of contributing to prevent PMTCT?  
• Does the integrated care service model designed by the project meet the needs of drug dependent pregnant women? |

1 The DAC Principles for the Evaluation of Development Assistance, OECD (1991)
The extent to which the training component is appropriate in response to the training needs of the service providers?

Effectiveness

- Did the project managed to establish enabling environment that ensured successful implementation of the pilot?
- Does the regulatory framework set within the framework of the project demonstrate commitment to ethical issues?
- Do ethical issues contribute to bottlenecks and obstacles for reaching project objectives?
- To what extent is the intervention effective in facilitating the sector reform in respect to policy change, quality improvement and governance re-structuring of the health system?
- To what extent has the project contributed to regional health authorities and medical institute’s ownership to promote the integrated care packages for drug-dependent pregnant women?
- How effective is the intervention in improving service providers’ knowledge and skills?
- To what extent have trained service providers (individuals) modified their regular practices? Which are enabling/constraining factors that facilitated/hindered this behavioral change?
- In the CIPC, where trained service providers work, to what extent have regular practices been modified in line with set standards?
- To what extent has there been an improvement in quality of care during delivery and post-natal care in the health facilities included in the project?
- To what extent is the M&E system effective in reinforcing skill application and tracking?
- To what extent do beneficiaries perceive any overall change in the health? Especially as a consequence of improved health care provision, decrease of health services’ access barriers and costs for beneficiaries?

Efficiency

- Does the project use the resources in the most economical manner to achieve its objectives? Are the available resources adequate to meet project needs?
- To what extent is training system efficient in terms of resource absorption as compared to the results achieved?
- To what extent is the communication package efficient in terms of reaching the target groups as compared to the absorbed resources?

Sustainability

- To what extent do MoH and other concerned national and local government agencies demonstrate ownership over the project?
- To what extent the project contributes and can be considered into the health and social sector reform strategy, so that government’s ownership can lead to their incorporation into national policies and assure sustainability of the results achieved?
- To what extent are the behavioral changes among health providers expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their capacity to continuously provide quality and equitable services?
- To what extent are the behavioral changes among drug dependent women expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their ability to access and use quality services for themselves and their children?

Coordination

- How stakeholders rate the coordination of activities between actors of different sectors on policy making and service delivery levels?
- Which coordination methods applied served the purpose?
- What are the shortcomings of coordinated action to ensure effectiveness and efficiency of integrated care delivery?
- To what extent the coordination mechanisms are institutionalized?

Coherence

- To what extent the project facilitates synergies and avoids duplications with interventions and strategies promoted by other UN agencies and development partners
- To what extent the project is in line with and contributes to the donor’s objectives for the Ukraine’s health and social sectors

Assessment Design

In order to meet assessment objective and results the assessment framework (Annex 3) was developed structuring the issues and questions as indicators that was measured or assessed during the assessment. The key questions were structured per each project strategy and allowed the consultant to identify achievements, strength and weaknesses as well as remaining bottlenecks.
The Assessment Framework also identified the sources of information and the methods the consultant applied, the range of documents reviewed and key informants interviewed for each question. The framework was seen as being part of a process rather than simply an end product to ensure there is clarity and agreement about what is required and how the assessment structure and methodology is derived from that.

**Methodology**

The assessment methodology comprised of a mix of site visits and observation, face-to-face semi structured interviews of key informants, focus group discussions, desk-based research and review of existing reports, documents and secondary data. Summary of Methods are outlined below:

**Desk Review:**
Review of documents was a major part of the assessment. The list of documents reviewed is listed in Annex 1.

**Semi-structured Interviews:**
Semi-structured Interview tool have been used for the key informants on the national, regional and municipal levels, policy makers and relevant public institutions/entities, UNICEF and project staff, administrative staff of service provider institutions, NGOs etc. The list of key informants is provided in the Annex 2. Prior to visiting key informants, semi-structured interview topic guides were developed based on the Assessment Framework to help ensure systematic coverage of questions and issues. The interview topics have been selected around the evaluation questions, but grouped and targeted according to the organization and/or individual being interview ed (Annex 4).

**Appreciative enquiry:**
This approach was used to explore successes and positive experiences in dialogue with individuals and groups of people and have been applied in order to strengthen understanding of why something worked well, and how success could be replicated.

**Field Analysis:**
A useful and quick visual tool was used to gain an overview of the different forces driving or resisting change that the project is trying to bring. Using Force Field Analysis helped to analyze the forces working for and against a policy and its realization.

**Focused Group Discussions (FGDs):**
The assessment also used the FGD method to obtain qualitative information. Three FGD were carried out for each pilot site and comprised of: i) Drug-dependent pregnant women who used the services; ii) Drug-dependent pregnant women who did not use the services; iii) Integrated service provision teams; and iv) Public sector social workers.

For each FGD specific FGD guide have been designed. FGD guide for service providers (Annex 5.1) reflected questions relevant to assessment objectives, while FGD guide for Drug-dependent pregnant women who used the services (Annex 5.2) was oriented towards measuring consumer access and satisfaction with the services, perceptions of quality of integrated service provision, additional demand for services and remaining barriers. Annex 5.3 presents FGD guide for drug-dependent pregnant women who did not use the services and attempts to understand reasons for not accessing the CIPCs. Annex 5.4 tries to understand the role of public social workers as well as to estimate their potential to play a vital role in identification of potential beneficiaries and referral to ICPC.
**Triangulation of findings:**
Finally the examination of data from the above sources has been carried out to arrive at conclusions and formulate recommendations.

**Ethical Issues:**
While designing the assessment methodology, the ethical issues were considered and the following approaches were applied:

- Kept assessment procedures (FGD and Semi-structured interviews) as brief and convenient as possible to minimize disruptions in respondents work process;
- To ensure that potential participants can make an informed decision the information will be provided about the purpose of assessment and final outcome as well as on the process and duration of interview and/or FGD. The consultant will also assure respondents about the confidentiality of the source for obtained information and will allow them to retain from answering the questions posed in case they feel uncomfortable to respond;
- Key informants will be interviewed face to face without presence of other individuals. As for the FGD, the group will be encouraged for open discussion around the assessment questions by avoiding presence of their superiors.
- The consultant will collect and analyze information as well as reported findings accurately and impartially.

**Data Sources**
The four major sources of data: people, site visits to a sample of oblasts supported by the INCHS program, documents and information system were used during the evaluation.

**People** - Individuals were consulted through individual interviews and focus groups;
**Site visits** – the consultant will visit all three project sites and carry assessment following proposed methodologies.
**Documents** - List of reviewed documents attached to the report
**Quantitative Analysis** - The consultant will utilize quantitative analysis to examine changes in selected but comparable indicators from available data.

**Stakeholder Involvement**
The consultant ensured active participation of key stakeholders in the assessment process. The assessment findings and recommendations were presented and verified at pace of the assessment with relevant key informants before final version of the report was produced. Moreover, initial draft of the report was shared and commented and latter were reflected and incorporated in the final report accordingly.

**Assessment Limitations**
The assessment experienced the following limitations:

- Due to the annual leave season some of the key informants being directly involved in the project were not available for semi-structured interviews though required information was collected by involvement of their colleagues in the assessment.
Due to the project’s low enrollment rates of drug dependent pregnant women organization of the FGD with 8-10 participants did not materialized, instead the FGDs were conducted with fewer numbers of participants. The latter limited the consultant to apply sampling for FGD participants.
Chapter II: Summary of Assessment findings

Project Achievements and Strength

**HIGH RELEVANCE**

The Intervention is highly relevant in advocating and facilitating achievement of the National HIV/AIDS strategy goals as well as contributes to the prevention of mother to child transmission and ensures quality MCH service provision to the target beneficiaries. The integrated care service model designed and implemented in Poltava and Dnepropetrovsk meet selected medical needs of drug dependent pregnant women.

**OWNERSHIP**

There is demonstrated ownership from MOH and local Health authorities as well as medical staff and NGOs in Poltava and Dnepropetrovsk. The MOH and local health authorities established supportive legal environment that regulates delivery of medical services to the beneficiaries through integrated care model.

