

*Good practices in Europe: HIV prevention  
for People Who Inject Drugs implemented  
by the International HIV/AIDS Alliance in  
Ukraine*

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# Good practices in Europe: HIV prevention for People Who Inject Drugs implemented by the International HIV/AIDS Alliance in Ukraine

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## ACRONYMS

|            |   |
|------------|---|
| ADB        | Asian Development Bank.                                     |
| AIDS       | Acquired Immune Deficiency Syndrome.                        |
| ART        | Antiretroviral Therapy.                                     |
| ARV        | Antiretroviral drugs.                                       |
| ASTAU      | Association of Substitution Treatment Advocates of Ukraine. |
| AU         | International HIV/AIDS Alliance in Ukraine.                 |
| CAHR       | Community Action on Harm Reduction.                         |
| CBO        | Community-Based Organization.                               |
| CDC        | United States Centers for Disease Control and Prevention.   |
| CEE        | central and eastern Europe.                                 |
| CIS        | Commonwealth of Independent States.                         |
| CITI       | Community Initiated Treatment Interventions.                |
| CoPCT      | Continuum of Prevention to Care and Treatment.              |
| CQA        | Continuous Quality Assessment.                              |
| CQI        | Continuous Quality Improvement.                             |
| CSW        | Commercial Sex Worker.                                      |
| CUP        | Condom Use Programme.                                       |
| DQA        | Data Quality Audit.   |
| ELISA      | Enzyme-Linked Immuno-Sorbant Assay.                         |
| EU         | European Union.   |
| FSW        | Female Sex Worker.  |
| FULCRUM    | NGO, 'Fulcrum/Tochka opory'                                 |
| GFATM      | Global Fund to fight HIV/AIDS, TB and Malaria.              |
| HIV        | Human Immunodeficiency Virus.                               |
| HQ         | Headquarters.   |
| HTC        | HIV Testing and Counselling.                                |
| IBBS       | Integrated Biological and Behavioural Surveillance.         |
| ICC        | Integrated Care Centre.                                     |
| IDU/IDUs   | Injecting Drug User(s).                                     |
| IEC        | Information, Education and Communication.                   |
| IRKH       | Inter-Regional Knowledge Hubs.                              |
| LGBT       | Lesbian, Gay, Bisexual, Transgender people.                 |
| MARA       | Most At-Risk Adolescents.                                   |
| MARP/MARPs | Most At-Risk Population(s).                                 |
| MSM        | Men-who-have-Sex-with-Men.                                  |
| NGO/NGOs   | Nongovernmental Organization(s)                             |
| NSP        | Needle and Syringe Programmes.                              |
| OI         | Opportunistic Infections.                                   |
| OST        | Opioid Substitution Therapy.                                |
| PDI        | Peer-Driven Intervention.                                   |
| PLHA       | People Living with HIV/AIDS.                                |
| PLWH       | People Living with HIV.                                     |
| PTSD       | Post-Traumatic Stress Disorder.                             |
| PWID       | People Who Inject Drugs.                                    |
| PWUD       | People Who Use Drugs.                                       |
| SMT        | Substitution Maintenance Treatment.                         |
| SRH        | Sexual and Reproductive Health.                             |

|                |   |
|----------------|---|
| SSE            | Secondary Syringe Exchange.                           |
| STI/STIs       | Sexually Transmitted Infection(s).                    |
| TB             | Tuberculosis.   |
| TG             | Transgender people.                                   |
| UAH            | Ukrainian Hryvna, the currency of Ukraine.            |
| UCSF           | University of California, San Francisco.              |
| UIC            | Unique Identifier Code.                               |
| United Kingdom | United Kingdom of Great Britain and Northern Ireland. |
| UN             | United Nations.                                       |
| UNAIDS         | Joint United Nations Programme on HIV/AIDS.           |
| UNICEF         | United Nations Children's Fund.                       |
| UNODC          | United Nations Office on Drugs and Crime.             |
| USAID          | United States Agency for International Development.   |
| USD            | United States Dollars.                                |
| WHO            | World Health Organization.                            |

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## 1. EXECUTIVE SUMMARY

Ukraine has experienced one of the worst HIV epidemics in Europe and the Commonwealth of Independent States (CIS) with HIV prevalence in the general adult population estimated at 0.62%, twice the average in the rest of Europe<sup>1</sup>. The latest available data from January 2014 estimates that there are 139,573 people living with HIV/AIDS officially registered in the country but with the actual number of PLHA being as high as 238,000; furthermore, AIDS-related mortality accounts for around 17,000 lives each year in Ukraine<sup>2</sup>.

Until recently, injecting drug use was the primary driver of this concentrated HIV epidemic but, more recently, heterosexual transmission has become more prominent. People who inject drugs (PWID) are especially vulnerable to HIV, as well as Hepatitis C, due to unsafe injecting practices since the first case of HIV was diagnosed in 1987. Other key population groups most at-risk of HIV/AIDS include female sex workers (FSW), men who have sex with men (MSM), most at-risk adolescents (MARA), as well as prisoners. The partners of PWID, FSW and MSM are also at an increased risk of HIV/AIDS, especially when condoms are not consistently used, as is the case in Ukraine.

There are estimated to be in the region of 310,000 PWID throughout Ukraine, most injecting home-made forms of opium and with a HIV prevalence of 19.7% in 2011. There are also considered to be approximately 80,000 FSW with a HIV prevalence of 7.3% and 176,000 MSM with a HIV prevalence of 5.9%<sup>3</sup>, far higher than the HIV prevalence of the general population aged 15-49 years at 0.62%<sup>4</sup>.

