INTEGRATION OF HEALTH CARE AND HARM REDUCTION SERVICES FOR PEOPLE WHO USE DRUGS

Internship Aids Foundation East – West and Mainline Foundation
Bridging the Gaps; health and rights for key populations

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ABBREVIATIONS

AFEW	Aids Foundation East-West
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ATS	Amphetamine type stimulants
BNN	National narcotics board
BtG	Bridging the Gaps
COC	Dutch associations for the integration of homosexuality
EMCDDA	European monitoring centre for drugs and drug addiction
GNP+	Global Network of People Living with HIV
HIV	Human immunodeficiency virus
HRI	Harm reduction international
IDU	Injecting drug users
IEC	Information, education and communication
IHRA	The international harm reduction association
INPUD	International network of people who use drugs
ITPC	International treatment preparedness coalition
LGBT	Lesbian, gay, bisexual and transgender
MSM	Men who have sex with men
MSMGF	Global Forum of MSM and HIV
NGO	Non-governmental organisation
NSWP	Global network of sex work projects
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PWUD	People who use drugs
STI	Sexual transmitted infections
TB	Tuberculosis
UNODC	The United Nations office on drugs and crime
VCCT	Voluntary and confidential HIV counselling and testing
WHO	World Health Organisation

CONTENT

EXECUTIVE SUMMARY

Background Drug use can have a significant impact on the quality of life and health of people who use drugs. However, the needs of people who use drugs are often unmet. Taken into account the universal right to health, health care and harm reduction services should be of high quality, acceptable, accessible and available. The integration of (harm reduction) services provides the opportunity for improving service provision for people who use drugs. Limited attention has been paid to the current situation of the integration of (health) services. This study fills that gap and in addition studies what is needed to sufficiently integrate services, to ensure acceptable, accessible, high quality and available health care for people who use drugs in Kyrgyzstan and Indonesia.

Objective The objective of the present report is to make recommendations to Aids Foundation East-West and Mainline foundation, part of the Bridging the Gap Alliance, on how to ensure the highest achievable health of people who use drugs by integrating services. This objective is achieved by providing insight into the current state of the integration of services and on how service integration can be improved in Kyrgyzstan and Indonesia.

Methods In order to provide an answer to the research question an explorative qualitative research was performed. First, a pilot interview and focus group discussion, with four participants, were conducted for familiarisation with the research subject. Thereafter, data were obtained via semi-structured interviews. The study population consisted of experts in the field of drug use, harm reduction organisations and services. In total 15 interviews were conducted which consisted of eight men and seven women. The interviews were recorded and transcribed verbatim. Thereafter, a content analysis was applied.

Results A wide range of harm reduction and health care services are available in both Kyrgyzstan and Indonesia. A distinction was made between the provision of governmental services and community based services. The accessibility, acceptability and quality of mainly the governmental services are not believed to be sufficient for people who use drugs. The accessibility was impaired by the lack of trust, stigma towards people who use drugs, the lack of funding, and time and locations of the service provision. Acceptability of services was impeded by the lack of choice and stigma, in addition services were not acceptable towards female drug users. Stigma causes fear among people who use drugs and misunderstanding towards people who use drugs. This misunderstanding and fear have a negative impact on the acceptability and quality of services. The most common definitions of integration of services among the respondents were “one stop shop” and “the referral system”. The main barriers that were

mentioned towards the integration of services were linked to the barriers of accessibility. The following barriers were mentioned: funding crisis, political willingness (commitment and priority), capacity and communication issues. The main facilitators towards integration of services involve: governmental support, mapping of available services and involvement of the community. These barriers and facilitators are mentioned to be fundamental part of a (un)successful integrated health system. In order for improvement of integration of services, the barriers need to be overcome and the facilitators can be used.

Conclusion This unique study provided an insight in the understanding of integration of services for PWUD among partner organisations of Mainline and Aids Foundation East West. Integration of services may be used as a strategy towards accessibility, availability, acceptability and quality, rather than integration of services being the outcome or objective. Integration of services is not an easy fixed solution but it is a complex process which demands for strict guidelines and monitoring. The results presented here could, however, facilitate improvement in the field of integration of services. The lack of funding, the lack of political support, low capacity of service providers and communication issues should be addressed in order to improve integration of services. In the future, assessments of separate regions, mapping of services and case studies should be done in order to improve the implementation of an integrated service system that is beneficiary to people who use drugs.

Keywords People who use drugs, integration of services, right to health, harm reduction, Indonesia, Kyrgyzstan

1. INTRODUCTION

In 2011, the Dutch government has funded an international programme, Bridging the Gaps – health and rights for key populations (BtG). BtG strives for accessible HIV and sexual transmitted infection (STI) prevention, treatment, care and support for three specific key populations, taking into account the universal human right to health and health care. Key populations can be described as more vulnerable and most-at-risk for HIV compared to the general population. This includes people who use drugs (PWUD), sex workers and lesbian, gay, bisexual and transgender (LGBT) people (Bridging the Gaps, 2013). This report focusses on the key population PWUD, both injecting and non-injecting drug users. Estimated by the United Nations Office on Drugs and Crime (UNODC), globally, there are around 27.5 million people who use drugs regularly. This is a considerably high number and therefore a highly relevant key population to study (UNODC, 2014).

Drug use has a significant impact on the quality of life and health of PWUD. Many studies have been done on the challenges for PWUD, challenges including health harms and access to health care (WHO, 2013). PWUD faces more health risks than people who do not use drugs. They are vulnerable for drug-related deaths, suicide, trauma, mental health conditions and infectious diseases such as HIV/AIDS, viral hepatitis A/B/C and tuberculosis (Sylla, 2007; UNODC, 2014; WHO, 2013). The overall increased health risks of PWUD may be due to risky behaviour and life-style. Infectious diseases are a main risk for injecting drug users, which is linked to sharing injecting equipment (WHO, 2013). However, the high level of health care needs of PWUD often go unmet. Sohler *et al.* (2007) reported that drug users were less likely to receive optimal HIV treatment than non-users. The lack of access to health care may be due to criminalisation, stigma and marginalization.

Several studies have reported that the previously mentioned challenges for PWUD may be due to, among other things, separate delivery of health care services (Cunningham *et al.,* 2011; Drainoni *et al.,* 2014; Samet *et al., 2001)*. The current health care and harm reduction services for PWUD are separately delivered, however the multitude of health risks of PWUD are often interrelated. Thus for an optimal treatment, health care provision could be integrated (Cunningham *et al.*, 2013). Recently, there is a growing attention towards the potential benefits of integrating harm reduction services into the general health care system. Samet *et al.* (2001) described several potential benefits for integrating mental health and harm reduction services into the primary care system, such as the increase of the overall well-being of patients with substance disorder, reduced stigma, identification of PWUD and prevention of relapse and reduction of long-term costs. Despite the given potential benefits, integration of care can be a

complex and ambiguous process that does not always results in sufficient and quality care. For example Humphreys *et al.* (2011) stated that providers may lack the knowledge to provide quality care for PWUD.

Overall, the beneficial effects of integration of services on the health of PWUD are still heavily debated, as is its definition. Most studies have focussed on evaluating the process of integrating services in high-income countries (Cunningham *et al.,* 2013*;* Drainoni *et al.,* 2014; Humphreys *et al.,* 2011; Samet *et al., 2001*). However, these findings are not generalizable to middle- and low-income countries and do not provide us with enough insights for a global scale. Therefore, the objective of the present report is to make recommendations to AFEW and Mainline, part of BtG Alliance, on how to ensure the highest achievable health of PWUD by integrating services. This objective is achieved by providing insight into the current state of the integration of services and on how service integration can be improved in Kyrgyzstan and Indonesia. This research used a qualitative study approach.

2. CONTEXTUAL BACKGROUND

In this chapter several themes around the research objective will be described. Firstly the term "people who use drugs" will be explained, and their health risks will be depicted. Secondly the human right to health will be explained in relation to people who use drugs and how violation of this right can be reduced with the use of harm reduction services. This will be followed by a brief description of the term "Integration of services". Subsequently the international HIV programme Bridging the Gaps (BtG) and its aims will be described. Finally the problem statement and research question will be clarified.

2.1 DRUG USE AND HEALTH CHALLENGES

The definition "people who use drugs" (PWUD) refers to people who repeatedly use illicit drugs, or misuse prescription drugs, through any route of administration, including injection, oral, inhalation, trans mucosal (sublingual, rectal, intranasal) or transdermal (A.D.A.M. Medical Encyclopaedia; WHO, 2014). The United Nations Office on Drugs and Crime (UNODC) estimated that globally 162 to 324 million people used an illicit drug at least once in the previous year, corresponding with 3.5 to 7.0 per cent of the world population between the ages 15 to 64. Amongst them are 16 million to 39 million people who use drugs regularly. Commonly used drugs amongst PWUD are cannabis, opioids, cocaine and amphetamine-type stimulants (UNODC, 2014). In 2008 the National Narcotics Board (BNN) of Indonesia estimated 3.3 million drug users in Indonesia within a population of 240 million people, of which 26 percent were experimental users, 27 percent were regular users, and 40 percent were drug dependent non-injectors and 7 percent were drug dependent injectors. The drug mostly used in Indonesia is cannabis (Ministry for National Development Planning Republic of Indonesia and UNODC, 2012; UNODC, 2014).Kyrgyzstan's population is around 5.5 million. In 2008 a total number of 9057 drug users was registered. Of these PWUD, 69.6 percent are injecting drug users. The most commonly used drug in Kyrgyzstan is heroin (UNODC, 2014).