Additional services, such as shelter for homeless drug dependent women, is financed by the local health budget are offered to target beneficiaries in Poltava.

**ENABLING ENVIRONMENT**

The introduction and institutionalization of the western model of integrated care in conservative environment and assurance of its effectiveness was approached with caution by UNICEF. In order to avoid discrimination of the model at early stage of its introduction as well as fear of the decision makers associated with innovative service delivery modality, the focus was made on introduction and implementation of medical service integration in the first year of the project. Results achieved so far demonstrates success of the project and calls for move to the next stage of development.

Basic enabling environment set by the project supported the introduction of integrated care model. The integrated services, including HIV testing and counseling PMTCT, management of pregnancy, labour and postpartum period, management of withdrawal syndrome in newborns, and psychosocial counseling provided at CICP facilities in Kiev, Poltava and Dnipropetrovsk. Trainings supported by the project equipped medical staff with necessary knowledge and basic skills for provision of quality medical services as well as stimulated change of their behavior, attitude and practice towards drug dependent women.

**ENROLLMENT AND HIGH BENEFICIARY SATISFACTION**

Numbers of drug dependent women who benefited from the project since the project initiation is yet low and account for only 41, though high satisfaction with integrated medical services are observed. They are clear about the harmful consequences for children of their drug use problems. The experience of being treated as human being absolutely free of charge first time in their lives, inspired drug dependent women to share experience to their former community members and spread the information about available services. Thus project beneficiaries become the most powerful mechanism to rich out and improve enrollment rates at integrated care sites.

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2 Project commencement date – July, 2011
PUBLIC AND CIVIL SOCIETY PARTNERSHIP
The project is a successful demonstration of close partnership between public and civil society organizations. Strong NGO presence is a prerequisite of initial results achieved. Besides it stimulated government contracting out of selected social services to NGOs, being innovative in Ukraine’s history.

NOTICEABLE IMPROVEMENT OF ATTITUDE TOWARDS BENEFICIARIES
The introduction of the integrated care model facilitated the recognition of pregnant drug-addicted women as a target group for integrated services by the health and social sector authorities. Trainings supported by the project led to noticeable change of medical staff behavior, attitude and practice at ICPC sites in Poltava and Dnepropetrovsk.

PROSPECTS OF SUSTAINABILITY
The first positive results empowered the local authorities’ to finance additional services, in order to satisfy unmet social needs of target beneficiaries. Moreover, the positive experience stimulates local governments to replicate the model to other cities. These developments demonstrate effectiveness of the pilot and ensure sustainability of project achievements. Moreover, the integrated care model in itself and a need for service package expansion and strengthening social services, breeds discussions and facilitates close inter-sectoral cooperation and collaboration of health and social sector partners.

Weaknesses and Shortcomings

LOW ENROLLMENT RATES
The number of women who benefited from the project is yet low and account for only 41 drug dependent women since the project initiation. While this raises concerns of project effectiveness and efficiency, there are certain objective reasons contributing to this result. Namely, proactive outreach to ensure client flow to the ICPC has been postponed until the integrated medical services were fully operational and ready to provide quality services to beneficiaries. Establishment of the regulatory framework enabling ICM operations had a slow uptake at start. Considerable advocacy efforts were put in place by UNICEF to gain national and local health authorities interest and support. These aspects eventually contributed to the low enrollment rates in the first year of the project.

Another contributing factor for a given result was difficulties in reaching target beneficiaries. Drug dependent people are usually marginalized from society and are forming their informal communities. The criminalization of drug use in Ukraine forces the community to hide and frequently change their location. To avoid imprisonment they fear to be contacted by stranger and/or use public services. Their style of life makes it difficult to reach them out. The given situation was further complicated by the project choice to reach out to too narrow target group, mainly pregnant drug dependent women, without approaching and/or involving their partners and family members. The latter served as a barrier not only for he enrollment, but also influenced OST treatment of target beneficiaries already engaged in the project.

As the project is on early stages of implementation, each pilot tested their own mechanism for identification and outreach of pregnant women. The assessment showed that mechanisms tested so far bear the passive character which in its term contributes to low enrollment rates. It is also notable that pilots where the NGO social workers are former drug users, apply better mechanisms and have better performance rates.
Apart from fear the target group has towards the general society that impedes the targeting, the lack of information about available ICM services is also evident.

**UNDERUTILIZED CAPABILITIES AND RESOURCES**

The Government initiated primary health care reforms, limited the project to heavily rely on the active participation of the newly introduced family physicians (FP) and general practitioners (GP) at the outset of the project. The latter in its turn contributed towards low level of identification of risk groups at early stage of pregnancy and consequent referral to the integrated service model. As the country already generated critical mass of trained FP and GPs, a main challenge ahead is to ensure that identification and service provision to target beneficiaries are initiated at the PHC, first contact level, and referred to the integrated care center.

As noted above, the ICM model focused on introduction and implementation of medical service integration in the first year of the project. Results achieved so far demonstrates success of the project and calls for move to the next stage of development. Namely, treatment of children born to drug dependent pregnant women in Pediatric clinics deserves attention. As no intervention was undertaken by the project for inclusion of such services in integrated medical service model, the beneficiaries interviewed complained about unfair treatment and attitude of medical staff, non-availability and high risk of dropping out from OST treatment in such institutions.

Furthermore, the assessment revealed that beneficiaries are identified and enrolled into the project in late stages of their pregnancy, therefore the ICM is limited to offer preventive care and information/education services such as family planning, education on safe pregnancy, breastfeeding, healthy lifestyle and newborn care to the target group. Should identification mechanisms been more effective, these services would have been readily available for the beneficiaries which is so lacking according to their information. In addition, according to unofficial statistics provided by the management team of the Reproductive Health and Perinatal Center around 25% of all deliveries in a given center are of drug dependent women who are not followed up to receive other services offered by the integrated care model.

Moreover, the project missed the opportunity to target women undergoing in-patient treatment at narcology centers due to the weak coordination between project and such centers. These group of women could have been targeted for preventive, education and information sharing activities.

Ukraine has well developed civil society sector. There are many NGOs targeting children, youth, women, drug users, etc., but their capacity is not utilized by the project that could resulted in better information sharing about available services to target groups. This is a lost opportunity for the project to improve enrollment levels as well as expand information base through using NGOs for reach out activities.

**LIMITED SOCIAL SERVICES OFFERED AS PART OF ICM**

Although initial strategy chosen by the project to focus mostly on offering integrated medical services as part of the ICM, attempts were made to provide limited social services as well. In the environment, where the public social workers’ role in relation of the project beneficiaries as well as eligibility of this group for public offered safety nets is not clear, the project mainly relied on NGO social workers to accompany beneficiaries and assist in finding ways to resolve social problems. Nonetheless, it is notable that NGO SWs do not possess adequate knowledge and skill set to work closely with public CWs as well as have limited information about available social
services and procedures. The latter confines effectiveness of project’s efforts in provision of adequate and quality social services.

**Lack of Coordination**

The assessment revealed that for coordination purposes the multi disciplinary teams (MDT) have been established by health departments of local administration in each pilot cities. The special decree regulates composition of the MDT and is comprised of representatives from health and social authorities, ICPC, infectionist, narcologist, NGO representative and NGO SW. The MDT meets on regular bases to discuss project implementation status as well as individual cases of beneficiaries. However, when requested no meeting minutes have been presented to assess the case management strategies applied by MDT. Moreover, key informants found difficult to provide information about number of cases discussed and resolved. Furthermore, some key informants from public social services noted that have limited if no information about the integrated care model.

The lack of coordination has also been revealed in legislation that governs provision of OST services. There are legislative collisions which creates barriers for access to OST and requires urgent resolution.