The response to HIV/AIDS in Ukraine has been problematic until quite recently. Ukraine has been undertaking health sector reforms and decentralization although funding for HIV/AIDS prevention, treatment and care has been very limited. The Government of Ukraine currently pays for some antiretroviral (ARV) medicines but provides no funding at all for HIV prevention. Consequently, external development partners, especially the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and the US Agency for International Development (USAID), have been the primary supporters to the HIV prevention programme in Ukraine. Signs are emerging, however, that regional level government administrations within Ukraine are recognizing the need to invest their resources in HIV prevention, particularly in light of the global economic constraints affecting donor funding.

Between 1999 and 2006, the number of PWID among new HIV infection cases increased in parallel with an annual decrease in the proportion of PWID among the total number of new HIV cases. But as a result of the ongoing HIV prevention efforts led by the International HIV/AIDS Alliance in Ukraine ('Alliance Ukraine') through its many local NGO and Government partners, between 2006 and 2013 there has been a clear decrease in the number

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<sup>1</sup> Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). National HIV/AIDS estimates. Kiev, UCSDDC, 2013; Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). HIV Infection in Ukraine. Bulletin No. 41, Kiev, UCSDDC, March 2014.

<sup>2</sup> Ibid.

<sup>3</sup> Berleva, G., Dumchev, K., Kasianchuk, M., Nikolko, M., Saliuk, T., Shvab, I., Yaremenko, O., Analytical Report: Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2012 based on the results of 2011 survey. Kiev, International HIV/AIDS Alliance, 2012.

<sup>4</sup> Op. cit.

of registered new cases of HIV among PWID as well as a continuing decrease in the proportion of PWID among the total number of new HIV cases in Ukraine.

The development of a HIV prevention, treatment and care programme in Ukraine by the Government has been spearheaded through support from Alliance Ukraine and its many local NGO partners across the country. A major achievement in this regard is that over the past 3 years, HIV prevalence among PWID under the age of 25 years has decreased. Such a reduction is largely due to the implementation of a comprehensive HIV prevention programme, including harm reduction, led by Alliance Ukraine and its partners, a response that began at the end of 2000 and was accelerated from 2004 to the present day at national scale. It is the national scale of this response by Alliance Ukraine through its partners that is of particular note for possible replication elsewhere.

The International HIV/AIDS Alliance is an international nongovernmental organization with its international secretariat in Brighton, United Kingdom, and currently comprises 40 nationally based, independent, civil society organizations around the world as well as seven Technical Support Hubs, all of which are dedicated to ending AIDS through community action. The Alliance seeks to work with communities through local, national and global action on HIV, health and human rights and is committed to collective action that will lead to a world without AIDS in which the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services that they need for a healthy life.

The Alliance started work in Ukraine at the end of 2000 and, after acquiring organizational and managerial independence, became a separate legal entity in March 2003 after the Ministry of Justice registered the 'International HIV/AIDS Alliance in Ukraine' as an international charitable foundation. As of July 2013, 'Alliance Ukraine' has 130 partner NGOs in 330 towns and cities throughout the country with annual funding in the region of USD15m, primarily as one of several GFATM Principal Recipients of Round 10. Of the 130 partner NGO's in Ukraine, the Alliance works on an ongoing basis with 76 local NGO's on HIV prevention interventions for PWID and their partners that involves more than 500 social workers, more than 100 lawyers and psychologists, more than 200 doctors and nurses, around 100 pharmacists, and approximately 400 staff responsible for administrative and financial management.

The purpose of this review is to document the work of Alliance Ukraine and to assess whether such work is a 'good practice' that could be replicated in other countries faced with a serious HIV/AIDS epidemic driven largely by unsafe injecting behaviours. The review was undertaken during July 2013 and data was updated where available in April 2014. Criteria have been developed to undertake a comprehensive assessment of the full range of support given by Alliance Ukraine and its local NGO and Government partners relating to the implementation, management and ongoing development of the national HIV prevention programme throughout Ukraine.

At present, there is agreement on a division of responsibility by the Government and the Global Fund in Ukraine as to which organizations will lead in specific areas of the HIV/AIDS response nationwide. Consequently, Alliance Ukraine is the lead agency responsible for HIV prevention. The response for HIV/AIDS care and support is led by the All-Ukrainian Network for PLHA, and treatment is the responsibility of the Government, led by the

Ministry of Health of Ukraine. As a result, this report focuses on the HIV prevention work of Alliance Ukraine and its partners throughout Ukraine and its linkages with HIV care and treatment services.

Based on the criteria outlined in Section 2, Introduction, of this report and a comprehensive review of the available documents, reports, published and unpublished literature, and from focus-group discussions with key populations in various locations in Ukraine, as well as meetings with a range of Government, NGO and UN stakeholders in the country, the overall conclusion is that whilst coverage of some of the harm reduction interventions in Ukraine is not yet optimal, the overall work of Alliance Ukraine is a 'good practice' that is suitable for possible replication in other countries for the following reasons:

1. All 9 interventions recommended by WHO, UNODC and UNAIDS are being implemented through Alliance Ukraine. Whilst coverage levels for opiate substitution therapy (OST), HIV testing and counselling (HTC) and access to antiretroviral therapy (ART) are not as high as required, obstacles are being overcome and an exponential increase in coverage has already commenced through such innovations as peer-driven interventions and active case management. Coverage of the sterile needle/syringe programme (NSP) is believed to be high as not all PWID need to access such commodities from the Global Fund-supported programme; pharmacies act as an alternative source of sterile needles/syringes;
2. Support is given to key populations, especially PWID, beyond the 9 UN-recommended interventions. For example, access to legal services, psychosocial support, family reintegration, vocational training and income earning opportunities is available through many of the Alliance local NGO partners throughout Ukraine. This has come about through extensive, targeted training from Alliance Ukraine and related certification processes, both for technical issues as well as for general management, administration and financial management of local NGOs;
3. The operation of 'Integrated Care Centres' is a 'good practice' model of making it relatively easy for key populations most at-risk of HIV/AIDS to access a full range of health services either at one site, or at several sites located very close together, usually within walking distance. This helps to reduce potential drop-out of people when referred from one health intervention to another. Such Centres usually provide NSP, OST, HTC, TB, STI and Hepatitis interventions, with a limited number also dispensing ART;
4. There is a very strong gender component to all of the services implemented by local NGOs throughout Ukraine based on the technical support given to them by Alliance Ukraine. There are also several examples of comprehensive harm reduction programming being implemented for most at-risk children and adolescents that could be replicated elsewhere;
5. Patient/client data is kept confidential at all times and a Unique Identifier Code (UIC) system is used for all HIV prevention work in the country;
6. Continuous quality assessment (CQA) and continuous quality improvement (CQI) exists and is being implemented by Alliance Ukraine with its local NGO partners with reviews undertaken on a quarterly basis. The development of innovative responses to