Drug use has a significant impact on the human life. PWUD have increased health risks, reduced access to health care and they may be socially excluded (Galea, 2002). The most extreme form of health risk is drug-related death due to overdose. In 2012 UNODC reported 183.000 drug-related deaths world-wide. PWUD are also more vulnerable to suicide, trauma, mental health conditions and infectious diseases such as HIV/AIDS, viral hepatitis A/B/C and tuberculosis (UNODC, 2014; WHO, 2013). The increased health risks may be due to risky behaviour and low socio-economic conditions. In particular, injecting drug users (IDU) are more susceptible to infectious diseases such as HIV and hepatitis, due to unsafe injecting practices such as sharing injecting equipment. The number of IDU globally lies between 8.9 million and 22.4 million

people, 13.1 percent of IDU are infected with HIV and more than half with hepatitis C (UNODC, 2014; WHO 2013).

Despite the increased health risks, the high level of health care needs of PWUD often go unmet. PWUD lack access to health care, which may be due to several barriers. Chitwood *et al.*(1999) states that PWUD, regardless of their increased risk on co-morbidities, were more likely not to receive needed treatment than non-users (Chitwood *et al.,* 1999). UNODC (2014) emphasizes the lack of accessible drug-related services, such as needle exchange programme or methadone maintenance treatment. In addition, it is stated that only one in six drug users has access to or receives drug dependence treatment (UNODC, 2014). Several studies were conducted on the barriers to access health care. Pinkham (2012) states that stigma, discrimination and criminalisation may be barriers for PWUD to access health care. Lang *et al.* (2013) confirm that stigmatization may be a barrier to health care access. Furthermore, they also state that the lack of education, waiting lists, lack of financial resources, lack of privacy, lack of personal safety and lack of health insurance may be prevailing barriers amongst PWUD to access health care.

2.2 HUMAN RIGHT TO HEALTH AND HEALTHCARE AND HARM REDUCTION

The often unmet health care needs of PWUD may result in the violation of the universal human right to health. The right to health is considered a fundamental part of our human rights, because on a day to day basis health is an essential and basic need of a human being, regardless of age, gender, socio-economic or ethnic background. The human right to health and healthcare as described in the Universal Declaration of Human Rights article 25 (1948) is: "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."*. To clarify the right to health and healthcare, the WHO states that the right to health can be described as the universal right to obtain the highest achievable health, both mentally and physically. Therefore, health care and social services should be acceptable, accessible, of high quality and available for everyone (WHO, 2013).

Harm Reduction International (IHRA, 2009) states that the denial of harm reduction services can result in the violation of the human right to health. The focus of harm reduction does not entail reducing drug use. The term 'harm reduction' refers to policies and programmes which main aim is to diminish drug-related harm, including health, social and economic consequences. (Hunt *et al.,* 2001; European Monitoring Centre for Drugs and Drug Addiction, 2010). Several studies have shown that providing harm reduction services result in the decrease of HIV and risk-related behaviour, a reduction in hospitalization and an improvement in access to health care

(Sambamoorthi *et al.,* 2000; Sylla *et al.,* 2007). The WHO, UNODC and UNAIDS composed a 'comprehensive harm reduction package', consisting of nine interventions shown in table 1.

Table 1 - Nine interventions that are in the harm reduction package composed by the WHO, UNODC and UNAIDS (Mainline, 2014).

Comprehensive harm reduction package
Needle and syringe programmes (NSPs)
Opioid substitution therapy (OST) and other drug dependence treatment
Voluntary and confidential HIV counselling and testing (VCCT)
Antiretroviral therapy (ART)
Prevention and treatment of sexually transmitted infections (STIs)
Condom programmes for IDU and their sexual partners
Targeted information, education and communication (IEC) for IDU and their sexual partners
Vaccination, diagnosis and treatment of viral hepatitis
Prevention, diagnosis and treatment of tuberculosis (TB)

In order to make harm reduction more sustainable Mainline and its partners developed another concept: The continuum of care (Mainline, 2014). Continuum of care does not solely focus on HIV and harm reduction. In addition, it focusses on human rights, diversity among PWUD and the socio-economic situation of PWUD. Mainline includes, in addition to the harm reduction package, the following interventions: night shelters, outreach work, drop-in centres, support in adherence to ART, services to partners and family of PWUD, and socio-economic rehabilitation (Mainline, 2014).

2.3 Integration of services

A potential strategy to make harm reduction services more accessible and sustainable may be integration of services (Drainoni *et al.,* 2014; Padwa *et al.*, 2009; Samet *et al.,* 2009; Suter *et al.*, 2007; Sylla *et al.,* 2007; Weisner *et al.*, 2001). Cunningham *et al.* (2013) implicate that the increased health risks of PWUD may be due to, among other things, separate delivery of needed services. The health risks of PWUD are often interrelated, thus for an optimal treatment, health care and harm reduction services could be integrated (Cunningham *et al.*,2013). Recently, there is an increasing body of knowledge on the benefits of integrating services . Padwa *et al.* (2009)

states that integration of services can lead to improved health, reduced substance use and healthcare costs savings. According to Samet *et al.*(2001) there are several potential benefits for integrating mental health and substance use services into the primary care system, such as the improvement of the overall well-being of patients and a decrease in long-term health care costs caused by, amongst other things, avoiding the awareness of HIV infection and the duplication of services. A qualitative study carried out by Drainoni *et al.* (2014) supports the theory of the potential beneficial value of integrated care. On the other hand, the WHO (2008) illustrates several critics for integrating services, it states that it might be risky to change a working system since it might develop inefficiencies in health care provision. In addition, integration of services asks for extra financial support for implementation.

2.4 Bridging the Gaps – health and rights for key populations

One of the objectives of the international programme Bridging the Gaps is integrating services in order to achieve *"universal access to HIV/STI prevention, treatment, care and support"* for three different key populations, which include people who use drugs (PWUD), sex workers and lesbian, gay, bisexual and transgender (LGBT) people. Bridging the Gaps is an alliance founded by five Dutch non-governmental organisations, which include the Mainline Foundation, Aids Foundation East-West (AFEW), Aids Fonds, Federation of Dutch Associations for the Integration of Homosexuality (COC) and Global Network of People Living with HIV (GNP+). Furthermore, the alliance consists of the following global partners: International Treatment Preparedness Coalition (ITPC), Global Forum of MSM and HIV (MSMGF), Global Network of Sex Work Projects (NSWP) and International Network of People Who Use Drugs (INPUD). The international HIV programme is funded by the Dutch Ministry of Foreign Affairs. Bridging the Gaps is set up to address human rights violations. Bridging the Gaps is set up in 16 countries, namely Costa Rica, Ecuador, Brazil, Kenya, Botswana, Zimbabwe, Uganda, South Africa, Pakistan, Nepal, Vietnam, Georgia, Ukraine, Tajikistan, Kyrgyzstan and Indonesia. This report focusses on PWUD in Kyrgyzstan and Indonesia, because of recent projects in these countries concerning integration of services (Bridging the gaps, 2013).

2.5 Global war on drugs – Kyrgyzstan and Indonesia

In 1961 the UN Single Convention on Narcotic Drugs was initiated which campaigned for the global war on drugs. The global war on drugs is an international legal framework that focusses on the prohibition of drug production, consumption and distribution. Rolles *et al.* (2012) states that the negative consequences of the war on drugs included the following: "the creation of a huge criminal market; the displacement of production and transit to new areas (the balloon effect); the diversion of resources from health to enforcement; the displacement of use to new

drugs; and the stigmatisation and marginalisation of people who use drugs." (Rolles *et al*, 2012, p. 8).

The ongoing war on drugs has a great impact on the laws in Kyrgyzstan and Indonesia. The Indonesian legislation on drug distribution contains a maximum sentence that is the death penalty, depending on the drug type(Nowak, 2008; Rolles *et al.*, 2012). Drug possession and consumption is punishable up to fifteen years imprisonment. In Kyrgyzstan the legislation in regard to drug possession and distribution contains of a sentence of three years imprisonment (EMCDDA, 2015).

2.6 Problem statement

Taken into account the universal right to health, all key populations should have acceptable, accessible, high quality and available health care. The key population PWUD have increased health risks, however reduced access to health. Therefore, the needs of PWUD are often unmet. The integration of services provides the opportunity for improving service provision for PWUD. However, limited attention has been paid to the current situation of the integration of (health) services. This study fills that gap and in addition it studies what is needed to sufficiently integrate services to ensure acceptable, accessible, high quality and available health care for PWUD in two case studies: Kyrgyzstan and Indonesia. The current report provides insight into the current state of the integration of services and how service integration can be improved in Kyrgyzstan and Indonesia. In order to make recommendations to AFEW and Mainline on how to ensure the highest achievable health for PWUD by integrating services.

To fulfil the aim of this research the following research question was formulated: What is the current state of the integration of health care and harm reduction services and how can service integration be improved in order to contribute to the highest achievable health of PWUD in Kyrgyzstan and Indonesia?

3. Theoretical background

This chapter elaborates on the theoretical concepts that will be used to achieve the research aim. In this chapter the different definitions of integration of services will be summarised, models of integrated services will be depicted, potential barriers, facilitators and principles of integration of services will be explained and the model of the universal human right to health and healthcare will be described.

3.1 Defining Integration of services

It is important to understand the term and definition integration of services in order to be able to compare, develop, implement and evaluate integrated health services. However, there still has been no consensus about the definition of term "integration of services" nor about the terminology. Suter *et al.* (2007) reflects on more than 70 definitions. Not only the definitions differ in literature, also the terminology of integration of services varies in grey literature. Overall the most commonly used terms are: linked care, shared care, cooperation, partnership or integrated care (Drainoni *et al.,* 2014; Samet *et al.,* 2009; Sylla *et al.,* 2007; Weisner *et al.*, 2001).

Integration of services is not a new concept, already in 1993 Gillies *et al.* defined integration of services as "*The extent to which functions and activities are appropriately coordinated across operating units – that is, any organisation within the system that is involved in the provision of health care services such as acute care and specialty hospitals, home health agencies, nursing home facilities, and single and multispecialty group practices – so as to maximize the value of services delivered to patients.*" (Gillies *et al*., 1993, p.468).