**Deficiency of Knowledge and State Support**

Physicians at ICM as well as drug dependent women who delivered at ICM, noted poor methods of treatment for child withdrawal syndrome. As treatment guidelines and protocols are not yet developed and approved by the MOH, physicians use symptomatic treatment for child withdrawal syndrome. Moreover, the child dose of morphine is not registered in the country, thus physicians use other medicines instead. Importantly as the state defined list of medicines for the given treatment is lacking, there are cases when the beneficiaries are asked to purchase medicines.

Another area where the assessment revealed insufficient knowledge is NGO Social workers. As the NGO social workers are mostly former beneficiaries and/or former drug users who have better access to target groups and are accepted by them, have limited knowledge and information and standardized procedures for utilization of available social services, except Poltava.

**Risks To Sustainability**

The funding of the integrated medical service provision to targeted beneficiaries is fragmented. Health service budgeting is mainly input based and financed from different, Oblast and local municipal funding sources. According to the new reform municipal budgets finance primary health care level facilities, while oblast budgets finance facilities of the secondary level and tertiary level is financed from the central budget. This reform is yet piloted only in three oblasts of Ukraine, out of which two are project pilot cites, Kiev and Dnepropetrovs. Furthermore, apart from change in funding principles, the reform also entails restructuring of the health sector by redistributing service providers from one level of care to another. A good example is case of women’s consultations which has been moved to secondary care level and thus entitled to be financed from Oblast health budget. Regardless of the reforms and source of financing, budgets allocated to health facilities are deficient which raises concerns. Although some pilots manage to spare medicines and other medical consumables for the project target patients, in case of...
increased enrollment ICPCs no longer will be able to ensure complete and free of charge services to drug dependent women.

Absence of social rehabilitation and protection services in the ICM raises risks of enrolled women not being able to integrate into society, abandon their child and return to their previous lifestyle.

**Poor Monitoring and Lack of Evidence For Advocacy**

The project lacked well formulated results framework with measurable indicators, baseline, targets and potential sources of progress verification. Reporting mainly focused on outputs produced during the reporting period, however less emphasised problems encountered and risks identified and potential ways of risk mitigation.

The project implementing partners paid less attention to the monitoring and reporting of project results and lessons learned that could have been used for demonstration of success achieved so far as well as different approaches introduced and tested by local authorities in pilot regions.

Well formulated evidence on the importance and potential benefits of the integrated care model could have served as powerful instrument for advocating central decision makers as well as local authorities to build a bridge between public (health and social) sector and the civil society.

All of the above limited UNICEF and other local partners to advocate for further expansion of the project in terms of services as well as geographically.

**Remaining Barriers**

The project shows initial results, however number of barriers still remain that restrict access to integrated care services as well as sustainment of the results. The assessment shows that people who have drug misuse problems in many cases have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behavior, etc.

The barriers outlined below were named by the project beneficiaries during the FGDs.

Drug dependent individuals, especially pregnant women still feel being marginalized and experience fear to contact public institutions other than ICM. Their friends and former community members are still hesitant to use services due to the stigma and public attitude. Furthermore, they lack information about available services.

Even those, who managed to enroll on OST, face psychological pressure from their drug dependent partners that push them to return to their old lifestyle. These women often lack parental and/or family support to continue treatment and bring up a child, which in its term appears as a barrier to pay everyday visit to OST clinic and pushes them to return back to their society. In such cases they are at risk of losing parental right.

Being unemployed appears to be another strong barrier for bringing up a child and their social integration. FGD participants expressed willingness to receive vocational education that would help them find jobs. However, also noted about non-responsiveness of public employment agencies to their queries.
Notably, geographical access barriers to IC services and transportation costs have also brought up as access barrier by the FGD participants. Some of them have to travel from far to get to the ICM by public transport and spend around two to four hours for round trip. Those who do not have family support have to carry their babies with them.

Project beneficiaries also noted problems they faced with the medical service providers for their children. Medical personnel at children’s policlinics and hospitals express unfavorable attitude towards them and often request payment for services. In case child is hospitalized mothers do not receive OST at the hospital and have to leave a child and travel to OST clinic.

Lack of OST prescription, take-home allowances or pharmacy dispensing has been named as another barrier. 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.
Chapter III: Lessons Learned

What can be said about the development of ICM? It is clear that none of the pilots have yet been able to completely fulfill the goal of truly bridging different parts of the health care and social systems 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 and social systems, uncertainty with ongoing reforms in both sectors, funding issues, staffing shortages and other problems. But it is equally clear that ICM has huge potential to reshape Ukrainian health and social sectors for the better, and not only for people dealing with drug dependency.

Current assessment has found that ICM is contributing to improvements in access to care and treatment and increasing cooperation across medical disciplines. At the ICM sites the majority of patients at all sites were found to have been informed about services available on-site or by referral. Core services such as narcological assistance, HIV, delivery and psychosocial consultation had consistently high uptake.

The project has 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,” said the head of maternity department at Dnepropetrovsk. Patients’ experiences have mirrored this, as in the words of Natalia, a participant in the Dnipropetrovsk ICM 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.”
Chapter IV: Recommendations

Recommendations are based on the findings of the assessment and a combination of inputs from service users and service providers, key informants, the expert reference network and the project staff.

**Recommendation #1: Expansion of Target Group and Outreach Activities**

The assessment revealed potential reasons for low enrolment rates. The project target group being too narrow and limited to only pregnant drug dependent women raises risks of justifying cost efficiency of the intervention in a long run. Furthermore, isolation of the given group for IC services although produces immediate results, but is shorthanded to minimize the risk of future relapse without targeting partners and family members. Moreover, focus on individuals with long history of drug dependency and ignorance of those risk groups that are vulnerable to join drug dependent’s community will only produce short-term results and will not minimize persistence of a given problem. In addition, given that identification of drug dependents, particularly of those being pregnant, usually happens at the late stage of pregnancy, the services provided bear mostly curative character and prevention is limited.

Thus it is highly recommended to widen project target group and include youth and partners of drug dependent women. This approach will ensure that potential risks groups are identified at early stage, targeted with preventive activities and when deemed necessary are given access to treatment and social care services and support.

**Recommendation #2: Ensure True Service Integration**

Integrated care for drug dependents’ is an approach that seeks to combine and coordinate all the services required to meet the assessed needs of the individual and requires i) treatment, care and support to be person-centered, inclusive and holistic to address the wide ranging needs of drug users; ii) the service response to be needs-led and not limited by organizational or administrative practices; iii) collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, care and support, through to rehabilitation and reintegration into the society.

What is referred to as integration in pilot sites is more co-location or collaborative partnership between health service providers and NGO social workers. While the assessment shows that people who have drug misuse problems in many cases have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behavior, etc. This means that a wide range of responses and support needs to be deployed to address those problems. Service users feel that there is no communication between the various agencies leading to frustration and disappointment for them. Agencies and service providers may not deliver an effective service because they do not have access to all the relevant information about an individual nor the awareness of the roles of other agencies who could potentially be involved in their care. Service users also feel that support is weighted towards the beginning of the recovery process, jeopardizing this process in the long-term.

Therefore there is emerging need for introduction of the true integrated care model which meets all service users’ needs and where both individuals and service providers work in an integrated way with other services. Recommended ICM should enhance the integration of medical services by inclusion of primary health care in a current model as well as further expansion by adding social care and support services.
An integrated care approach founded on cooperation and collaboration between all relevant providers will have a number of benefits for individual service users. It will i) promote early assessment and intervention for service users; ii) remove barriers to progressing towards stabilization / rehabilitation; iii) provide more consistent, coordinated and comprehensive care; and iv) ensure a more holistic and quicker response.

The benefits for those commissioning, managing and providing services will include the opportunity to i) take a comprehensive view of the planning, commissioning and delivery of services; ii) develop “whole person” approaches to service delivery; iii) manage a broader range of services directly, in a way which is responsive to the individual’s needs; iv) break down cultural and other barriers, to develop a better understanding of others’ skills, and to develop a wider range of personal skills in dealing with clients; v) develop a wider skill base among staff, to meet more effectively the needs of individuals; vi) recognize and utilize the strengths and areas of expertise of all parties involved; and vii) make the best use of available resources by managing the care of people in a coordinated and cost-effective way.