programmatic and service delivery challenges is a very strong component of the work, such as peer-driven interventions (PDI) and community-initiated treatment interventions (CITI). Considerable efforts have been made by Alliance Ukraine to support the development of national, regional and community organizations to represent key population groups, and to assist specific people from each community to become representatives to advocate themselves for what their community needs in terms of services;

7. There is an increasing involvement of staff of Government health care facilities in partnership with local NGO personnel in the delivery of key population services; this provides both cost-savings as well as helps to make health services more sustainable in the longer term through the retention of qualified, knowledgeable and experienced staff who can provide quality services for key populations; this is particularly the case for the OST programme;
8. The unit cost, per year, for HIV prevention services for key populations is at a level that is lower than many other countries but possibly higher than can be funded by the Government of Ukraine under current economic constraints;
9. A significant number of positive changes have come about in the legislative, administrative and financial spheres due to advocacy undertaken by Alliance Ukraine, sometimes as part of a coalition of organizations within Ukraine and sometimes with the support of organizations in the region and beyond. However, most of the changes have come about due to the delicate work undertaken by the staff of Alliance Ukraine itself, in close consultation with their local NGO partners;
10. Alliance Ukraine continues to nurture the development of national, regional and community organizations to strengthen the health system to respond to the needs of key populations and to assist people from each community to become representatives to advocate for what their community needs and to become involved in the development, implementation, monitoring and evaluation of programmes within the broader health and social sectors.

In addition, the work of Alliance Ukraine belongs in a broader international context as their work is both influenced by, and greatly influences, harm reduction and HIV prevention practice in other countries. This perspective comes from Alliance Ukraine being part of the global network of organizations that is the International HIV/AIDS Alliance that connects their work to developments and experiences in other countries and to global policy and HIV technical fora, and its practice is informed by the Alliance's mission, values and good practice standards. The technical support hub run by Alliance Ukraine for the benefit of countries in the region, and the leading role that Alliance Ukraine takes in the Community Action on Harm Reduction (CAHR) programme, are clear examples of how Alliance Ukraine informs the practice of other Alliance organizations elsewhere, including those nearby but also much further afield, including in Asia and Africa. The production of quality harm reduction publications made available either online or in-print, or both, is yet another example of the international dimensions of the Alliance's work in spreading good practices well beyond Ukraine.

The rapid scaling-up of quality harm reduction services for key populations is one of the primary goals of the Alliance, but this might not happen in Ukraine due to the lengthy process of achieving real, practical change from the Government and its key agencies, in particular the Ministry of Health and the Ministry of Interior, including the police.

A total of twenty recommendations are given at the end of this report that highlight some of the opportunities for the future, as well as some of the challenges in responding to the needs of people who remain stigmatised and discriminated against, especially in terms of their basic right to health care in the community.



## 2. INTRODUCTION

Ukraine is located in eastern Europe and has borders in the north with Belarus, to the north and east by the Russian Federation, to the south by the Republic of Moldova and Romania, as well as the Black Sea, and to the west by Poland, Slovakia, and Hungary, respectively.



**Map 1: Map of Ukraine and neighbouring countries.**

<http://data.un.org/CountryProfile.aspx?crName=UKRAINE>, accessed 30 June 2013; see also, Statistics Division, Department of Economic and Social Affairs. World Statistics Pocketbook, Series V, No. 37. New York, United Nations, 2013, p204.

With a population estimated at 45,190,000 in 2011, of which 68.9% live in urban areas, the country comprises 24 oblasts, or provinces, with Kiev the capital city with a population of around 2,829,000<sup>5</sup>. A comparison of the estimated population size for each of the key populations at-risk of HIV in Ukraine in 2011, as well as their respective estimated HIV prevalence, is summarized in Table 1, below.

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<sup>5</sup> Statistics Division, Department of Economic and Social Affairs. World Statistics Pocketbook, Series V, No. 37. New York, United Nations, 2013, p204.

| 2012  | MSM                 | PWID                | FSW           |
|---|---------------------|---------------------|---------------|
| Estimated population size (range)                                       | 200,100–<br>248,700 | 278,750–<br>387,800 | 60,200–93,600 |
| <b>Recommended estimate for calculating prevention service coverage</b> | <b>176,000</b>      | <b>310,000</b>      | <b>80,000</b> |
| <b>HIV Prevalence</b>   | <b>5.9%</b>         | <b>19.7%</b>        | <b>7.3%</b>   |

**Table 1: Estimates of the general size of key populations most at-risk of HIV and prevalence in Ukraine, 2012**

Source: Berleva, G., Dumchev, K., Kasianchuk, M., Nikolko, M., Saliuk, T., Shvab, I., Yaremenko, O., Analytical Report: Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2012 based on the results of 2011 survey, Kiev, 2012.

**People Who Inject Drugs (PWID)** is usually defined in Ukraine as a group of people in which the individual is injecting drugs without a doctor’s prescription within the previous 30 days<sup>6</sup>.