A distinction among the definitions can be made by perspective of the stakeholder. In this case the two most prominent stakeholders are service providers and users (Lloyd, 2005). Different stakeholders have different views on how services should be integrated. For the user integrated services are succeeding when health care and harm reduction delivery is "*seamless, smooth and easy to navigate*" (Loyd *et al.*, 2005, p. 9). Service users want health care and harm reduction delivery as a whole. Which entails providers who know about all aspects of the client's health and a minimum amount of separate visits. For providers of harm reduction and health care services, integration is thought of in a more technical way. Service delivery must be provided, managed, financed and evaluated in coordination or together. This means that while providers might think that services are integrated it may not be perceived as integrated by the user (Loyd *et al.*, 2005).

The most often used definitions among literature on integration of services are depicted in table 2 (Billings, 2005; Hardy, 1999; Kodner and Spreeuwenberg, 2002; Mur-Veeman *et al.*, 2003; Suter *et al.*, 2006; WHO, 2002).

Table 2 - multiple definitions of "integration of services" (Billings, 2005; Hardy, 1999; Kodner and Spreeuwenburg, 2002; Suter *et al.*, 2006; WHO, 2001).

Definition	Source
"Well-planned and well-organized set of services and care processes, targeted at the multidimensional needs/problems of an individual client, or a category of persons with similar needs/problems … built up by elements of acute health care, long-term care, social care, housing and services such as transport and meals. It should also address empowerment of older persons, to enable them to live their lives as independently as possible."	Billings, 2005, p.6
"*services, providers, and organisations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client."*	Suter *et al.*, 2006, p. 5
"Coherent set of products and services, delivered by collaborating local and regional health care agencies."	Hardy, 1999, p.99
"*Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between [different] sectors.***"**	Kodner and Spreeuwenberg, 2002, p. 3
"an organisational process of coordination which seeks to achieve seamless and continuous care, tailored to the patients' needs and based on a holistic view of the patient"	Mur-Veeman *et al.*, 2003 p. 227
"Integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."	WHO, 2001, p. 7

3.2 TYPES OF INTEGRATION OF SERVICES

In this section different types of integration of services are discussed. Integration of services avoids fragmented health care and aims to provide coordinated care. Two main types of integration of services can be distinguished in vertical and horizontal integration, shown in

table 3. Both types of integration focus on the continuum of care, which refers to "*achieving continuity of care over time*" (WHO, 2008, p.3).

Vertical integration entails "*bringing together of different levels in the one hierarchy.*" (England and Leester, 2005, p. 2)). It refers to integration within one specialized service system an example of this is healthcare or harm reduction. Vertical integration can be illustrated as a network of public and private providers with a strong referral system (WHO, 2008; Richardson *et al.,* 2012).

Horizontal integration can be defined as "*brings together previously separated services, professions and organisations across different sectors to better serve service users with multiple disadvantages and complex needs*" (Richardson and Patana, 2012, p. 4). In addition, horizontal integration can be distinct by three subtypes; co-location, collaboration and cooperation.

Co-location refers to integrating services at one location or at the same time (WHO, 2008; Richardson *et al.,* 2012). Co-location aims to provide health services together to reduce travel and time costs and increase health service adherence. For example by the use of a "one-stop shop" which include services that are provided at one single site specific to the needs of a specific target group (Jamison *et al.,* 2006; WHO, 2008). Another example is "case-management", in this case the patient will be linked to a case-manager who facilitates appropriate client-centred services (AFEW, 2006).

Collaboration refers to a good collaboration amongst services (WHO, 2008; Richardson *et al.,* 2012). Important factors in this type of integration are knowledge of providers and strong referrals. Providers form a network that work together, and share information and training.

Cooperation is defined as a fully integrated system where providers communicate and work together (Richardson *et al.,* 2012; WHO, 2008). Cooperation mainly focusses on effective policy-making, management functions and communication, which provides a better outcome for patients.

Table 3 - types of integration of services (England and Leester, 2007; Patana *et al., 2010*)

Types	Subtypes	Meaning
Vertical integration		*"bringing together of different levels in the one hierarchy."*
Horizontal Integration		*"brings together previously separated services, professions and organisations across different sectors to better serve service users with multiple disadvantages and complex needs"*
	Co-location	Integration of services at one location or at the same time - "One-stop shop" - Case-management
	Collaboration	Integration of services through good collaboration amongst services due to shared knowledge and referral
	Cooperation	A fully integrated system

3.3 Facilitators, Barriers and Principles of Integrated Services

Different studies have shown barriers and facilitators of integrated services (Kodner *et al.*, 2002; Ling *et al.*, 2012 Richardson *et al.*, 2012; Shortel *et al.,* 1992, Suter *et al.,* 2007). Integration of services can be impeded by potential barriers. Common barriers found in literature are: financial costs, providers' willingness for involvement and change, complex administration and management, national authorities, the lack of resources, the division between different professions, absence of guidelines or protocols, ineffective data sharing and stigma for provider and user (Kodner *et al.*, 2002; Ling *et al.*, 2012 Richardson *et al.*, 2012; Shortel *et al.,* 1992, Suter *et al.,* 2007). The effectiveness of service integration can be increased by facilitators which involve: (joint)training, close partnership, development of networks and communication channels, good leadership, available resources and a supportive organisational culture (Kodner *et al.*, 2002; Ling *et al.*, 2012 Richardson *et al.*, 2012; Shortel *et al.,* 1992, Suter *et al.,* 2007). Common barriers and facilitators are shown in table 4.

Table 4 - potential barriers and facilitators for integration of services (Kodner *et al.*, 2002; Ling *et al.*, 2012 Richardson *et al.*, 2012; Shortel *et al.*, 1992, Suter *et al.*, 2007)

Barriers	Facilitators
Financial costs	(joint)Training
Lack of willingness for involvement & change by provider	Development of network and communication channels
Complex administration and management	Close partnership
Unsupportive national authorities	Available resources
Lack of resources	Supportive organisational culture
Division between professions	Good leadership
Absence of guidelines and protocols	
Ineffective data sharing	
Stigma for provider and user	

Suter *et al.* (2007) reviewed several facilitators and barriers in order to provide a concise guideline to successful integration of services. Ten principles were set up for planning and implementing a successful integrated health care system, shown in table 5. With this guideline, the current situation of integrated services can be examined and recommendations on future improvements can be made.

Table 5 - Ten principles of a successful integrated system (Suter *et al.*, 2007).

Ten principles of a successful integrated health system by Suter *et al.* (2007)	
"Care across the continuum"	- *Providing seamless and streamlined health care services and processes* - *Cooperation between organisations* - *Multiple points of access*
"Patient Focus"	- *User (and family) engagement and input* - *Focus on specific population* - *Need-based management*
"Geographic coverage and rostering"	- *Linked services in proximity of each other* - *Increased access* - *Integrated service takes responsibility for a specific population*
"Clinical care (teams, best practice guidelines, protocols)"	- *Multi-disciplinary teams, where roles amongst providers are clearly distributed* - *The use of provider-developed and evidence-based guidelines and protocols*
"Quality improvement / performance measurement"	- *Constant monitoring, measuring, evaluating and improving* - *Performance compared to patient outcomes* - *Measuring cost-effectiveness*
"IT and communication"	- *Computerized data system to enhance communication and information exchange by providers*
"Organisational culture and leadership"	- *Strong and supportive leader* - *Organisational culture with a shared vision of integrated services*
"Physician integration"	- *Integrate a leadership role for physicians* - *Information sharing between physician and other services*
"Governance structure"	- *Governance providing incentives and coordination for integrated services* - *Governance structure including community and physician representatives*
"Financial management"	- *Stable financial management* - *Funding*

3.4 Human right to Health

AFEW and Mainline Foundation use a human right based approach meaning that health related policies and programmes are related to human rights principles. As previously described, the human right to health according to the WHO can be explained as the universal right to obtain the highest achievable health, both mentally and physically. In order for PWUD to obtain the highest

achievable health, this report focusses on the integration of health care and harm reduction services in order to make health care more available, accessible, acceptable and of good quality.

The General Comment, implemented by the UN Committee on Economic, Social and Cultural Rights, is depicted in a model (figure 1; WHO, 2013). The right to health exists of the attainment of appropriate health care and necessary social services (e.g. potable water, sanitation, nutrition and housing). Governments are obligated to respect, protect and fulfil this right. In other words, governments should not interfere with, prevent other parties to interfere with, and take active steps to support the attainment of ones rights. According to the right to health, health care and social services should be: acceptable, accessible, of high quality and available. According to this model health services, goods and programmes should be available to PWUD. Subsequently, health care services should be accessible to PWUD, in terms of services being affordable and easy to reach, the target group must be aware of information that exists about the services and health care services must be accessible without discrimination. Regarding ethics, cultures, gender and stage of life, health care services and goods should be acceptable to PWUD. Lastly, health care services and goods must be of good quality (WHO, 2013).

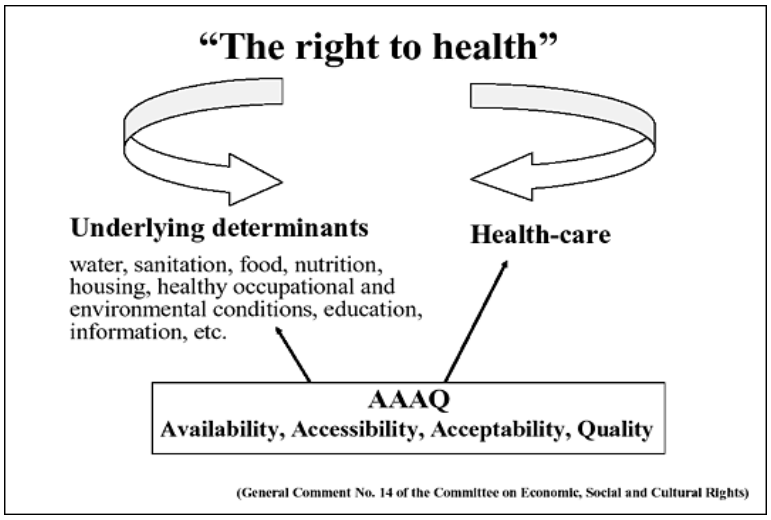

Figure 1 – The model for the human right to health (WHO, 2013).