Therefore the overarching aim of true ICM is to help drug dependents to overcome their drug problem and their associated health and social difficulties by providing effective, coordinated and timely treatment, care and support.

The goals of ICM should be:

- **Reduce illicit drug use** by stabilizing on a substitute medication or detoxifying (where appropriate), by reducing the range of different substances being used by the individual, by reducing the frequency of drug use and by minimizing the risk of future relapse. The ultimate goal may be to help the individual to stabilize or to become drug free.
- **Reduce the risk of the spread of blood-borne viruses**, in particular the risk of HIV, hepatitis B and C, and other blood-borne infections from injecting and sharing injecting equipment.
- **Reduce the risk of mother to child transmission of HIV and other blood-borne diseases**
- **Improve all aspects of health** by assisting the individual to reach and maintain a state of good physical and psychological health. This will be partly achieved by the goals above, but drug users may also have a number of other physical health problems to address. Mental health problems are a serious problem amongst this population, particularly depression and anxiety.
- **Reduce involvement in criminal activity**, in particular to reduce the need for criminal activity to support or finance drug use, including prostitution and theft by ensuring access to OST treatment.
- **Improve personal, social and family functioning** by assisting the individuals to maximize their ability to make clear and rational decisions and enable them to develop a level of social and family interaction with which they feel comfortable. This may include an improvement in family relationships and the development of new social networks.
- **Improve education and employment prospects** by assisting the individual to access existing opportunities to increase their employability and providing support to them while they are undertaking education or training, or beginning voluntary or paid employment.
- **Improve stability of housing / accommodation** by assisting the individual to access opportunities for housing, or improvements in housing and to provide support while they are undertaking any change in housing.
RECOMMENDATION #2.1: Define basic package of services to be provided by ICM

In order to meet the goal and objectives of the project it is highly recommended to define basic list of services that ensures treatment, care and support and addresses the wide ranging needs of drug users. Further extension of medical and social services and support will contribute towards better quality service and care provision to the project beneficiaries and will ensure sustainment of desired outcomes.

RECOMMENDATION #2.2: Introduce effective Case Management Function as a transitional model

The key principles underpinning the ICM are planning, design and management of integrated care. Case management is the overall term that covers the elements needed to ensure a more coordinated and effective approach to services including planning, commissioning and operational management. The critical factor is that the relevant range of services is under single management. Joint management needs to happen at different levels including strategic and operational levels.

Considering ongoing reforms in social sector as well as capitalizing on the positive experience of public and civil society collaboration, it is recommended that case management function, as a transitional model, is delegated to the NGOs.

In a given model drug dependent individuals are identified and information passed to the Case Management Center (CMC) for further planning, design and management of integrated care. The CMC assesses the case with the following objectives: i) identification of the type and level of need and the attributes and aspirations of the individual; ii) agreement jointly with the individual, and other service providers as appropriate, of an action plan for treatment, care and support; iii) agree goals and arrangements for review and reassessment; and iv) communicate the outcome of the assessment process to the appropriate providers and make arrangements of matching service provision.

From the assessment process, a profile of the individual could be created to cover: i) the type and level of needs; drug and treatment of other health problems, social support, life skills; ii) particular circumstances e.g. family problems, emotional and behavioral problems likely to create barriers to progress; iii) the aspirations and attributes, with particular attention to positive experiences in the past; iv) goals – short term and longer term.

As a result of the assessment the Action Plan (AP) is developed which draws together the outcomes of the assessment process, judgment of staff; and the profile. The AP should recognize the needs, attributes and aspirations of the individual. It should offer a systematic way to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable service provider(s) to design and deliver the appropriate treatment, care and support “package”. The action plan should specify: a) the goals; b) the agreed treatment approach for drug use and the service provider; c) the actions to address other problems e.g. housing, family support, offending behavior, personal and social skills, education and training needs; d) what will constitute progress and how it will be measured; e) dates for reviewing progress, who will be involved and the format; and f) the main contact.

CMC should also be charged with ongoing assessment and review to measure the progress made by the individual towards goals including a) improvements in health; b) improvements in family and social functioning; c) reducing criminal behavior; d) reduction in
drug use; e) improvements in self-esteem and motivation; f) movement towards employability. A planned review should take place at regular intervals to ensure that the care plan is revised to take account of changing needs and circumstances and that service providers are meeting needs appropriately and the agreed quality standards.

**RECOMMENDATION #2.3: Develop integrated care pathways and treatment guidelines/protocols**

An Integrated Care Pathway (ICP) should determine locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It should form all or part of the clinical record, documents about care given and should facilitate the evaluation of outcomes for continuous quality improvement. Particular emphasis should be given to the development of clinical guidelines and protocols, especially for “newborn withdrawal syndrome”.

**RECOMMENDATION #2.4: Develop staffing norms and job descriptions**

The effectiveness of the new ICM will require to be fully staffed with required medical and social service professionals with clear roles, competencies and responsibilities. Therefore it is recommended that staffing norms and job descriptions for each position is well thought through and approved by national and local authorities.

**RECOMMENDATION #2.5: Design assessment tools**

Difficulty in identification, reaching out drug users and provision of required services by the public structures raises need for the development of the different levels of assessment tools. Three levels of assessment may be appropriate: i) simple assessment (or screening); ii) comprehensive assessment; and iii) specialist (or in-depth) assessment.

It may be appropriate to capitalize on the opportunity of a first contact by conducting a **simple assessment (or screening)** to ensure an appropriate referral is made. This first level assessment could be described as the “gateway” into a process of care. It should be a helpful, non-threatening experience designed to encourage the individual to engage in a more in-depth exercise. The data collected at the stage is likely to be relatively basic, probably socio-demographic information, perhaps cursory information about their drug use and its likely impact on the individual’s ability to access services. This tool is generally to be used by the first contacts being it GP/FP and/or any other individual within health and social sector as well as NGOs actively working on grassroots level.

**Comprehensive assessment** may be used in health and social care settings when the individual has made a direct approach or has been referred by another agency. This assessment could cover more detailed information on drug use and other factors such as housing, employment, health and benefits. This assessment should allow some decisions about treatment, care and support to be made, or whether it is appropriate to refer an individual elsewhere.

**Specialist (in-depth) assessment** may be appropriate when a client has been referred to a specialist agency or has moved on from entry-level assessment. This assessment would cover in detail the nature and extent of drug use, physical and psychological health, personal and social skills, social and economic circumstances, previous treatment episodes and assets and attributes of the individual. These last two tools can be used by CMC.
RECOMMENDATION #2.6:  ICM Staff Training

Staff should have access to regular training in the competencies appropriate to the level of assessment and care that they are engaged in. It is recommended to identify, streamline and fund training for health, social and NGO professionals engaged in work at ICM. Develop integrated training curricula including assessment techniques, evidence based interventions, referral systems, coordination of care and review mechanisms, training in case management and development of integrated care plans, identification of dedicated liaison positions within services to enable better feedback mechanisms and continuity of care across services.

RECOMMENDATION #2.6:  Formulate ICM funding and incentives based reimbursement Methodologies

The ICM effectiveness is also subject to joint resourcing. The latter is the overall term that covers all aspects of resources brought together in a ‘pot’ to provide a single focus for the planning, commissioning and delivery of services. It encompasses staff, money, equipment (in its widest sense) and property and any other resources currently made available within each of the existing separate agencies to deliver services. To be effective, the ‘pot’ needs to be as comprehensive as possible. The budget can be aligned within existing powers or ‘pooled’.

Moreover, introduction of the incentive based reimbursement is recognized by an assessment to be addressed. Provision of incentive payment schemes that enable adaptation of services to better integrate care and/or allow for stronger referral pathways for service users with complex needs has to be addressed. The Project can capitalize on the recent experience of incentive based reimbursement of GP/FP for provision of primary health care services to the population.