**Female Sex Workers (FSW)** are often also referred to as ‘Commercial Sex Workers’ (CSW) and are defined as individuals for whom the provision of sex services is their main occupation (or one of their key sources of income) and who have been involved in the sex business for some time (more than once) within the previous 6 months.

**Men who have Sex with Men (MSM)** is usually defined in Ukraine as a male individual with experience of sexual contacts with men (oral or anal) within the last 6 months; this group also includes men who provide sexual services to other men for money.

**Most at Risk Adolescents (MARA)** refers to children and young people who are most at risk of HIV infection as a result of their risky behaviour, namely: injecting and non-injecting drug users; adolescents who practice unprotected sex; male adolescents who have sex with males; adolescents who practice sex for profit and those who are deprived of care, and are homeless and live on streets.

This review describes the work of Alliance Ukraine and its government, NGO and CBO partners in the delivery of a comprehensive range of interventions for the prevention of HIV/AIDS among key populations at-risk of HIV/AIDS and the natural extension of the programme to the provision of care and treatment to PWID. Such interventions are governed by Law No. 1026-VI of Ukraine entitled, the ‘State programme of prevention of HIV infection, treatment, care and support of HIV infected and people living with AIDS for 2009-2013’<sup>7</sup>.

<sup>6</sup> Berleva, G., Dumchev, K., Kasianchuk, M., Nikolko, M., Saliuk, T., Shvab, I., and Yaremenko, O. Analytical Report: Estimation of the Size of Populations Most-at-Risk for HIV Infection in Ukraine as of 2012 based on the results of 2011 survey. Kiev, International HIV/AIDS Alliance, 2012, p9-10.

<sup>7</sup> <http://zakon2.rada.gov.ua/laws/show/2861-17?nreg=2861-17&find=1&text=%E7%EC%E5%ED%E8%E5%ED%ED%FF&x=0&y=0#w11>, accessed 30 June 2013;

HIV/AIDS is a particular health issue for a country as its impact can be felt far beyond the individual's health condition. As noted in a World Bank report of 2006,

“AIDS affects all agents in an economy: households, businesses, and the government, and its effects impact many of the economy's aspects: greater mortality and morbidity; reduced labor supply, labor efficiency, and labor productivity; loss of investment in human capital and diminished returns to such investment; increased health care spending and the loss of tax revenues; and decreases in public and private savings and investment, among others. Reduced fertility among women infected with HIV amplifies the demographic decline and is responsible for longer term effects”<sup>8</sup>.

### **‘Good Practice’ Criteria**

The UN has no specific definition of ‘good practice’ as it relates to harm reduction among key populations, including sex workers, men who have sex with men, and people who inject drugs. However, the UN does recommend targets for coverage and for the quality of such services, as well as for availability and accessibility to those services at a cost that can be met by those most in need of the services<sup>9</sup>.

Consequently, **‘Good Practice’ criteria used in this review** is defined to include the following:

1. All nine UN recommended interventions are being implemented;
2. At least 50% of the targeted populations are covered by each intervention;
3. Referral, assisted referral, case management systems exist to link clients between services with patient/client drop-out rates consistently falling as a result;
4. Psychosocial support and linkage to vocational training and income earning opportunities are available to clients;
5. Different services are integrated at one location, i.e. one-stop shop, or located nearby to each other;
6. There are specific services available for females, children, adolescents, young people and prisoners, including people in pre-trial detention and on probation;
7. All client/patient data is kept confidential at all times by service providers;
8. Coordination and collaboration takes place with other sectors, agencies and services, including local administration and law enforcement;
9. Continuous Quality Assessment (CQA) of services and staff exists and is being implemented;
10. A mechanism for Continuous Quality Improvement (CQI) exists and is being implemented;

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English language translation available at [http://www.unicef.org/ceecis/The\\_State\\_HIV-AIDS\\_Program\\_for\\_2009-2013\\_narrative\\_EN.pdf](http://www.unicef.org/ceecis/The_State_HIV-AIDS_Program_for_2009-2013_narrative_EN.pdf), accessed 28 April 2014.

<sup>8</sup> International HIV/AIDS Alliance in Ukraine / The World Bank. Socioeconomic Impact of HIV/AIDS in Ukraine. Washington, DC, The World Bank, May 2006, pix-x.

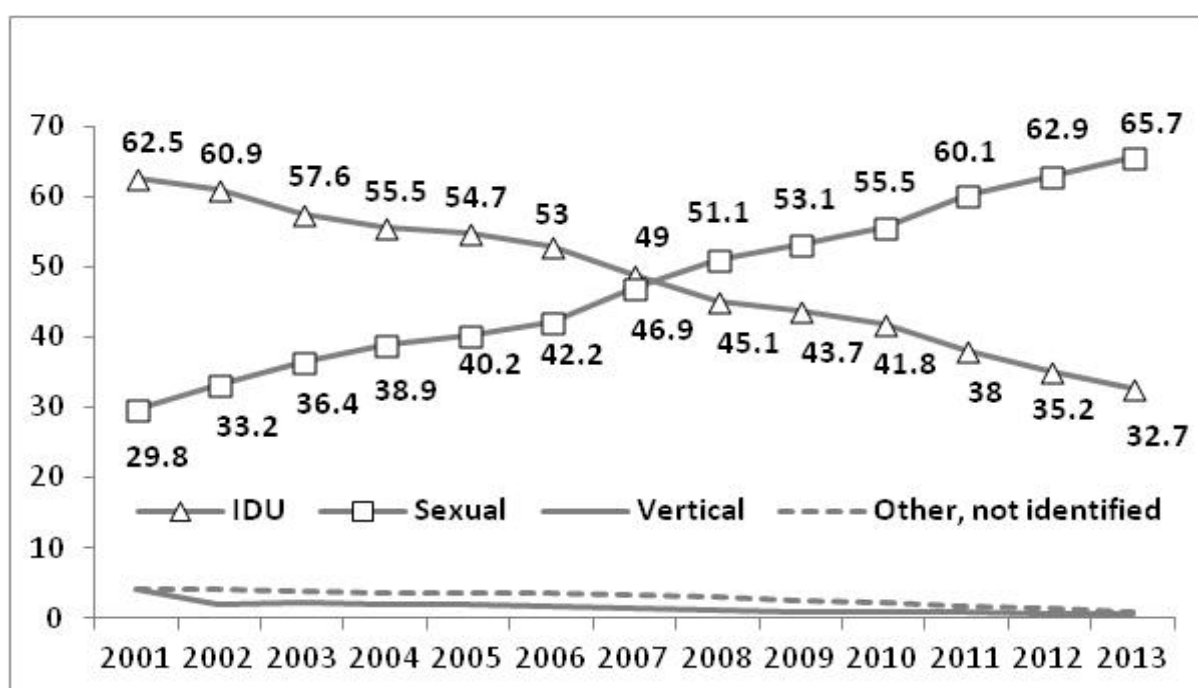
<sup>9</sup> WHO, UNODC, UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. Geneva, WHO, 2012.