4. SUB QUESTIONS

To fulfil the aim of this research the following research question will be answered: *What is the current state of integration of services and how can service integration be improved in order to ensure the highest achievable health for PWUD in Kyrgyzstan and Indonesia?* In order to answer the main research questions the following sub questions are created. Firstly the current situation of services provision is questioned, in order to create an understanding on how services may be integrated (1a). Furthermore, the definition and current state of integration of services is questioned (1b and c). Thereafter, requirements for improvement of the integration of services are questioned (2), in order to improve the current state of service provision (1a).

1. *What is the current situation of service provision and integration of services thereof in Kyrgyzstan and Indonesia?*
    a. *What is the current situation regarding harm reduction and health care services for PWUD in Kyrgyzstan and Indonesia, according to the human right to health?*
    b. *How is the term integration of services interpreted by the different partner NGOs of Mainline and AFEW in Kyrgyzstan and Indonesia?*
    c. *What is the current state of integration of service in Kyrgyzstan and Indonesia?*
2. *How can the integration of services for PWUD be improved in order to ensure better accessibility, quality, availability and acceptability for PWUD in Kyrgyzstan and Indonesia?*
    a. *What are the barriers for the integration of services according to the partners of the BtG Alliance?*
    b. *What are facilitators for the integration of services according to the partners of the BtG Alliance?*

5. METHODOLOGY

This chapter depicts the methodology of this study. It describes the methods used, the study population, and it justifies the choices made. In order to answer the research question a qualitative research was performed. Data was obtained via semi-structured interviews on cases in Kyrgyzstan and Indonesia. The study population consisted of experts in the field of drug use, harm reduction organisations and (integrated) services.

5.1 RESEARCH DESIGN

To answer the research question, a qualitative research was performed in order to obtain different perspectives, meaning and insights (Gray *et al.*, 2007). The study was explorative in order to assess the understanding of integration of services among partners and the extent of integration of services in the current situation (Gray, 2007). This was assessed by analysing the motives, behaviours, opinions and beliefs of different stakeholders about the research subject. Prior to the actual data collection, a pilot interview and FGD were conducted. This allowed for familiarisation of the research field. Thereafter, data was collected via semi-structured interviews. The interviews were transcribed verbatim. Subsequently a content analysis was performed in order to identify themes and illustrate inferences from the data (Clatworthy and Jones, 2001). Furthermore, the data was organised according to the themes and put in a matrix.

5.2 TARGET POPULATION AND SAMPLING

In April 2015 a partner forum of Bridging the Gaps (BtG) was held, a meeting where (international)partners of the BtG Alliance were invited to advise on strategies. During this forum, respondents were sampled for a pilot interview and FGD. In total, one partner was interviewed for the pilot and four participated in the pilot FGD (PR1-PR5). Purposive sampling was used in order to select respondents (R1-R15) for this research according to specific characteristics and knowledge (Gray, 2014). The target population that was selected for this study are experts from national and international NGOs involved in harm reduction services, integrated service facilities, primary health care facilities and PWUD. In total, 15 respondents were included of which 12 were interviewed through Skype, one was interviewed face-to-face and two were questioned via email. The countries of interest during the current study were Kyrgyzstan and Indonesia. A non-random sample was obtained due to the small number of respondents. Strict criteria were upheld to select respondents in order to obtain accurate information. The respondents included in this research contained one or more of the following criteria: (1) work at an national organisation that works with or has knowledge of PWUD in Indonesia or Kyrgyzstan, (2) work at an international organisation that works with or has

knowledge of PWUD, (3) speak English or has the availability of an interpreter, (4) facilitate health care services for PWUD. An overview of the respondents that were included is depicted in table 6

Table 6 – respondents included

Respondent	Gender	Organisation	Country
PR1	Male	Nai Zindagi	Pakistan
PR2	Female	WONETHA	Uganda
PR3	Female	WONETHA	Uganda
PR4	Female	NBY	Vietnam
PR5	Female	North Star Alliance	Kenya
R1	Male	PKNI	Indonesia
R2	Male	Rumah Cemara	Indonesia
R3	Female	Mainline	Netherlands
R4	Male	UNODC	Indonesia
R5	Male	Karisma	Indonesia
R6	Male	Yayasan Yakeba	Indonesia
R7	Male	PEKA	Indonesia
R8	Female	AFEW	Kyrgyzstan
R9	Male	Independent Public Health and Humanitarian Aid Consultant	Netherlands
R10	Female	AFEW	Kyrgyzstan
R11	Male	INPUD	United Kingdom
R12	Female	HRA	United Kingdom
R13	Female	Independent Public Health Consultant	Malaysia
R14	Female	Podruga Foundation	Kyrgyzstan
R15	Female	Asteria	Kyrgyzstan
R16	Female	UNDP	Kyrgyzstan

5.3 Data Collection

Data collection of the research were carried out between April and June 2015. In order to explore the research field, a pilot interview and focus group discussion (FGD) were performed. The semi-structured interviews broaden the insight from experiences of the respondents.

5.3.1 Pilot interview and Focus Group

The pilots provided preliminary insight into the study population and on integration of services. The pilot interview was conducted with the partner of BtG from Pakistan, which, according to Mainline Foundation and AFEW, experienced best practice of integrated services. In addition, the pilot FGD was performed with four partners of BtG that are involved in working with sex

workers and the integration of services. During the pilot interview and FGD, data was gathered on the following concepts: integration of services, harm reduction services for PWUD, barriers to access services for sex workers and PWUD, current health issues for sex workers and current integrated services.

5.3.2 INTERVIEWS

Through semi-structured interviewing, comparable qualitative data were gathered. Interviews were used to provide insight and understanding to the depth of meaning of the concept "integration of services" (Ritchie *et al.*, 2013). The interviews were semi-structured in order to apply structure to the research, however it allowed for an unstructured exploration and for the use of probes (Cohen, 2008). In addition, the respondents could provide more in-depth answers of their own views. New issues and concepts arose from semi-structured interviews (Wilson, 2014). In total, 15 respondents were included , of which12 of the interviews were conducted through Skype, one face-to-face and two through emails. The duration of the interviews varied from 27 to 88 minutes. After an introduction of the research, open questions were asked to minimalize the influence on the respondents. The following topics were addressed during the semi-structured interviews: interpretations of the definition "integration of services", the current situation of (integrated) services in Kyrgyzstan and Indonesia and requirements in order to improve integrated services. In the end of the interview a summary of the answers in the interview were reviewed, in order to minimize misunderstanding. Subsequently, the respondents were asked if they had additional information or questions. Lastly, the respondents were acknowledged for their participation in the interview. Appendix one provides a detailed overview of the interview guide. The interviews were recorded and were transcribed verbatim with the use of Express Scribe. A summary of the transcript was made and sent to the interviewees.

5.4 DETAILED ANALYTIC APPROACH

In order to answer the research question and to make recommendations on the integration of harm reduction services, the data generated from the interviews were analysed. After finalizing the transcripts and summaries the data from the interviews was analysed via content analysis (Gray, 2007). The initial analysis was open coding, which entailed labelling and a raw analysis of the data. The concepts of the theoretical background were used to make a preliminary coding guide for open coding. Furthermore, concepts that emerged from the data were added to the existing concepts and coding guide. Next, focused coding was applied in order to re-examine the open coding and to further focus on the data. Lastly, axial coding was applied. The coding guide was used in order to organise meaningful phrases derived from the interviews, in order to carry out a matrix analysis (Gray, 2014). The final coding guide is shown in appendix 2.

5.5 ETHICS

In order to protect the privacy of interviewees respondents were asked to provide their informed consent prior to the interviews (Gray, 2014). Most of the interviews were conducted through Skype, therefore the respondents were asked to provide the informed consent orally. Summaries were talked through at the end of each interview or a summary of the interviews was sent to the respondents. This enabled the respondents to verify and change data if necessary. All respondents confirmed that the gathered data was accurate in their opinion. In this report the respondents are anonymized.

6. RESULTS

In this chapter the results of the qualitative analysis of the interviews will be presented, gathered via interviews as described in the previous chapter. The data originated from the knowledge and experience of the respondents as a provider, client or representative of national or international NGOs. With the results shown in this chapter, the sub-questions can be answered. In accordance with the sub questions and analysis of the interviews, the results are categorized into topics. First the current situation of services for people who use drugs (PWUD) in Kyrgyzstan and Indonesia is depicted according to availability, accessibility acceptability and quality. Furthermore, the current situation of the integration of services in Kyrgyzstan and Indonesia is described. Lastly, possible improvements for integration of services are illustrated according to the influential factors (barriers and facilitators).

6.1 THE CURRENT SITUATION: SERVICES FOR PWUD

To make an overview of the current situation of services for PWUD in Kyrgyzstan and Indonesia, the availability, accessibility, acceptability and quality of the healthcare and harm reduction will be illustrated. With this overview the question can be answered why integration of services may be useful in the context of Kyrgyzstan and Indonesia.

