"Medications for opioid use disorder during the war in Ukraine: a more comprehensive view on the government response—Authors' reply"

Daniel J. Bromberg,[a,b] Lynn M. Madden,[c,d] Anna Meteliuk,[e] Roman Ivasiy,[d] Samy J. Galvez de Leon,[b,d] Konstantin Klyucharyov,[f] and Frederick L. Altice[b,c,d,g,*]

[a]Department of Social and Behavioral Sciences, Yale School of Public Health, Yale University, New Haven, CT, USA
[b]Yale Center for Interdisciplinary Research on AIDS (CIRA), Yale University, New Haven, CT, USA
[c]APT Foundation, New Haven, CT, USA
[d]Section of Infectious Diseases, Yale School of Medicine, Yale University, New Haven, CT, USA
[e]International Charitable Foundation "Alliance for Public Health", Kyiv, Ukraine
[f]Charitable Organization "Parus", Kharkiv, Ukraine
[g]Department of Epidemiology of Microbial Diseases, Yale School of Public Health, Yale University, New Haven, CT, USA

The Lancet Regional Health - Europe 2023;26: 100583

Published Online xxx https://doi.org/10.1016/j.lanepe.2023.100583

The author correctly restates Ukraine's Ministry of Health's (MoH) efforts and rapid responses taken as Russia invaded Ukraine,[1] including rapidly transferring medications for opioid use disorder (MOUD) to safer locations, manually distributing MOUD to sites inaccessible by transportation routes and allowing a 30-day supply of MOUD.[2,3] These rapid, unprecedented responses were the result of a functioning and responsible government that urgently passed legislation and enacted new guidelines to meet public health needs. We commend these efforts.

All content published related to innovations in collaboration between governmental and private MOUD clinics in Kharkiv, however, remains accurate.[3] It represents a specific, but critical time in the war and is supported by extensive interviews, participation on regular MoH conference calls, in-depth review of Kharkiv data, and weekly Network for the Improvement of Addiction Treatment (NIATx) coaching calls. As MoH enacted MOUD policy, NIATx has collaborated to help guide MOUD scale-up since 2014. Synergy between NIATx and MoH to achieve scale-up goals continues.[4]

As observed using a bundle of implementation tools from NIATx, Ukraine's successful experience adapting to the COVID-19 pandemic helped improve the country's emergency preparedness response so that its MOUD providers could act promptly during war. The government's urgently enacted policies during the pandemic unknowingly supported subsequent rapid enrolment of new patients and better treatment retention using NIATx with no increase in mortality. At that vulnerable time, such policies were implemented successfully despite concerns from addiction specialists regarding the risks of diversion, overdose, and dropout.[5]

During a NIATx site visit to Kharkiv in October 2021, we documented private clinics' operational efficiencies, including clinical checklists, process improvement techniques, and take-home dosing allowances which were implemented earlier than in governmental clinics. We also observed an existing informal, but dedicated, collaboration between governmental and private MOUD clinics. When MoH signed a contract with a private clinic in Kharkiv during the war, this *de facto* innovative "public/private cooperation" was formalized through a contractual relationship allowing onsite MOUD storage and governmental clinicians to treat their patients at private clinics.

To understand the unprecedented public/private collaboration in Kharkiv during war requires further understanding of Ukraine's complex MOUD landscape. All governmental MOUD clinics report their patients monthly to MoH, while less than two dozen among the hundreds of private clinics do so. For governmental clinics, reports are linked to governmental procurement and distribution, but not for private clinics who rely on MOUD purchased by patients from pharmacies. One private clinic prototype is fully compliant with governmental regulations (Orders 200 and 393) and legally provides "maintenance" MOUD. They report to MoH but do not receive medications. Some private clinics closest to the conflict, however, inconsistently reported during the war due to logistical constraints. This is observed by marked reporting fluctuations and confirmed through supplemental interviews. A second prototype, representing most private clinics, prescribes MOUD not as maintenance, but as extended "supervised withdrawal" and does not report data to MoH. Nonetheless, such patients contribute to MOUD scale-

DOIs of original articles: https://doi.org/10.1016/j.lanepe.2022.100582, https://doi.org/10.1016/j.lanepe.2022.100490

Abbreviations: MoH, Ministry of Health; MOUD, Medications for opioid use disorder; NIATx, Network for the Improvement of Addiction Treatment

*Corresponding author.
E-mail address: frederick.altice@yale.edu (F.L. Altice).

up as prescriptions are often extended over months, with official reporting undercounting MOUD coverage. A prescription drug monitoring program requiring pharmacies rather than clinics to report might address under-reporting.

The MoH correctly states that "normally," private clinics cannot receive governmental medications and gain profit. Yet the circumstances then were anything but normal. With massive shelling in Kharkiv, patients and providers were frightened and MOUD continuity was uncertain. Some private clinics offered to pay the MoH for MOUD to assure treatment continuity. Assuring pharmacy supplies for private patients to purchase MOUD through policy changes might have met a greater public health benefit. Consequently, pharmacy stores of MOUD were depleted early leaving most patients in private clinics without MOUD and their treatment continuity was jeopardized. Stabilized methadone patients (e.g., 80–100 mg) either stopped or had to re-enrol as "new patients" at governmental clinics where they initially received under half their maintenance dose. Dosing reductions or discontinuity leads to a clinically painful abstinence syndrome and heightened psychological distress. Consequently, these patients were at heightened risk for drug injection, overdose, HIV and HCV transmission, and suicide, which occurred when Russia illegally annexed Crimea in 2014.[6] The exceptional patient on supra-therapeutic methadone doses (e.g., 300 mg), however, requires an individually tailored response. Creatively finding solutions to avoid unnecessary treatment discontinuity, potentially through enacting new legislation or alternative financing programs, would represent a more holistic public health response for both public and private patients, especially given the volatile nature of the ongoing war.

Contributors

FLA and DJB wrote the manuscript with input from LMM, AM, and KK. RI and SJGDL reviewed the manuscript and approved the final version.

Declaration of interests

The authors have no competing interests.

References

1 Ivanchuk I. Medications for opioid use disorder during the war in Ukraine: a more comprehensive view on the government response. *Lancet Reg Health Eur*. 2022. https://doi.org/10.1016/j.lanepe.2022.100582.
2 Altice FL, Bromberg DJ, Dvoriak S, et al. Extending a lifeline to people with HIV and opioid use disorder during the war in Ukraine. *Lancet Public Health*. 2022;7(5):e482–e484.
3 Bromberg DJ, Madden LM, Meteliuk A, et al. Medications for opioid use disorder during war in Ukraine: innovations in public and private clinic cooperation. *Lancet Reg Health Eur*. 2022;20:100490.
4 Altice FL, Bromberg DJ, Klepikov A, et al. Collaborative learning and response to opioid misuse and HIV prevention in Ukraine during war. *Lancet Psych*. 2022;9(11):852–854.
5 Meteliuk A, Galvez de Leon SJ, Madden LM, et al. Rapid transitional response to the COVID-19 pandemic by opioid agonist treatment programs in Ukraine. *J Subst Abuse Treat*. 2021;121:108164.
6 Carroll JJ. Sovereign rules and rearrangements: banning methadone in occupied Crimea. *Med Anthropol*. 2019;38(6):508–522.