11. Innovation to address challenges is an integral part of the programme, together with operational research activities;
12. Sustainability of Services: Increasing role of Government staff in service delivery;
13. Sustainability of Services: Increasing proportion of local and/or central Government funding to services, including the no-cost provision of government buildings for service delivery;
14. The financial cost of each intervention is at a level that central and/or local Government funding can sustain in the future;
15. Ongoing advocacy takes place to remove legislative, administrative, financial and societal obstacles to the rapid scaling-up of quality harm reduction services for key populations through the active and meaningful involvement in the development, implementation, monitoring and evaluation of each service by relevant key populations;
16. Sharing of lessons learnt, technical skills, etc., through publications and online materials;
17. A mechanism in place for clients/patients to give feedback on effectiveness of each service;
18. A strong monitoring and evaluation system is functioning and provides timely and useful reports for all levels of the programme;
19. Specific technical training is provided to staff and refresher training is available and undertaken on a periodic basis;
20. Training in administration, finance, human resource, fundraising and general management issues is provided to relevant staff and refresher training is available and undertaken on a periodic basis.

### 3. THE DEVELOPMENT OF THE HIV/AIDS RESPONSE IN UKRAINE

The first HIV case in Ukraine was identified in 1987 in the city of Odessa<sup>10</sup>. Until around 2008, Ukraine experienced a concentrated HIV epidemic amongst key populations, especially among people who inject drugs (PWID), fueled by unsafe injecting practices of predominantly home-made opiates made from poppy cultivated within Ukraine. Other key populations are also affected, including female sex workers (FSW) and men who have sex with men (MSM) and their partners<sup>11</sup>.

By 2008, the primary mode of HIV transmission changed from injecting drug use to heterosexual sex, as can be seen in Fig. 1, below.



**Fig. 1: Routes of HIV transmission in Ukraine, 2001-2013**

Source: L.V. Gromashevsky Institute for Epidemiology and Infectious Diseases of the National Academy of Medical Sciences of Ukraine. HIV infection in Ukraine, Newsletter No. 41. Kiev, Ukrainian Centre for AIDS Prevention and Control, Ministry of Health, 2014, p17.

However, among the general population aged 15-49 year, Ukraine still has the highest estimated HIV prevalence rate in eastern Europe and central Asia at 0.62%<sup>12</sup> and, as noted in the most recent publicly available HIV report of the Ukrainian Centre for Socially Dangerous Disease Control of the Ministry of Health Ukrainian Centre for AIDS Prevention and Control of the Ministry of Health, “Ukraine is experiencing the most severe HIV epidemic in eastern Europe and the CIS [Commonwealth of Independent States, formerly part of the Soviet

<sup>10</sup> Nieburg, P., Carty, L. Injection Drug Use in Ukraine: The Challenges of Providing HIV Prevention and Care, A report of the CSIS Global Health Policy Center. Washington, DC, Center for Strategic & International Studies, March 2012, p1.

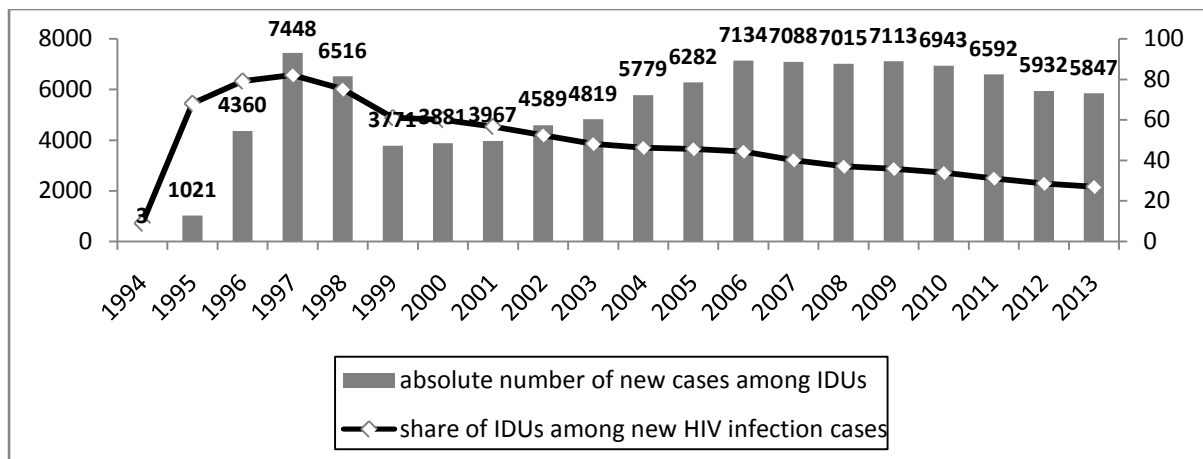
<sup>11</sup> Ministry of Health of Ukraine. Ukraine harmonized AIDS response progress report, January 2010-December 2011. Kiev, International HIV/AIDS Alliance, 2012, p22;

<http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=6>, accessed 30 June 2013.