6.1.1 AVAILABILITY OF SERVICES

Health services, goods and programmes should be available to PWUD in order to ensure their right to health. Almost all the respondents from both Kyrgyzstan and Indonesia mentioned the wide range available services recommended for drug users. Health care and harm reduction that were available and mentioned are: needle and syringe programme, methadone maintenance program/opioid substitution therapy, HIV testing and treatment, condom provision, rehabilitation, basic health care, national insurance, overdose prevention, information, training, education, legal aid and social services. The following comment was made by a representative of a NGO in Kyrgyzstan reflects the wide range of services:

"So we have syringe and needle exchange programme, we have methadone substitute therapy, we have prevention of overdose with Naloxen, we have testing and consulting on HIV, we have client management programme, we have social centres like drop-in centres, community centres for women, and for drug users and for ex-prisoners, we have rehabilitation centres, we have detox therapy, friendly pharmacist services, ARV therapy, diagnosis and prevention and treatment of TB."(R8)

Respondents from both countries emphasized the distinction between services that are made available by **community based centres or the government**. Opioid substitution therapy (OST), needle and syringe programmes (NSP) and abstinence based rehabilitation are delivered by the national government in both countries. The following cynical comment was made by the programme manager of an Indonesia non-profit organisation, it illustrates the available services by the government in Indonesia:

"*The government provides the methadone, the needle and syringe and the rehab centre. And then they provide the prison too."*(R5)

In Kyrgyzstan, respondents mentioned that especially methadone is delivered by the government. This is illustrated with the following comment from an independent public health consultant: *"Methadone is an opiate, therefore strict regulations for distribution are upheld."*(R9)

Harm reduction services are mainly delivered by community based centres or NGOs. In Indonesia, the community based services were harm reduction services and services that are tailored to the needs of PWUD. In Kyrgyzstan it was mentioned that the HIV testing and "*social services*" for PWUD were provided in NGOs.

Respondents from Indonesia were uncertain about the availability of services in the **future**. It was mentioned by a representative of a community based organisation in Indonesia that the availability of services may decrease in the future, he illustrated this phenomena with the following quote:

"*But since the support is not very stable and the government of Indonesia keep changing their commitment about their standards, it is really difficult for us to keep providing those services."*(R7)

Some of the respondents mentioned that **certain services** were unavailable. Services for hepatitis C are unavailable in most of the cities in Indonesia and in the whole of Kyrgyzstan. In addition, in Kyrgyzstan sexual reproductive health services were unavailable, this was not mentioned by Indonesian respondents.

The availability of services was not sufficient for several **subgroups** of PWUD. Although harm reduction and health care services are available for most PWUD, some respondents in Indonesia mentioned that services were unavailable for **imprisoned** drug users. A respondent from a community based organisation in Indonesia mentioned: *"People forgot about the prison."*(R2) However, for Kyrgyzstan it was mentioned that methadone is available for PWUD the prison. This is illustrated with the following comment: *"It is really unique that Kyrgyzstan has OST, methadone, in the prison*."(R13 - independent public health consultant)

Another group for whom services are not sufficiently available are **amphetamine users**. This is a main issue specifically mentioned in the case of Indonesia. There are no services tailored specific for the needs of amphetamine users, since the focus is mainly on providing services to IDU. Due to the shift in drug use from heroin (injecting) to amphetamines (non-injecting), this was mentioned as an upcoming problem in Indonesia. The following comment reflects on this situation:

"*We are not really finding new clients, new injecting drug users, but you know there is this shift to ATS use and that is a big problem, because we don't have proper treatment for methamphetamine users.* "(R15 - independent public health consultant)

This may have great consequences for amphetamine users and the HIV prevalence among amphetamine users. The possible consequences are illustrated by a community based organisation from Indonesia with the following quote:

"*Before, when they were injecting drug users, they were not infected with HIV because they get clean needles and they get a lot of information at that time. Then they stop injecting, and then after two or three years, they will use again but different substances, such as amphetamines and alcohol, and then they get the HIV from sexual transmission."*(R6)

Another factor that influenced the availability of services for PWUD was the **region** where services were provided. The availability of services for PWUD differed per region, district or city. Urban districts such as west-Java, Jakarta and Bali in Indonesia were likely to have all services available for PWUD. However, it was mentioned that in rural areas in Indonesia the availability of services for PWUD was much lower. In Kyrgyzstan the urban area like Os and Bishkek were known to have all services available for PWUD and the rural area were not likely to have a complete service package available for PWUD.

Thus, a wide range of services are available in Kyrgyzstan and Indonesia for people who use drugs. Services can be distinguished by provision of community based organisations or government. The availability of services regarding hepatitis C and sexual reproductive health is challenged. In addition, the availability of services for PWUD is challenged for specific regions and subgroups of PWUD, and the availability of services in the future is uncertain.

6.1.2 Accessibility to services

According to the human right to health, health care services should be accessible to PWUD. Accessibility should be sufficient to PWUD in terms of services being affordable, without discrimination and easy to reach. According to the respondents, services were not sufficiently

accessible for PWUD in Kyrgyzstan. A respondent from an international harm reduction organisation illustrated the global lack of access to services needed by PWUD, she mentioned:

"Access to services like opioid substitution therapy is very low globally. About eight people who use out of a 100 currently access OST."(R12)

The accessibility of services is sufficient for a limited amount of PWUD due to the **lack of money**. This is illustrated by the following comment from a national harm reduction organisation in Indonesia:

"*The funding is quite ridged, the government provides a limited funding if they provide for instance for ten or 20 people who use drugs to access this service"*(R7)

In addition, a respondent from an international NGO stated that globally PWUD do not have sufficient access to health care and harm reduction services due to, among other things, the affordability. She mentioned: *"It just takes too much money and energy and therefore it is not easy accessible enough."*(R3) This is also mentioned for Indonesia, for example in Sumatra, according to a respondent from a community based organisation in Indonesia, 94 percent of the IDU in Sumatra shared needles, due to low affordable NSP services(R1).

All respondents agreed on the difference in accessibility between services that were provided by **the government or by community based organisations**. Most of the respondents from both countries emphasized that community based services were accessible, whereas services provided by the government were not accessible.

Respondents believed there were several barriers that limit the accessibility of services of governmental services. **The lack of trust** towards the government and law enforcement is mentioned as a major barrier in Kyrgyzstan and Indonesia. Respondents mentioned that PWUD are afraid to access services and to give their identity, because registered PWUD are more likely to be criminalized. A respondent from a harm reduction organisation mentioned: *"The trust of people who use drugs is still too low to access the governmental clinic services" (*R2) Most of the respondents mentioned that the PWUD are imprisoned by the law enforcement. A respondent from an international NGO focused on HIV/AIDS and drug use emphasized that PWUD are afraid to access harm reduction and health care services, which is illustrated by the following comment:

*"But the problem is especially in the primary health centre because of the law enforcement officers, which can arrest their clients near the methadone substitution or syringe exchange programmes"(*R8)

In addition, the respondents explained that law enforcement and PWUD are both put under pressure by the government. Because of incarceration of PWUD, there is a low access to services specific for PWUD. This is illustrated by the following comment by an independent expert on HIV/AIDS and drug use in Indonesia:

"There is a kind of target of getting an insane number of people into drug treatment, this year in fact it is more people than the highest estimate of drug users in the country. So it is an unattainable estimate. And I think that people really are under pressure and are really afraid essentially for their lives because of they are forcibly put into rehabilitation or jail"(R13)

In order to increase trust towards governmental services among PWUD, involvement of the community was mentioned by the respondents. An international expert on harm reduction and drug use mentioned outreach work and peer support as a strategy to increase the accessibility of NSP. He mentioned: "*We have to bring services to the people. We should not sit and wait with clean needles for them."*(R3)

Furthermore, **registration** was mentioned to impact the accessibility of services. All the respondents from Kyrgyzstan mentioned that for PWUD, who are not able to identify, health care and harm reduction were inaccessible. For example, respondents mentioned that PWUD in Kyrgyzstan that have been to prison will re-enter civil society without identification card, which makes it impossible for them to access the services. "*It means that they can only go to the private clinics and receive very expensive medical services."*(R10)

In the case of Indonesia, registration was also mentioned to impact the accessibility of services. This was mentioned by an independent expert on drug use and HIV/AIDS as follows:

"You have an ID card and you have a local address in Jakarta, so if you go to another district you can't access your medication from your district."(R13)

Stigma and discrimination was also mentioned as a barrier to accessibility. In Indonesia this may be due to the repressive drug policy "the war on drugs". This is illustrated by an expert on harm reduction and drug use from an international organisation. He mentioned:

"Well the major driver is the repressive drug policy. Which leads to criminalization. And it is criminalization that drives stigma and discrimination."(R11)

In Kyrgyzstan stigma and discrimination is also prevalent. Experts on HIV/AIDS and drug use in Kyrgyzstan mentioned there is stigma from service providers, law enforcement and self-stigma that decreases accessibility.

Thus, respondents from both countries mentioned that in areas where stigma and discrimination are rife, PWUD are reluctant to access health care and harm reduction services. PWUD feel misunderstood by health care providers, the respondents mentioned that providers do not know how to take care of the drug user. In addition, self-stigma is also a reoccurring reason why PWUD do not access services, this is illustrated by a respondent from a national NGO from Kyrgyzstan.

"People who inject drug are often driven away from services which is often because of stigmatizing themselves, or health care workers might have stigmatizing attitudes towards drug users and might not want to work with drug users."(R12)

Other barriers that emerged from the analyses were **time and location**. Ten of the respondents mentioned that traveling time and location of services was an issue regarding the accessibility of health care and harm reduction services for drug users. In addition, the opening hours of governmental services posed a barrier for PWUD to access services. Services that are physically fragmented, makes it necessary to travel to different locations in order to access all needed services. Which in addition costs time and money. The issue of time and location is illustrated in the following comment by a respondent from a national NGO in Kyrgyzstan:

*"It is location and the time they spend for the services, even methadone and sometimes syringe exchange can be in other places. So it's really hard for them."(*R8)

In addition, the following statement given by an independent expert on HIV/AIDS and drug use provides more insight on this issue:

" People who use drugs don't have money and especially for the people who use drugs with AIDS that have to go to AIDS centres that are not centrally located, it is difficult to travel from one place to another."(R9)

Respondents mentioned the importance of reducing time and location barriers. In order to reduce those barriers, integration of services was mentioned to be a strategy.