RECOMMENDATION #3  ENSURE SUSTAINABILITY OF INTEGRATED CARE MODEL

RECOMMENDATION #3.1  Promote rights of service users

Service user participants in the assessment reported favorably on services that were friendly, free, and interconnected. These kinds of service provide easy access to treatment and have potential to facilitate continuity of care. The government should recognize and actively support health and social system reform that brings the inclusion of service users with drug dependence problems in line with the accepted conditions for service users in other parts of the health and social systems. The Government has to align national Health and Social Strategy priorities to guarantee access for people with drug problems to services that provide a non-threatening and friendly environment and develop a consistent approach between future national strategies for specific measurable health and social outcomes for service users with drug dependence problems as well as ensure these outcomes are monitored and reported annually at service, municipal, oblast and national levels.

RECOMMENDATION #3.2  PROMOTE TOP DOWN INTEGRATION

The world wide experience of integrated care models defines two main types “bottom up” and “top down” models. The “bottom-up” integration is mainly initiated by one or more local service agencies without reference to particular federal or state initiatives or
requirements and is a less formal agreement where agencies work together with a general sense of goodwill. The presence of strong local advocates for integration in this type of situation can be a major factor in initiating and maintaining an integrated service system that meets local needs. The “top down” integration is mandated by the national level, defines integration policies and funding models supporting integration across agencies.

The given assessments revealed that level of integration in piloted ICMs mostly bear the “bottom up” character. Additional services incorporated in the models were mostly driven by strong local advocates and supporters, and consequently resulted in different integrated care modalities. The latter is vulnerable to political and individual risks and raises concerns of sustainability. In order to mitigate these risks the government is advised to promote “top down” integration. Overall, a vision emerges that signals the continued need for a national, conjoint illicit integrated health and social service systems.

**RECOMMENDATION #3.3**  
Integration of the ICM model in the new five year National AIDS strategy

Inclusion of the new ICM model in the new five year National AIDS strategy will demonstrate government commitment towards achievement of the strategy goals including the PMTCT.

**RECOMMENDATION #3.4**  
Develop National legislation regulating ICM

Development of enabling legal environment is another recommended action required by the national and local governments to ensure effective integration of health and social services and its operations. New legal documents have to be developed that regulates basic package of integrated care services, ICM structure, staffing, functions, care pathways and treatment guidelines and protocols, accountability forms and rules, performance monitoring and evaluation requirements as well as funding and incentives based reimbursement modalities.

**RECOMMENDATION #3.5**  
Harmonization of existing legislation

The assessment revealed legislative collisions to be an access barrier for the appropriate services. Therefore, it is essential that thorough review and harmonization of existing legislation is given a priority.

**RECOMMENDATION #4**  
**INTENSIFICATION OF ADVOCACY EFFORTS**

Implementation of above recommendations will necessitate strong advocacy efforts from UNICEF and will require active engagement with the policy makers in the social and health sector reform agenda formulation. Suggested actions are listed below but not limited to:

- organization of round table discussions, policy discourses related to ICM health and social protection and assistance issues as well as need for introduction of the CMC on national and local levels with participation of public, private, civil society organizations, donors, implementing agencies and beneficiaries.
- Development of the ICM promotional (beneficiary stories) materials for advancement of the ICM on national and local levels, as well as organization of the working sessions with local administration of the pilot sites and presentation of the pilot results, weaknesses, gaps and way forward should be considered.
- Publicity and promotion of ICM in non-pilot oblasts & cities through conferences, working meetings etc.
- Support establishment of friendly cities by utilization of city administration and ICM staff to promote experience to non-pilot cities/oblasts

**RECOMMENDATION #5  ENHANCE INFORMATION/COMMUNICATION ACTIVITIES**

It is highly recommended to intensify and re-align education campaigns to address the stigma of illicit drug use. Seek to change public perceptions of illicit drug use so that these issues are recognized as legitimate and integral parts of health and social care.

Develop and distribute information brochures on availability, location and procedures to receive IC services. For this purpose use innovative distribution channels (NGOs, SWs, GP/FPs, Diagnostic and consultancy centers, RH/FP centers, AIDS centers, TB centers, Youth clinics, narcology centers, etc.). Moreover, the assessment revealed that project beneficiaries have willingness and can play a pivotal role in dissemination of information. To improve access to information they suggested placing information posters in common location of drug users, public transport etc.

**RECOMMENDATION #6  DEVELOPMENT OF COMPREHENSIVE M&E FRAMEWORK AND SYSTEM**

The Government should recognize the need for M&E that focuses on the establishment of national indicators detailing the target population, treatments, care provided and outcomes. The project is advised to commission the design of M&E framework that measures quantitative and qualitative indicators required for national statistics and project performance evaluation. Introduction of anonymous patient surveys that measure knowledge, attitudes and practice as well as satisfaction with quality of service provision and level of social assistance and support is recommended to be considered in the M&E framework. UNICEF is advised to commission technical assistance and support of M&E framework and system development as well as finance training of all involved parties in accurate data collection and analysis.
ANNEXES

ANNEX 1: List of Documents Reviewed

1. The State Program to ensure HIV prevention, treatment, care, and support to HIV-positive people and patients with AIDS for years 2009-2013
2. Progress in prevention of mother-to-child transmission of HIV infection in Ukraine: Results from a birth cohort study
3. Ukraine Health System Assessment, 2011
5. Service provision to pregnant women who use drugs, M. Hepbern, 2010
6. Evaluation report on training in providing care for pregnant women using drugs and alcohol
7. MOH Decree #417, 15/07/2011
9. MOH Decree # 716 On approval of the Clinical Protocol on Obstetric Care “Prevention of Mother-to-Child Transmission of HIV”
10. MOH Decree on the charter of the Multi-disciplinary team operations
11. MOH Decree on implementation of the pilot project
12. Dnipropetrovsk Regional Administration Health Department Decree # 917, 08/11/2011 On implementation of the pilot project
13. Poltava Regional Administration’s Health Department Decree #999, 31/10/2011 On implementation of the pilot project
14. Kiev Regional Administration’s Health Department Decree #437, 16/11/2011 On implementation of the pilot project
15. Service needs assessment of drug dependent women, 2012
ANNEX 2:  List of Key Informants