<sup>12</sup> Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). HIV Infection in Ukraine. Bulletin No. 41. Kiev, UCSDDC, March 2014.

Union/USSR] countries”<sup>13</sup>. As of January 2014, there were 139,573 people living with HIV/AIDS (PLHA) officially registered in Ukraine<sup>14</sup> but with the actual number of PLHA being as high as 238,000; furthermore, AIDS-related mortality accounts for around 17,000 lives each year in Ukraine<sup>15</sup>

Between 1999 and 2006, the number of PWID among new HIV infection cases increased in parallel with an annual decrease in the proportion of PWID among the total number of new HIV cases, as can be seen in Fig. 2, below. Furthermore, between 2006 and 2013, there has been a clear decrease in the number of registered new cases of HIV among PWID as well as a continuing decrease in the proportion of PWID among the total number of new HIV cases.



**Fig. 2: Officially registered HIV infection cases of PWID by year, 1994-2013**

Source: L.V. Gromashevsky Institute for Epidemiology and Infectious Diseases of the National Academy of Medical Sciences of Ukraine. HIV infection in Ukraine, Newsletter No. 37. Kiev, Ukrainian Centre for AIDS Prevention and Control, Ministry of Health, 2012, p10 (data for 1994-2011); L.V. Gromashevsky Institute for Epidemiology and Infectious Diseases of the National Academy of Medical Sciences of Ukraine. HIV infection in Ukraine, Newsletter No. 41. Kiev, Ukrainian Centre for AIDS Prevention and Control, Ministry of Health, 2014, p52 (data for 2012-2013).

Of concern, though, is that the ‘new wave’ of HIV infections through heterosexual sex appears to be largely as a result of risky sexual behaviours of PWID and their sexual partners and/or clients<sup>16</sup>.

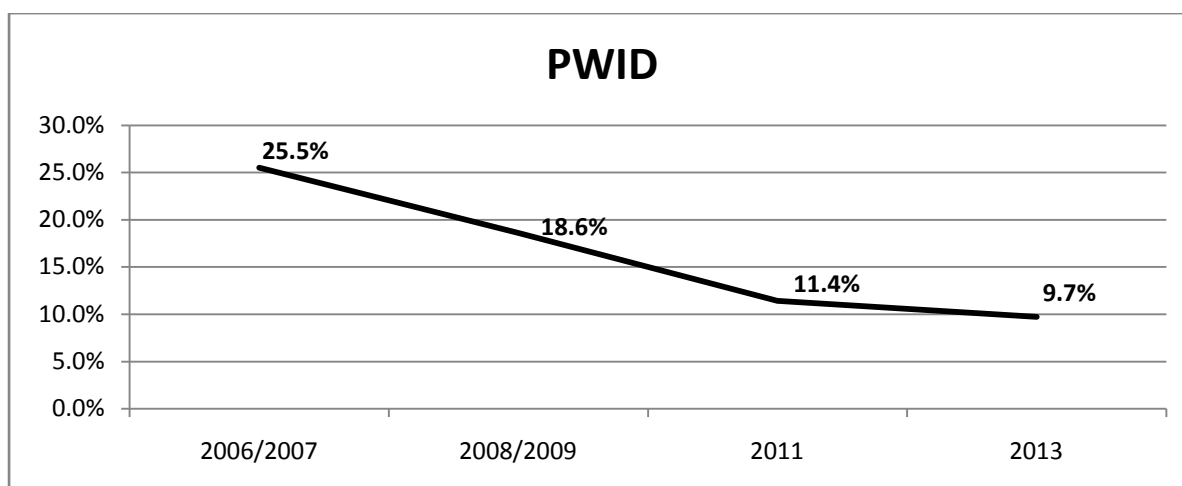
A major achievement, however, is that over the past 3 years, HIV prevalence among PWID under the age of 25 years has decreased, as shown in Fig. 3, below.

<sup>13</sup> Ukrainian Centre for AIDS Prevention and Control. HIV infection in Ukraine, Newsletter No. 37. Kiev, Ministry of Health of Ukraine, 2012, p4.

<sup>14</sup> HIV infection in Ukraine, Newsletter No. 37, Ibid., as cited in, UNAIDS, The Joint UN Programme of Support on AIDS for 2012-2016, Kiev, 2012.

<sup>15</sup> HIV infection in Ukraine, Newsletter No. 41, Op. cit.

<sup>16</sup> HIV infection in Ukraine, Newsletter No. 37, Op. cit, p10.