Another common barrier that emerged from the data is **being a female drug user**. The respondents from Kyrgyzstan and Indonesia mentioned the low access of services for female drug users, due to marginalisation or having children. Consequently, female drug users have increased health risks. This is illustrated by an independent expert on drug use and HIV/AIDS:

*"They are depending on their man to provide the same services and with our current system that you need show your ID and count the number of needles, this is for one person, so they continue to share the needle."(*R13)

The moral values of religion were also mentioned as a reason for the low access of services for female drug users. This was illustrated by a respondent from a national NGO in Kyrgyzstan in the following comment:

"The religion does also affect some people, especially for a society woman of a Muslim group, they cannot even go to the medical doctors without husbands' permission"(R10)

6.1.3 ACCEPTABILITY OF SERVICES

Health care services and goods should be acceptable to PWUD in terms of ethics, culture, gender and stage in life. It was mentioned by the respondents that in both countries acceptability is impeded by several factors.

The lack of choice is a reoccurring issue amongst Indonesian respondents, however this is not found in the case of Kyrgyzstan. Respondents from Indonesia mentioned the lack of choice as an unacceptable factor in service provision. Compulsory abstinent based rehabilitation is provided by the government in Indonesia, if drug users register as a drug user they have two choices: go to prison or go to compulsory abstinent based rehabilitation. Subsequently, people who use drugs are forced to abstinent based rehabilitation, which makes governmental services unacceptable. A respondent from an international NGO for drug user mentioned: *"The choice due to the regulation is to go to rehabilitation or to jail."*(R3)

Another pressing issue that was mentioned, was the lack of choice in needles. Needles that are distributed in Indonesia are not considered appropriate by all PWUD. The independent expert on drug use and harm reduction shared the following:

"Whereas in Indonesia, it is like only one needle one syringe type for everybody, because it is procured at a national level, by the national AIDS commission, so there has never been really an assessment of the acceptability and the appropriateness of the paraphernalia. And I think that is important, because if you want service uptake you kind of need to answer to the needs of the users you know." (R13)

Stigma on PWUD was mentioned to cause inacceptable services. This may be due to the negative propaganda of governments against PWUD and misunderstanding of the society towards PWUD. Stigma and discrimination is mentioned for both countries. Stigma held by providers causes unfriendly services, which consequently leads to PWUD not coming back to those services.

The acceptability of services is impaired for **female PWUD**, to their special needs for sexual reproductive health services and due to their role in taking care of their children. The following comment illustrates the lack of acceptable services towards women and being a mother:

"Generally, all of the harm reduction programmes are for men, I hardly ever meet out-reach workers who are female and as you know female drug users are more hidden and they hardly access clean needles, so they are very high at risk. But you know first they are women and if they are mothers, it makes it, it compounds it. Sure how do I leave my children if I go to the methadone treatment and if they go to the methadone, men are hackling me. "(R13 - independent expert on HIV/AIDS and drug use)

6.1.4 QUALITY OF SERVICES

The scope of the quality of services was influenced by two factors namely: capacity of (skilled)service providers and monitoring of the quantity of uptake.

The **number of service providers** is in both Kyrgyzstan and Indonesia very low, thus health care and harm reduction provider cannot offer a wide range of quality services to the PWUD. It was also mentioned that a significant amount of providers were not skilled in order to provide a quality of services to PWUD, which may cause a maltreatment and impact the health of PWUD. In addition, due a low number of providers there is no space for proper follow-up. The low quality of follow-up increases the drop-out rates in Indonesia. An independent expert on drug use and HIV/AIDS mentioned:

"It is not easy you know, we keep pushing NGOs to find people to test, and then they bring people to the clinics and get them tested and then they leave them and there is no control that is why we lose so many of them. And Indonesia has an atrocious drop-out rate, so that is a real shame." (R13)

Currently, service provision is monitored by the **quantity** of PWUD in for example rehabilitation centres, instead of whether or not they facilitated the right care or services to them. Therefore, the quality of services was decreased, in addition relapse and the lack of adherence to treatment were increased. This is illustrated with the following statement by an independent expert on HIV/AIDS:

"Because the narcologists get salary per filled bed per day, so there is no incentive at all to really provide good rehabilitation, for example to try new methods or to begin a therapeutic peer community or other ambulant rehabilitation methods." (R 9)

6.2 CURRENT SITUATION: INTEGRATION OF SERVICES

The current situation of the integration of services is depicted. First an overview is made of the definitions on integration of services according to the partners of the Bridging the Gaps (BtG) Alliance. Furthermore, examples are given on services that are already integrated in Kyrgyzstan and Indonesia.

6.2.1 DEFINING INTEGRATION OF SERVICES

The respondents were asked to define integration of services, in order to make an overview of the understanding on integration of services among the partners of the BtG Alliance. Concerning the integration of services different definitions were mentioned. Six of the respondents defined integration as "a one stop shop", which entails physical integration of services in one place. A respondent from an Indonesian community based organisation described this as follows:

"Integration of services is a strategy to make people love the services and that they will come back again, because everything is under one roof." (R1)

Whereas, six other respondents defined the integration of services as services being connected to each other via referral or good collaboration. The following statement made by a respondent from an International organisation illustrated this as follows:

"It is not necessary that all the services are in one building. But the most important thing when talking about integration of services is about the linkage between the services, clear information and a clear referral system."(R4)

Three other respondents explained integration of services according to its aim. They described integration of services as very broad and complex. Furthermore, they described it as a strategy to optimize the health of drug users and, health care and harm reduction provision. A national harm reduction expert illustrated this with the following comment:

"So integration in our understanding is how we can provide services to PUD so they can maintain their health at the point they want to maintain."(R7)

All respondents mentioned their preference of integrated services over distinct services. A respondent from an international NGO emphasized the comfort for PWUD, he mentioned:

"*I think you agree as ordinary people we like to come to one place, we don't like to go to another place, to some specialist in the third place. It is more comfortable to come to one place."* (R11)

The goal of integration of services was described by several key factors. Firstly, respondents mentioned that integration of services may lower barriers towards the accessibility of services. Secondly, respondents mentioned that integration of services might increase effective and efficient service delivery. Thirdly, respondents thought integration of services would lower discrimination and stigma. Lastly, respondents stated that integration of services could increase sustainability of services provision. It was mentioned that in order to uphold services for PWUD integration was key. This can be illustrated with the following comment from an international expert on harm reduction:

"I mean you have to kind of walk the line and make sure that services are integrated and appropriate and not creating quite vulnerable stand-alone services, which are very specialized that they become too expensive to run" (R12)

6.2.2 INTEGRATED SERVICES

According to the respondents multiple pilot programmes have been implemented for the integration of services. However, it is noticeable that one respondent from an Indonesian community based organisation thought that integration of services is impossible in Indonesia, he mentioned:

"*It is most of the time impossible to integrate treatment and rehabilitation with harm reduction services. It is like oil and water."* (R1)

More than half of the respondents mentioned pilot programmes on the integration of services. In Kyrgyzstan, client management was explored, whereas respondents from Indonesia mentioned the one-stop principle. In addition, the first steps are made towards a trial for a one stop shop in Kyrgyzstan.

Client management, also mentioned as case management, is focused on escorting people who use drugs to the services they need. The aim of client management is integrating service provision by strong referral with a case manager between services. In Kyrgyzstan, NGOs provide PWUD with a partnership network of service providers in order to fulfil their comprehensive treatment needs. This is illustrated by a representative of a national harm reduction in Kyrgyzstan with the following comment: *"With our organisation we support the client management programmes. Some of donors they call it client management, but it is more about escort when the drug user need to go to a lot of services. Client management is a tool for prevention of HIV and they work with complex of problems of clients."* (R15)

The one stop shop principle was mentioned as a model that achieved provision of integrated services to people who use drugs. In Indonesia, it was mentioned that community based

organisations try to integrate harm reduction services with health care services, this is illustrated by an ex-client and representative of a national community based organisation, he mentioned

"*We try to integrate treatment and rehabilitation services and also harm reduction services for example needle and syringe and also condom use. Drug users go to the place and set up their treatment plan with the psychologist and counsellor and it is one hundred percent voluntary based. And it is open all the times, so the clients keep come back to the place, even though it is a small place for only 30 people, but more than 30 people stay there. It is best practice."*(R1)

One of the respondents from Kyrgyzstan also mentioned a one stop shop pilot programme by CDC. People who use drugs can receive information, condoms, syringes, methadone, and testing on HIV. An expert of an international NGO in Kyrgyzstan illustrated this by the following statement:

"*First we have a one stop shop, we have it on the basis of the city AIDS centre, and they provide services like they have a TB specialist there and they have methadone and syringe needle exchange programme. But the one stop shop is only for the people who are living with HIV now, so not everyone can go there."*(R8)

6.3 IMPROVEMENT OF THE INTEGRATION OF SERVICES

The respondents mentioned several factors that withhold services from being integrated and other factors that have facilitated integration of services in the past. In order to improve the integration of services, barriers should be overcome and facilitators may be used.

6.3.1 BARRIERS FOR THE INTEGRATION OF SERVICES

Respondents mentioned several barriers that withhold services from being integrated. The most commonly mentioned barriers for the integration of services were the barriers the respondents mentioned for the availability and accessibility of services. Most of the respondents linked barriers for the integration of services to a weak current (public) health system. In order to overcome the barriers towards integration of services, the barriers towards the accessibility and availability of services should be decreased. Other common barriers involve the funding crisis, political willingness (commitment and priority), capacity and communication issue.