1. Rudi Luchman, Deputy Representative, UNICEF
2. Gabbi Akimova, Child Protection Specialist, UNICEF
3. Olena Sakovych, Youth & Adolescent Development Specialist, UNICEF
4. Mariia Matsepa, M&E Specialist, UNICEF
5. Tetyana Tarasova, HIV/AIDS Officer, UNICEF
6. Tarasyuk Larisa, deputy Chief on technical issues, Central polyclinic, Darnitsiy district
7. Kerzhanetskaya Tatiana, Midwife, ANC, Darnitsiy district
8. Nizova Nataliya, Professor, Director of Ukrainian Aids Center
9. Martsinovska Violetta, Senior researcher, laboratory of parenteral hepatitis and HIV-infections, Institute of Epidemiology and Infectious Diseases, epidemiologist of Ukrainian AIDS Centre
10. Igor Kuzin, Head of M&E Center, Ukrainian AIDS Center
11. Dr. Leonid Vlasenko, Narcologist, Technical Assistant IHRD on OST, regional coordinator ICF
   "William J. Clinton; in Dnipropetrovsk oblast, Medical Coordinator in the pilot project supported by UNICEF
12. Vorobei Lyudmila, Ob/Gyn, Deputy Director of the Kiev City Reproductive and Perinatology Centre
13. Zhilchuk Svetlana, Ob/Gyn, Kiev City Reproductive and Perinatology Centre
14. Galitskiy Victor, Head of Obstetric Department, Kiev City Reproductive and Perinatology Centre
15. Golikova Oksana, Deputy Director Kiev City Reproductive and Perinatology Centre
16. Filenko Larisa, Head of Intensive Care Department for Newborns Kiev City Reproductive and Perinatology Centre
17. Alla Gagarina, Psychologist, Service Center for Women and Girls
18. Maryna Zelenskaya, Head of Department of HIV, State Service for HIV/AIDS and Other Socially Dangerous Diseases
19. Sadovskaya Eugeniya, Head of international relations sector, State Service for HIV/AIDS and Other Socially Dangerous Diseases
20. Biloshchitska Nataliya, Head of project management sector, State Service for HIV/AIDS and Other Socially Dangerous Diseases
21. Vladymyr Yarui, Director Kiev City Narcological Clinic 'Sociotherapy'
22. Galina Khomyak, Narcologist, Kiev City Narcological Clinic 'Sociotherapy'
23. Iryna Dzhelmach, Senior Midwife, Kiev City Narcological Clinic 'Sociotherapy'
24. Valentyna Zalesskaya, Deputy Head of Kiev City health administration
25. Pavlyuk Galyna, Head of Obstetrical-Gynaecological Department, Kiev City health administration,
26. Rutsushyn Lesya Mikhailovna, Head of Darnitsa district health administration
27. Olena Davis, Head of Coalition of HIV-Services Organizations
28. Tymoshevskaya Victoria, International Renaissance Foundation, Public Health Programme, Director
29. Rebecca Tolson, Deputy Director, International Harm Reduction Initiative, Public Health Programmes, Open Society Institute
30. Valentyna Grigorivna Ginzburg, Head of Dnipropetrovsk Oblast Health Administration
31. Mikhailova Victoria Victorovna, Deputy Head, Dnipropetrovsk Oblast Health Administration
32. Kaira Ekateryna Vladimirovna – Deputy Head, Dnipropetrovsk Oblast Health Administration
33. Alla Akhtyamova, NGO Way Life, social worker of the project, liaison person between clients and health facilities
34. Lyudmila Kolomiets, Senior social worker, NGO Way Life
35. Palekhina Lyudmila, Psychologist, NGO Way Life
36. Gerasimova Olga, Manager on information issues, NGO Way Life
37. Kolesnik Alexander, Regional Representative of Charitable Fund 'All Ukrainian Network PLWHA' in Dnipropetrovsk Oblast
38. Mikhailo Yaroshevs'ky, International HIV/AIDS Alliance in Ukraine, Regional coordinator in Dnipropetrovsk region
39. Anastasiya Zagnich, Dnipropetrovsk City Social Services for Family, Children and Youth
40. Victor Petrovych Lusak, Head of Poltava Oblast Health Administration
41. Igor Alexandrovych Perogov, Deputy Head, Poltava Oblast Health Administration
42. Maxim Demchenko, Director NGO 'Light of Hope', Poltava Oblast Health Administration
43. Korotych O, Deputy Chief, Poltava City Maternity Hospital
44. Fedorova Olga, Head of ANC, Poltava City Maternity Hospital, Ob/Gyn
45. Galinovska S., Acting Head of Narcological Clinic, Poltava
46. Kosichenko Sergiy, Head of the in-patient Department, Narcological Clinic
47. Maxim Demchenko, Director NGO 'Light of Hope'
48. Nadezhda Tymoshevska, Deputy Director, NGO 'Light of Hope'
49. Sergiy Zhuk, Deputy Director, Psychologist, NGO 'Light of Hope'
50. Andryushchenko S., social worker, NGO 'Light of Hope'
51. Budnikova Olga, Director City Centre City Social Services for Families, Children and Youth (SSFCY)
52. Babych Oleg, NGO 'Konvictus, Ukraine', social worker;
53. Sukhoparova Iryna, Head of Kiev Oblast Fund 'Hope and Trust'
54. Tysichenko Svitlana, All Ukrainian Fund 'Step by Step', Director
55. Moskalets Alina, Programme Manager, NGO 'Step by Step'
56. Savchenko Lidiya, All Ukrainian Network People Living with HIV/AIDS
57. Ilchenko Alvina, Project Manager, ICF "William J. Clinton"
## ANNEX 3: Assessment Framework

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Issues and detailed questions</th>
<th>Indicators</th>
<th>Sources of data</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R1</strong></td>
<td>To what extent are the project design, strategy and approach appropriate to achieve the set objectives</td>
<td>The project design, strategy and approaches are appropriate to achieve the set objectives</td>
<td><strong>Documents:</strong> Project documents National HIV/AIDS strategy UNICEF Country Program</td>
<td><strong>Desk Review</strong></td>
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<tr>
<td></td>
<td>Project interventions match UNICEF Country Programme objectives and strategies. Congruence between project strategy and stakeholders priorities and needs (including national targets for HIV/AIDS strategy).</td>
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<tr>
<td><strong>R2</strong></td>
<td>Is the project positioned and designed appropriate to respond to specific local needs and conditions?</td>
<td>The project is designed appropriate to respond to specific local needs and conditions</td>
<td><strong>Documents:</strong> Project documents National HIV/AIDS strategy UNICEF Country Program</td>
<td><strong>Desk Review</strong></td>
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<tr>
<td></td>
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<td><strong>Key Informants</strong> UNICEF staff Project staff MOH State Services on HIV/AIDS and other Socially Dangerous Diseases; National AIDS Center Regional and Municipal State Health Administrations Regional and Municipal HIV Coordination Councils Municipal Social Services for Youth NGOs FGD Service Providers Drug-dependent pregnant women</td>
<td><strong>Semi-Structured Interviews</strong></td>
</tr>
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<td><strong>R 2.1</strong></td>
<td>To what extent is the training component appropriate in response to the training needs of the target groups?</td>
<td>Assessment of HPs knowledge prior to training exposure. Proportion of trained Health Professionals (HPs) who correctly practice skills</td>
<td><strong>Documents:</strong> Pre-training assessment reports Progress Reports Training Reports</td>
<td><strong>Desk Review</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Key Informants</strong> CIPC administration National and local health authorities</td>
<td><strong>Semi-structured Interview</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>FGD</strong> Service Providers</td>
<td><strong>FGD</strong></td>
</tr>
<tr>
<td><strong>R2.2</strong></td>
<td>To what extent is the Project Contribute</td>
<td>The Project Contribute</td>
<td><strong>Documents:</strong></td>
<td><strong>Desk Review</strong></td>
</tr>
<tr>
<td>R3</td>
<td>Does the integrated care service model designed by the project meet the needs of drug dependent pregnant women?</td>
<td>Integrated care service model designed by the project meet the needs of drug dependent pregnant women as identified by needs assessment</td>
<td>Documents: Needs assessment</td>
<td>Key Informants: CIPC administration, National and local health authorities</td>
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<tr>
<td>E1</td>
<td>Is conducive legislation in place to support effective utilization of new integrated services?</td>
<td>Legislation supports institutionalization of new integrated services</td>
<td>Documents: MOH and local health authority Decrees other legal documents</td>
<td>Desk Review</td>
</tr>
<tr>
<td>E2</td>
<td>Does the regulatory framework set within the framework of the project demonstrate commitment to ethical issues? Do ethical issues contribute to bottlenecks and obstacles for reaching project objectives?</td>
<td>Ethical issues are addressed in the regulatory framework and does not impede the achievement of final results</td>
<td>Documents: MOH and local health authority Decrees other legal documents</td>
<td>Desk Review</td>
</tr>
<tr>
<td>E3</td>
<td>To what extent is the project governance structure suitable to implement the project in an efficient, participatory and transparent manner</td>
<td>The project implementation structure is suitable to implement the project in an effective way Evidence of timely implementation of planned activities and results achieved.</td>
<td>Documents: Project staff structure Project documents (implementation plan, progress reports, M&amp;E reports, etc.) Key Informants: Project staff</td>
<td>Desk Review Semi-Structured Interviews</td>
</tr>
<tr>
<td>E4</td>
<td>To what extent is the intervention effective in facilitating the sector reform in respect to policy change, quality improvement and governance re-structuring of the health system? To what extent has the project contributed to regional health authorities and medical institutes ownership to promote the integrated care packages for drug-dependent pregnant women?</td>
<td>Demonstrated ownership on the national and local levels is evident Integrated service delivery concept accepted by the policy makers and considered in sector reform strategies</td>
<td>Documents: Health and Social Sector reform strategy papers Key Informants: Health and Social Sector authorities Integrated service providers FGD providers</td>
<td>Desk Review Semi-Structured Interviews</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Documents:</td>
<td>Key Informants</td>
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<tr>
<td>E 5</td>
<td>How effective is the intervention in improving service providers’ knowledge and skills? To what extent have trained service providers (individuals) modified their regular practices? Which are enabling/constraining factors that facilitated/hindered this behavioral change? In the CIPC, where trained service providers work, to what extent have regular practices been modified in line with set standards?</td>
<td>Service providers are equipped with required knowledge and skills to provide integrated services, are motivated and have enabling environment to practice</td>
<td>Managers of CIPC, FGD providers</td>
<td></td>
</tr>
<tr>
<td>E 6</td>
<td>To what extent has there been an improvement in quality of care during delivery and post-natal care in the health facilities included in the project?</td>
<td>Quality of care measured by outcomes justifies service quality improvement</td>
<td>Progress reports, M&amp;E report, Quality measurement indicators</td>
<td></td>
</tr>
<tr>
<td>E 7</td>
<td>Was the project M&amp;E system appropriate to capture and document project progress information and achievements To what extent is the M&amp;E system effective in reinforcing skill application and tracking? To what extent has the monitoring and evaluation (M&amp;E) system generated evidence to effectively inform this policy agenda</td>
<td>M&amp;E system is in place and tracks main indicators. Monitoring findings used for further planning /adjustment of the project</td>
<td>Progress reports, M&amp;E report, Program staff</td>
<td></td>
</tr>
<tr>
<td>E 8</td>
<td>To what extent do beneficiaries perceive any overall change in the health? Whether the project interventions influence health seeking behavior of beneficiaries? Especially as a consequence of improved health care provision, decrease of health services’ access barriers and costs for beneficiaries?</td>
<td>Access barriers released and service utilization increased</td>
<td>Progress reports, M&amp;E report, Beneficiary Surveys</td>
<td></td>
</tr>
</tbody>
</table>