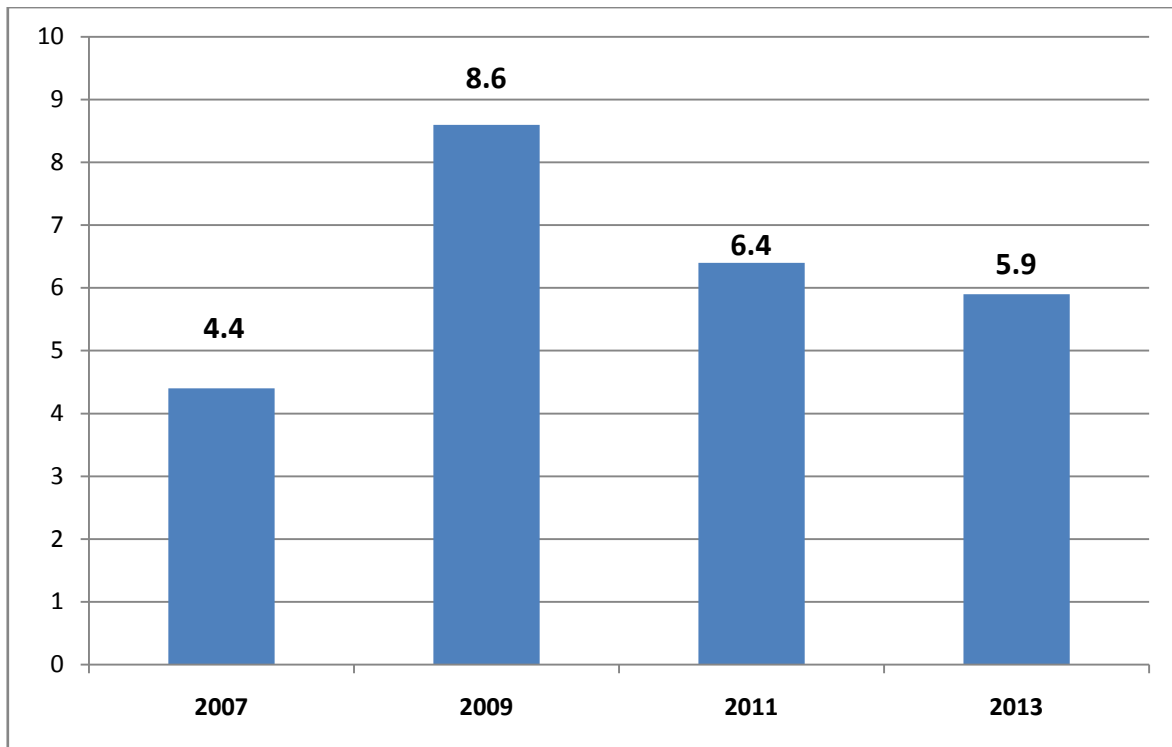


**Fig. 3: HIV prevalence among PWID under 25 years of age in 9 most affected regions of Ukraine**

Source: Based on sentinel surveys among PWID (2006 and 2007), IBBS data, which was conducted among FSW in Ukraine in 2007, 2008, 2009, 2011 and adjusted with data of IBBS 2013.

HIV prevalence among Men who have Sex with Men (MSM) is estimated at 5.9%, as can be seen in Fig. 4, below, which is a major issue in itself but remains relatively small compared to other key populations in Ukraine, totalling no more than 0.4% of all HIV cases in the country as of 2011, although the number of cases continues to rise. The socio-demographic characteristics of the MSM community include an average age of 28 years (+/- 8 years), with 83% of MSM having never been married and 35% living alone; 43% of MSM report living with relatives or parents<sup>17</sup>.

<sup>17</sup> UCSF/CDC. Ukraine HIV Data Synthesis Project: Final Report. Kiev, UCSF/CDC, January 24, 2013, p25; [http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm\\_en\\_2011.pdf](http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm_en_2011.pdf), accessed 30 June 2013.



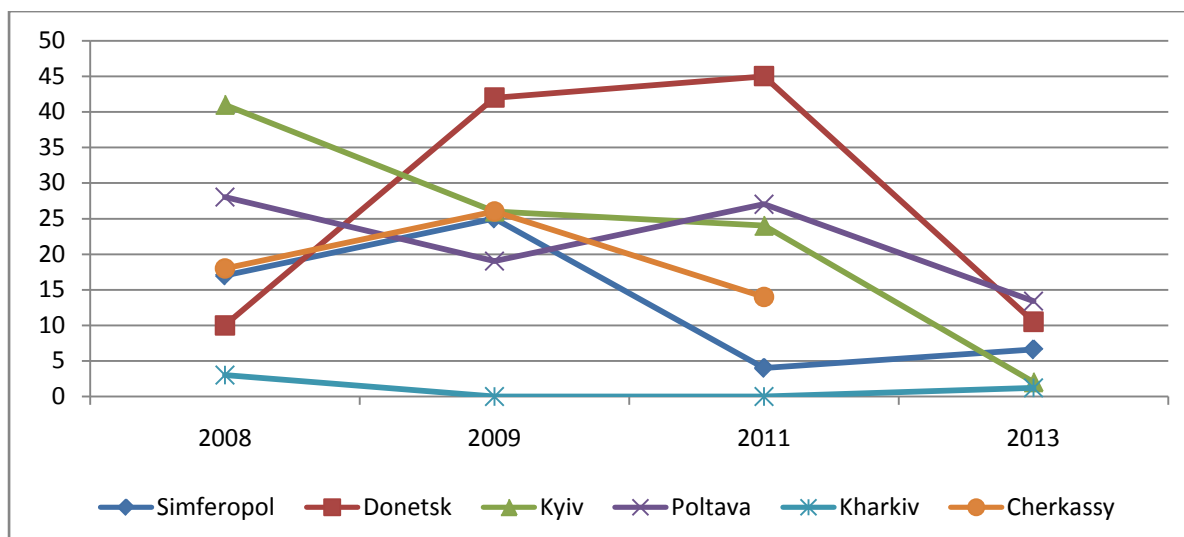
**Fig. 4: HIV prevalence among MSM, 2007-2013**

Source: Ministry of Health of Ukraine. Ukraine Harmonized AIDS Response Progress Report, January 2010-December 2011. Kiev, 2012, p215, based on IBBS data, which was conducted among MSM in Ukraine in 2007, 2008, 2009, 2011 and adjusted with data of IBBS 2013.