All the respondents have mentioned **money** at least once as a barrier to the integration of services. Respondents mentioned that due to low funding, service providers have low salaries. In addition respondents mentioned that due to low salaries, service providers lacked the incentive to integrate other services into their already existing tasks. Not only the lack of funding was an

issue, also in terms efficiency in spending money. An expert from an international harm reduction organisation mentioned new strategies of redirecting money concerning drug use. She mentioned:

"We are asking for a redirection of spend away from punitive responses, and an upscale of spend into health and human rights approaches to drugs. We argue that just a percentage of what we are spending globally on law enforcement we would cover harm reduction approaches globally. So we are actually not focussing on let's take the money away from other health issues, we are more focussing let's talk about what makes sense in terms of spend in drugs." (R12)

In addition, it was mentioned that HIV and drug use slips down the political agenda. The lack of priority results in the lack of funding. A respondent from a community based organisation in Indonesia mentioned:

"One of our problems is about the fund, because a lot of people think why should we support the drug users, because we still have a lot of other issues in the public community." (R6)

Thus, another major barrier is the **lack of governmental support** for harm reduction services in general and also for integrating services. In terms of laws and regulations, due to the use of death penalty for drug (trafficking) offenses harm reduction services are under pressure. The following statement made by a respondent from a community based organisation illustrates this as follows:

''But the most important thing is the willingness of the government. How can we maybe treat in comprehensive packages if there is no support at all for harm reduction from the Indonesian government? ''(R1)

A third common barrier that was mentioned is the **capacity shortage**, this means that there are not enough health care providers to offer integrated services. Human resources were especially low, due low incentives and low salaries. One of the respondents from an international NGO illustrated this barrier according to an existing example Indonesia, he mentioned:

"For example in PuskesMas, the community health centre, they only have few doctors to deliver all the services required by the government, there are if I am not mistaken 35 different services available in that community health centre." (R4)

The last major barrier was the **lack of communication** between services. It was mentioned that in order to achieve good integrated services and referral thereof, good communication is needed. This was illustrated by an independent expert on drug use and HIV/AIDS as follows:

"And all these organisations are actually working in similar locations, but they don't talk to each other but they actually share quite a number of clients. So you know we programmed it in such a way that they are working separately. So now the challenge is how we bend, not only to integrate the services, but get them to refer the clients to each other, and do the case management with each other so they know more about the clients they are servicing." (R13)

6.3.2 FACILITATORS FOR THE INTEGRATION OF SERVICES

In spite of all the previous mentioned barriers, experts on integration mentioned several facilitating factors for integration of services. The following facilitators can be used as a strategy to improve integration of services: improve governmental support, mapping available services, stakeholder meetings, developing guidelines and the involvement of the community.

Governmental support is considered central in achieving effective integration of services. It was identified that governmental support could lead to reducing financial problems and lowering stigma. An expert on harm reduction (R5) mentioned that governmental support was needed to attain sustainable integrated services. Another facilitator for sustainability is tapering out the funding. Respondents mentioned that because of retraction of funding, pilot programs on integration of services stop. Thus, in order to maintain the pilot programmes and facilitate sustainable integrated services, an expert from an international harm reduction organisation mentioned the following:

"I think from an international perspective there needs to be a proper plan in place before funding is withdrawn. So there should be a kind of tapering of a funding not a just an end, matrix like political will, you know the engagement of civil society, the ability for the civil society to receive funds from the government, that there is a mechanism in place, and that NGOs can retract their services."(R12)

Another facilitator is **mapping services per area**. It is mentioned that due to a lack of information of existing services throughout the country referral cannot take place. Therefore, mapping of available services over different areas can strengthen the referral system.

Meetings between different stakeholders that concern integration of services was mentioned as a facilitator at organisational level. In Bali, understanding between key stakeholders was increased due to the involvement of all parties. This is illustrated by an expert of a community based organisation in Indonesia with following statement:

"Because we try to engage all the stakeholders between all the services, in order to make services more friendly between the doctor, the nurse and the drug user"(R6)

In addition, the **meaningful involvement of the community** and (ex)drug users in the whole process of delivering services was also mentioned as a facilitating factor to integration of services. In addition, respondents mentioned that this could increase adherence to treatment and self-management for the PWUD of their condition. Furthermore, this could decrease stigma and the risk of relapse. Examples of community involvement are: community peers, outreach workers or social workers. This is illustrated by the following statement:

"It takes two to tango. So the government and the civil society they need to work together. We really need to look at strengthening referral and having perhaps community peer educators working within the system to ensure there is seamless movement of communication between one service provider to another." (R13 - independent expert on drug use and HIV/AIDS)

Lastly, respondents agreed that it is critical to set up **modules, guidelines from best practices and assessment tools** in order to facilitate integration of services. New assessment tools about the existing services should be made in order to value the existing integrated services. Findings can be used in order to advocate to the government or donors. Furthermore, it was mentioned that modules derived from best practices should be set up in order to facilitate integration of services in other cities or districts.

7. DISCUSSION

This research provided insight into the current situation of and future requirements for the integration of services for Mainline and AFEW and their partner organisations in Kyrgyzstan and Indonesia. So far, there is a considerable amount of literature on integration of services for people who use drugs, but limited attention has been paid on integration of services in Kyrgyzstan and Indonesia. This unique study provides insights into integration of services for people who use drugs in Kyrgyzstan and Indonesia. In addition, this study examined to what extent the partner organisations of Mainline and AFEW have integrated services in Kyrgyzstan and Indonesia. Important barriers for the integration of services were found that need to be overcome in order to improve integration of services. To further improve the integration of services in Kyrgyzstan and Indonesia, the facilitators found in this study can be used.

The study findings on the current situation of service provision suggested that there is a wide range of harm reduction and health care services available in both Kyrgyzstan and Indonesia. There is a distinction between governmental and community based services. Governmental services mainly include: opioid substitution therapy, (abstinence based) rehabilitation and needle and syringe programmes. Community based services involve: (peer) social support, voluntary rehabilitation, condom provision, education and training. However, the accessibility, acceptability and quality of these services are not believed to be sufficient for PWUD. The lack of money is a recurring factor that withhold services from being accessible, acceptable and of good quality to PWUD in both countries. The lack of trust in the government and therefore in their services was a major barrier towards accessibility of services. This may be due to the current global war on drugs and in specific the strict legislation on drug use in Kyrgyzstan and Indonesia. Moreover, the global war on drugs resulted in increased stigma and criminalisation of PWUD. Stigma and criminalisation is significant in both countries which causes misunderstanding and fear among PWUD and also towards PWUD. These barriers have a significant negative impact on the acceptability and quality of services. Curtis (2010) and Friedland *et al.* (2007) confirm, in the case of respectively Ukraine and Russia, that a lack of trust and criminalisation are two major barriers to treatment access and integration of services.

The study findings documented two main types of horizontal integration of services. Vertical integration of services was not mentioned by the respondents, this may be due to the current aim of bringing together two different care sectors including health care and harm reduction. Hence, two main types of horizontal integration of services are mentioned. The first type of horizontal integration of services was defined as services being connected to each other via referral and/or good collaboration, with a system that aims to optimize the health of PWUD. This

type of integration resonates with the second type of horizontal integration "collaboration" by Richardson *et al.,* 2012. The second type of integration of services was defined as a one-stop shop. This involves physical integration of services in one place. This type of integration corroborates with the first type of horizontal integration "co-location" by Richardson and Patana (2012). This type of integration specifically refers to overcoming time and location obstacles, which are found in this study as barriers for accessibility of services for PWUD in Kyrgyzstan and Indonesia. Therefore, mentioned by the partners as a strategy towards improving the accessibility of services. According to Richardson and Patana (2012) the highest degree in horizontal integration of services is "cooperation" which was not mentioned by the respondents. The absence of this definition insinuates that the respondents may not find this strategy to be desirable. This may be due to high costs of the implementation and the amount of capacity needed of a fully integrated health care system. In addition, it may be due to the lack of trust of among PWUD and therefore lower access to governmental services. Hence, a fully integrated system of health care and harm reduction, in the case of cooperation, might cause a decreased accessibility to services for PWUD.

The most significant barriers to the integration of services that were mentioned were barriers related to the accessibility of services. This noticeable result may indicate the intertwining of accessibility and integration of services, there is a significantly strong linkage between the barriers of accessibility and the integration of services. However, it could also indicate a lack of knowledge among the partners on integration of services. Nevertheless, the main barriers that were mentioned to integration of services are comparable with the found barriers in the literature, related to accessibility. Funding crisis and communication issues were both mentioned by Suter *et al.* (2007). Loveday & Zweigenthal (2011) resonates that the lack of funding is a fundamental barrier to the integration of services. Buffington & Jones (2007) confirms the potential impact of funding crises, indicating that budget crisis leads to considerable reduction of services. Hence, accessibility of services decreases which in turn reduces integration of services. In addition, it is mentioned by the respondents and in literature that a capacity shortage, in terms of a lack in providers as well as resources, impedes the integration of services. This capacity shortage inflicts ineffective data sharing and the lack of willingness to take up extra tasks (Kodner *et al.*, 2002; Ling *et al.*, 2012 Richardson *et al.*, 2012; Shortel *et al.,* 1992, Suter *et al.,* 2007). The literature suggests complex administration and management as a barrier towards integration of services; interestingly this is not mentioned during the interviews. This suggests that there is a lack of experience among the respondents with this type of integration of services for which extensive administration and management was needed.

The study suggest that major facilitators for the integration of services include: governmental support, mapping available services, set up guidelines and the involvement of the community. It was identified that governmental support could lead to reducing financial problems and lowering stigma and criminalisation. Therefore, decriminalisation may be significant to facilitate integration of services. WHO (2012) confirms that in the case of Portugal decriminalisation of drug use removes significant barriers towards integration of services. In addition, community involvement was a significant facilitator mentioned by the respondents. The importance of community involvement, with outreach workers and peer support, in regard to integration of services is widely recognised. The findings of Loveday & Zweigenthal (2011) were consistent to the results that stigma may be reduced by means of community involvement, in order to increase successful integration. Volkow & Montaner (2011) corroborates that lack of access to services and the misconception from the community should be addressed in order to improve the integration of services. Several authors reported similar findings on peer support; they have shown that peer support is effective in improving service provision, adherence, trust among PWUD, and engagement of clients within integrated service system (WHO, 2012, Chaisson *et al.,* 2001, Broadhead *et al.,* 2002 and Grebely *et al.,* 2010). The facilitators were in accordance to seven out of ten principles of Suter *et al.* namely: "Care across the continuum", "Patient focus", "Geographic coverage and rostering", "Clinical care", "Quality improvement/performance measurement", "Physician integration" and "Governance structure". The other principles are focussed on a more technical view on integration of services. This can be linked to the previously mentioned lack of knowledge on administration and management processes regarding integration of services among the respondents.