**EFFICIENCY**

| EF 1 | Does the project use the resources in the most economical manner to achieve its objectives? Are the available resources adequate/sufficient to finance all project activities? | Available resources are adequate/sufficient to finance all project activities | Project Budget, Financial Status reports (monthly/quarterly) | Desk Review |

**Documents:**
- Training materials
- Pre-post test results
- Training reports
- M&E report
- Manager of CIPC
- FGD providers
- FGD
- Managers of CIPC
- FGD providers
- FGD
- Managers of CIPC
- FGD
- Program staff
- FGD Beneficiaries
- FGD Beneficiaries
- Project Budget, Financial Status reports (monthly/quarterly)
<table>
<thead>
<tr>
<th>EF2</th>
<th>To what extent is training system efficient in terms of resource absorption as compared to the results achieved?</th>
<th>Financial analysis demonstrates efficiency of expenditures on trainings</th>
<th>Documents: Project Budget, Financial Status reports (monthly/quarterly)</th>
<th>Desk Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>EF 4</td>
<td>To what extent are the communication packages efficient in terms of reaching the target groups as compared to the absorbed resources?</td>
<td>Financial analysis demonstrates efficiency of expenditures on communications</td>
<td>Documents: Project Budget, Financial Status reports (monthly/quarterly)</td>
<td>Desk Review</td>
</tr>
<tr>
<td>SUSTAINABILITY</td>
<td>S 1</td>
<td>To what extent do MoH, Ministry of Social Protection and other concerned national and local government agencies demonstrate ownership over the project?</td>
<td>Examples of ownership such as joint program/project, co-financing, in-kind contribution, policy, etc.</td>
<td>Documents: Health and Social Sector policy, State health and social Programs, Semi-structured Interviews</td>
</tr>
<tr>
<td>S 2</td>
<td>To what extent the project contributes and can be considered into the health and social sector reform strategy, so that government’s ownership can lead to their incorporation into national policies and assure sustainability of the results achieved?</td>
<td>Through advocacy efforts the project contributed to the incorporation and/or plans for incorporation of integrated care services in the reform strategies</td>
<td>Documents: Health and Social Sector policy, State health and social Programs, Semi-structured Interviews</td>
<td>Key Informants: Program staff, National and local health and social sector authorities, NGOs, Partners, FGD, Social Workers, Providers</td>
</tr>
<tr>
<td>S 3</td>
<td>To what extent are the behavioral changes among health providers expected to last? What are the bottlenecks and gaps along the continuum of care that hinder their capacity to continuously provide quality and equitable services?</td>
<td>Health providers are motivated, skilled and have enabling environment to perform tasks and deliver quality services</td>
<td>Key Informants: Program staff, National and local health and social sector authorities, NGOs, Partners, FGD, Social Workers, Providers, Semi-structured Interviews</td>
<td></td>
</tr>
<tr>
<td>S 4</td>
<td>To what extent are the behavioral changes among drug dependent women expected to last? What are the bottlenecks and gaps along the continuum of Access, psychological, ethical, gender related and other barriers are eliminated</td>
<td>Key Informants: Program staff, National and local health and social sector authorities, NGOs, Partners, Semi-structured Interviews</td>
<td></td>
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</tr>
</tbody>
</table>
S5  What are the main factors that contribute to the sustainment of the outcomes

<table>
<thead>
<tr>
<th>Table</th>
<th>Care that hinder their ability to access and use quality services for themselves and their children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Social Workers FGD Providers</td>
</tr>
</tbody>
</table>

S5  What are the main factors that contribute to the sustainment of the outcomes

<table>
<thead>
<tr>
<th>Table</th>
<th>Strong regulatory, institutional (health, social and civil organization cooperation) and financial systems are in place to ensure sustainment of outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD</td>
<td>Documents State funding (Mid-Term Expenditure Framework) National and local health and social authorities budget Forecasts</td>
</tr>
<tr>
<td></td>
<td>Key Informants MOH, Local Health Authorities and other government entities Donors/Partners</td>
</tr>
<tr>
<td></td>
<td>Desk Review Semi-structured interviews</td>
</tr>
</tbody>
</table>

S6  What is the country based Institutional set-up for Governing the Integrated Care Delivery policy implementation and how its sustainability is ensured?

<table>
<thead>
<tr>
<th>Table</th>
<th>Strong Governing structure in place w/t suitability guarantees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documents MoH documents Integrated Care Policy Legal documents</td>
</tr>
<tr>
<td></td>
<td>Key Informants MOH, Local Health Authorities and other government entities Donors/Partners</td>
</tr>
<tr>
<td></td>
<td>Document Review Semi-structured interviews</td>
</tr>
</tbody>
</table>

S7  Did UNICEF PMTCT Project include strategies to ensure sustainability

<table>
<thead>
<tr>
<th>Table</th>
<th>Sustainability Strategies embodied in the project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documents Project related documents</td>
</tr>
<tr>
<td></td>
<td>Document Review</td>
</tr>
</tbody>
</table>

COHERENCE (C)

C1  To what extent is the project contributing to and in line with national policies and priorities for the MCH sector

<table>
<thead>
<tr>
<th>Table</th>
<th>The project contributed to and is in line with national policies and priorities for the MCH sector - Degree/level of integration of programme strategy and activities into Uzbekistan institutions and programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documents MCH, Health Reform Policy Documents and Plans</td>
</tr>
<tr>
<td></td>
<td>Key Informants MOH respective Departments Partners</td>
</tr>
<tr>
<td></td>
<td>Desk Review Semi-Structured Interviews</td>
</tr>
</tbody>
</table>

C2  To what extent the project facilitates synergies and avoids duplications with interventions and strategies promoted by other UN agencies and development partners

<table>
<thead>
<tr>
<th>Table</th>
<th>The project is facilitating synergies and avoiding duplications with interventions and strategies promoted by other UN agencies and development partners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documents Coordination meeting minutes MOH Coordination Council meeting minutes</td>
</tr>
<tr>
<td></td>
<td>Key Informants MOH respective Departments Partner’s UNICEF Project Staff</td>
</tr>
<tr>
<td></td>
<td>Desk Review Semi-Structured Interviews</td>
</tr>
</tbody>
</table>

C3  To what extent is the project in line with and contributing to the donor’s objectives for the health and social sector

<table>
<thead>
<tr>
<th>Table</th>
<th>The project is in line with and contributing to the donor’s objectives for the health and social sector in Ukraine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documents UNICEF MCH, HIV/AIDS and Health Strategies EU global health policy etc.</td>
</tr>
<tr>
<td></td>
<td>Key Informants MOH respective Departments Partner’s UNICEF Project Staff</td>
</tr>
<tr>
<td></td>
<td>Desk Review Semi-Structured Interviews</td>
</tr>
<tr>
<td>CR 1</td>
<td>How stakeholders rate the coordination of activities between actors of different sectors on policy making and service delivery levels? Which coordination methods applied served the purpose?</td>
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<tr>
<td>CR 2</td>
<td>To what extend the coordination mechanisms are institutionalized? What are the shortcomings of coordinated action to ensure effectiveness and efficiency of integrated care delivery?</td>
</tr>
</tbody>
</table>
### Annex 4: Semi-structured Interview guide (sample)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH – National level</td>
<td>R2; R 2.1; R2.2; R3; E 4; S 1; S 2; S 3; S 4; S 5; S 6; C 1 C 2; C 3; CR 1; CR 2</td>
</tr>
<tr>
<td>Local Health Authorities</td>
<td>R2; R 2.1; R2.2; R3; E 4; S 1; S 2; S 3; S 4; S 5; S 6; C 1; C 2; C 3; CR 1; CR 2</td>
</tr>
<tr>
<td>Social Services – National level</td>
<td>R2; R3; E 4; S 1; S 2; S 3; S 4; S 5; S 6; C 1</td>
</tr>
<tr>
<td>Social Services - Local level</td>
<td>R2; R3; E 4; S 1; S 2; S 3; S 4; S 5; S 6; C 1</td>
</tr>
<tr>
<td>CIPC administration</td>
<td>R2; R 2.1; R3; E 4; E5; E 6;</td>
</tr>
<tr>
<td>UNICEF</td>
<td>R2; E 3; C 2; C 3; CR 1; CR 2</td>
</tr>
<tr>
<td>Project Staff</td>
<td>R2; E 7; S 2; S 3; S 4; C 2; C 3; CR 1</td>
</tr>
<tr>
<td>NGOs</td>
<td>R2; R3; S 1; S 2; S 3; S 4; CR 1</td>
</tr>
<tr>
<td>Partners</td>
<td>R3; S 1; S 2; S 3; S 4; S 5; S 6; C 1; C 3; CR 2</td>
</tr>
</tbody>
</table>
Annex 5. Focused Group discussion Guides

Annex 5.1 Guide for Service Providers

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
   a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
   b. every statement is right;
   c. please do not hesitate to disagree with someone else;
   d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Relevance
• Are training contents (including protocols and guidelines) suitable for integrated care delivery system? Why?
• Was this training pertinent to your current daily work? Why?
• Before attending the training, did you feel the need to upgrade your knowledge and skills? Why? In which field/s?
• Do patients appreciate the improvement of quality care in your health facility? Why do you say this?
• Since you started applying the acquired skills, is there any noticeable improvement in the health status of the patients/community who attends your health facility? Why do you say this?

Effectiveness
• Do you feel that the training enabled you to fully apply, in your daily practice, what you have learnt? Why?
• How often do you apply the acquired skills and knowledge into work practice?
• Were you reluctant to accept new practices/procedures (reluctant to change)? Which ones? Why?
• Did the acquired knowledge and skills affect (could be both, positively and negatively) your self-confidence and the value you put on your daily work? Why?
• What is the significance, if any, of providing quality integrated care?
• Is there a supportive supervision and monitoring system in place? Is this system able to support you to apply acquired skills, and reliable information and data for decision makers? Why? Please describe. What is your involvement in the monitoring process?

Outcomes
• Project focuses on improving the quality of Mother and Child health care for drug-dependent pregnant women and child born to them as well as provision of comprehensive package of services. In doing so, has the project brought some improvement also in the management of health facility resources? Why do you say so?
• In your health facility, has the quality of care for drug-dependent pregnant women and child born to them improved? Why do you say so?

Sustainability
• At the work place, are there some conditions that prevent you to correctly practice your skills? (i.e. non-confident in skills despite training, shortage/lack of basic equipment/amenities, drugs, time constraints, referral etc.). Please, describe.
• Are you receiving any incentive/did you expect to be incentivized/awarded for delivering quality services? Please, describe.

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you
Annex 5.2  FGD Guide for drug-dependent women who received services

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
   a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
   b. every statement is right;
   c. please do not hesitate to disagree with someone else;
   d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Relevance

• What kind of information did you receive that encouraged you to utilize CIPC services?
• Was the content and form of information you’ve received relevant to your demands?
• Was the content of materials easy to understand and practical?
• Do you think that services offered and received at CIPC met all your needs?

Effectiveness

• How would you assess the visit and services you received at CIPIC, duration and process of the visit and topics of counseling if you received it?
• Do you think that social workers helped you to access the services?
• Did you face any ethical or other types of barriers to access services?
• If you were to decide the design of integrated service provision, what will you propose?

Sustainability

• What are the main problems you faced in getting the quality services?
• Are you satisfied with services received? Why?
• Will you recommend/advocate your friends and community members to use CIPC services? If not please explain.

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you
Annex 5.3  FGD Guide for drug-dependent women who have not received services

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
   a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
   b. every statement is right;
   c. please do not hesitate to disagree with someone else;
   d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Relevance

• Have you ever received information about integrated services? If yes please explain whether these services can potentially meet your demands
• What kind of information you would like to receive that will encourage you to utilize services?
• Are there any barriers that prevent you for seeking required services?
• Do you think that if all services you need are concentrated in one medical center you will be willing to utilize?

Effectiveness

• Do you think that social workers and/or NGOs can helped you to access required services?
• Do you think that ethical issues prevent you to access services?
• What are the sources and types of information you will be interested to receive that can encourage you to seek care?
• If you were to decide the design of integrated service provision, what will you propose?

Sustainability

• What are the main problems you faced in getting the quality services?
• What are main service provision criteria that would satisfy you? Why?
• Will you listen to your friend’s and community members recommendation to use CIPC services? If not please explain.

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you
Annex 5.4  FGD Guide for social workers

1. Introduction to the objectives of the research
2. A brief introduction to the rules of focus groups
   a. everything said and done is confidential and will not be used outside the room except for the purposes of this research;
   b. every statement is right;
   c. please do not hesitate to disagree with someone else;
   d. but do not all talk at once
3. Ask people to describe who they are and say few words about themselves
4. Introduce the topic under review
5. Ask questions

Relevance

- Did the project empowered you with knowledge and skills required for you daily work in relation to drug dependent pregnant women?
- If yes was the content and form of information you’ve received relevant to your demands?
- Was the content of materials easy to understand and practical?
- Do you think that you can play a vital role in assisting drug dependent pregnant women to access required health and social services?

Effectiveness

- Is the environment conducive for performing your functions?
- If not, please explain what are the main impediments/bottlenecks that hinder effective performance of your functions?
- Did you face any ethical or other types of barriers to advocate drug dependent women to use integrated care services?
- If you were to decide the design of integrated service provision, what will you propose? What will be the role of Social workers?

Sustainability

- What are the main problems you faced in provision of quality services to drug dependent pregnant women?
- Are you satisfied with services you provide? Why? If not please explain.
- Do you think that there is adequate coordination between social workers and health service providers? How would you rate the referral system in place on the scale from 1 to 3, where 1 is excellent and 3 is bad?
- What are the main motivating factors that would encourage you to continue and/or improve service provision to the target group of women?

6. Ask if they would like to add further comments.
7. Bring the meeting to a close by summarizing the main points.
8. Thank you