7.1 STRENGTHS AND LIMITATIONS

The strengths of this study include the variety within the study population and the use of two countries which makes a solid base for this research. The variety within the study population leads to a broad view on the subject. The respondents are cautiously selected. Firstly, the respondents are from different national organisations from Kyrgyzstan and Indonesia. Secondly, in order to enrich the data respondents from international organisations are also included. Lastly, respondents with different experiences are included, for example as an (ex)drug user or an expert on drug use or HIV. This ensures the completeness of the current study.

The study used comparable data derived from two countries which provided unique insight into future requirements for improvement on a more global scale. Data may suggest country specific or general barriers and facilitators for integration of services. These findings may be used in future programmes for AFEW and Mainline and for developing future guidelines of Bridging the

Gaps (BtG). In addition, the current study on integration of services for PWUD was an incentive for comparable studies for other key populations of BtG, namely sex workers and LGBT people.

One of the limitations of the current study was the language barrier, which had a significant influence on the interpretation of the questions by the respondent and the interpretation of the answers by the researcher. Most of the respondents were not native English speakers, which caused misunderstanding during the interviews. However, during some of the interviews the respondents were assisted by their colleagues to minimize the misunderstanding. In addition, the answers of the respondent were summarized in the end of the interview in order to verify correct interpretation.

Another important limitation of the current study is caused by the use of Skype. In the process of transcribing the interviews, some of the interviews were hard to understand. Additionally, conversations were occasionally interrupted due to an inconsistent internet connection. Also, body language was missed due to Skype, which might have influenced the interpretation of the interviews.

We also have to take into consideration that answers of the respondents were influenced by social desirability bias. The respondents that work at partner organisations of Mainline and AFEW may have answered according what they felt was appropriate to the researcher, and to Mainline and AFEW.

7.2 Conclusion

This study provided a unique insight in the understanding of integration of services among partner organisations of Mainline and AFEW. The results suggest that integration of services is a strategy used in order to improve available and accessible services for PWUD. Integration of services is not an easy fixed solution but it is a complex process which demands for strict guidelines and monitoring. Collaboration and co-location have been documented as the two types of integration of services defined by the partners of the BtG Alliance. Programmes on the development of integration of services should address the funding crisis, the lack of political support, low capacity of service providers and communication issues. In addition, several criteria should be upheld in order to sufficiently implement integration of services, namely: governmental support, stakeholder meetings and community involvement. In the future, every country and region must be assessed on social and cultural aspects as well as existing services and the accessibility of those services. In addition, further research is needed for the specific subgroups within PWUD. For Indonesia, the subgroups needing for additional research are ATS users and female drug users. For Kyrgyzstan this is also the case for female drug users.

Additional case studies are needed per country and region. The assessment of separate regions or countries improves the increase knowledge on whether or not an integrated service system is beneficiary to PWUD in that region. Thus, integration of services should be used as a strategy towards accessibility, availability, acceptability and quality, rather than integration of services being the outcome or objective.

8. RECOMMENDATIONS

The aim of this study is to make recommendations to Aids Foundation East-West and Mainline foundation, part of the Bridging the Gap Alliance, on how to ensure the highest achievable health of people who use drugs by integrating services. In order to contribute to future programmes of AFEW and Mainline and the development of guidelines for Bridging the Gaps. The following recommendations have resulted from the findings. It should be noted that the recommendations are not applicable to every situation due to varying circumstances:

CREATE UNDERSTANDING

This study suggests that it is important to create understanding among partners about the concept integration of services, about the definition as well as the use. Integration of services should not be seen as an objective, rather as a strategy towards services being available, accessible, acceptable and of high quality. Understanding can be created by Mainline and AFEW with the use of workshops and discussions with the partner organisations. By creating understanding among partners, further assessments can be done whether or not the strategy integration of services, in any of its forms, is desirable for the partner.

TOOLS TOWARDS INTEGRATION OF SERVICES

There are a wide range of pilot studies mentioned. However, details on best practices for the integration of services were not captured or documented. To create lessons learned and best practices several tools may be used. First of all, case studies on best practices on the integration of services per location, district or area is needed. In addition, a needs assessment and context analysis should be applied, in order to establish the situation of a specific setting. These specific settings require context specific approaches for the integration of services. In addition, specific settings might have different priorities in service provision.

This study also suggests that it is needed to assess the specific needs of marginalised groups within PWUD, such as female drug users, imprisoned drug users and young people who use drugs. It is necessary to first assess all the different circumstances that can influence the accessibility, availability, acceptability and quality of services, before applying the strategy.

ENHANCE THE EXISTING INTEGRATION OF SERVICES

The referral system between services can be improved by mapping existing services. In order to enable a referral system, all available services should be mapped. By creating awareness of existing services, service providers can refer more efficiently to other services.

In addition, the process of monitoring and evaluation should be increased. It is valuable to monitor the existing services and integrated services, therefore assessment tools according to the human rights model should be set up.

Furthermore, advocacy for the redirection of funding with help the use of lobby and presenting monitoring reports. Redirect funding to ensure that there is political will so that there is a conducive environment for services to be able to run. Progressive forces in the drug field agree that the global war on drugs has failed. There is still an enormous spending on enforcement-related costs. This money should be redirected towards the strategy of public health and to integration of services. This in turn increases accessibility of services for PWUD.

Lastly, it is needed to increase the partners' focus on the involvement of the community. Due to the increase of peer support and outreach work, several barriers towards the accessibility as well as the integration of services can be overcome.

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10. APPENDICES

10.1 APPENDIX 1: INTERVIEW GUIDE

The interviews in this study were semi-structured, this applied structure to the research. In addition, it allowed for an unstructured exploration via spontaneous questions. The following interview guide is the predetermined structure for the interview, however not all questions are in this guide. The additional question in response to the answers of the respondents are left out of this guide.

Introduction

Word of welcome: Welcome and thank you for making yourself available to take part in this interview.

Introducing interviewer: I am a master student Management, Policy Analysis and Entrepreneurship in the Health and Life Sciences at the VU University in Amsterdam. Currently I conduct a research on integration of services for AFEW and the Mainline Foundation. I will conduct interviews with experts on this research topic in Kyrgyzstan and Indonesia.

The aim of the interview: The aim of conducting interviews is to create an overview off the insights of experts concerning the health of drugs users and integration of health care and harm reduction services. If you have any information that might not be questioned but is useful for this research, feel free to add this.

The study aim: The aim of this study is providing insight into the current state of the integration of services and on how service integration can be improved to ensure the highest achievable health for PWUD in Kyrgyzstan and Indonesia.

Time of the interview: The interview last about one hour.

Recording the interview: Would it be all right to record this interview? Your answers will be anonymised during the report. And in order for you to check your answers I will send a summary of the interview to you.

Organisation

- What kind of work do you do at … (the organisation). (in regard to integration of services)

Services for PWUD

- What kind of services does your organisation provide for drug users?
- What are necessary thing you have to consider when providing services to drug users?
- What kind of services does … (your country) have for drug users?
- Do drug users make use of the services you or your country provide?
    - If not, why not?
    - If so, what do you think contributes to that?
- How accessible are services for PWUD in your country?
- How can you increase accessibility of services for PWUD?
- What are the barriers for drug users to use services?
- What are the challenges to provide harm reduction services to drug users?

Integration of services

- How do you define the term integration of services?
- Does your organisation integrate services?
    - If yes, can you elaborate on how you do that?
    - If not, why not?
- How does your organisation use/think of integration of services?
- Can you tell me more about your experiences with integration of services?
- What are possible advantages of the integration of services?
    - What about the disadvantages?
- How does you organisation work together with other NGOs / public health to integrate services?
- Which/Are services integrated in … (your country)?
    - Do you know any services that are integrated in your country?
- Do you think that services should be integrated?
    - If so, which services should be integrated?
    - If so, how should services be integrated?
- What is the policy on integration of services in Indonesia/Kyrgyzstan concerning drug users?

Improvement

- What are barriers that withhold services to be integrated?
- Can you give examples where integration of services failed, and do you know why?
- How can integration of services be improved, are there any facilitators that are known?

- What are best practices of integration of services?
- In order to benefit the health of drug users, what would you consider to be in a minimum package of integrated services?
- Can you describe an example of where integration of services have worked?
    - How can accessibility of health care (services) for drug users be improved?
    - How does integration of services improves the quality?
    - How does integration of services improves the acceptability?
    - How does integration of services improves the availability?
- What are your recommendations on the integration of services concerning the human right to health of drug users?

Closing

Summary: Summarize the important subjects and answers.

Additional information: Do you want to add any information that might be useful to this study?

Procedure: Your answers will be used for this study, I will report your answers anonymously. To check your answers I can send you a summary of this interview, if preferred. Feel free to contact me, if you have any questions or information you will think of in the future.

Remaining questions: Do you have any questions or remarks right now?

Thanks: Thank you again for making time to contribute to this study and interview.

10.2 APPENDIX 2: CODING GUIDE

For the analysis the following coding guide was created and used. Phrases were labelled according to the code and sub code, subsequently the phrases were put in the matrix for further analysis.

Table 7 - Coding guide used for data analysis

Codes	Sub codes
Current situation: Service provision	Availability • Barriers • Facilitators Accessibility • Barriers • Facilitators Acceptability • Barriers • Facilitators Quality • Barriers • Facilitators
Current situation: Integration of services	Definition Current models The aim of integration of services Minimum package
Improving integration of services	Barriers to integration of services Facilitators to integration of services Best practices Lessons learnt