Female Sex Workers (FSW) are also a key population at-risk of HIV in Ukraine. Of particular note is that HIV prevalence among FSW appears to be highest in cities with the highest incidence of HIV among PWID. In a survey in 2011, the HIV prevalence among those FSW who had reported never using drugs was 6% nationwide, whereas the prevalence rate was 32% among FSW who reported ever using drugs but not in the past year, and 41% among FSW who reported injecting drugs within the previous year<sup>18</sup>. Consequently, there appears to be a direct link between injecting drug use and FSW and higher prevalence of HIV in Ukraine. Fig. 5, below, shows the HIV prevalence among female sex workers by city in Ukraine between 2008 and 2013.

<sup>18</sup> Ibid., p55.





**Fig. 5: HIV prevalence among female sex workers by city, Ukraine, 2008-2013**

Source: UCSF/CDC. Ukraine HIV Data Synthesis Project: Final Report. Kiev, UCSF/CDC, January 24, 2013, p43, based on IBBS data, which was conducted among FSW in Ukraine in 2008, 2009, 2011 and adjusted with data of IBBS 2013.

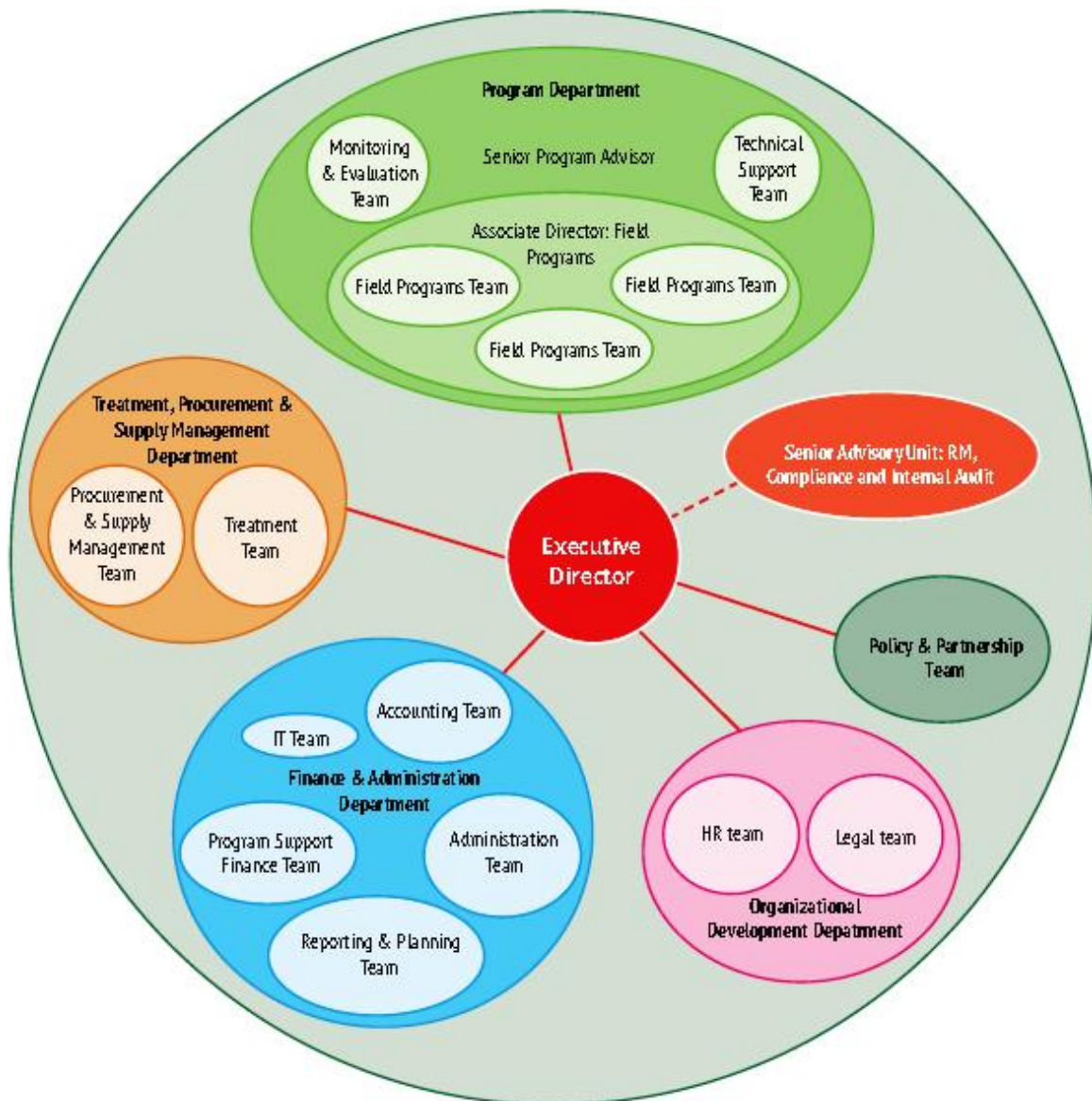
The initial response by the Government to the rising HIV epidemic among key populations was weak and there continues to be a relative lack of emphasis by the Government on HIV prevention amongst PWID, MSM and FSW, respectively. Fortunately, the national HIV prevention portfolio was undertaken by the Alliance in partnership with local NGO's and local Government administration throughout Ukraine, resulting in a dramatic increase in the delivery of HIV prevention interventions throughout the country from 2004 to the present.

The Alliance is an international nongovernmental organization with its international secretariat in Brighton, United Kingdom, and currently comprises 40 nationally based, independent civil society organizations around the world – referred to as Linking Organizations – and Country Offices, as well as seven Technical Support Hubs, all of which are dedicated to ending AIDS through community action. The Alliance seeks to work with communities through local, national and global action on HIV, health and human rights and is committed to collective action that will lead to a world without AIDS in which the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life<sup>19</sup>.

The Alliance started work in Ukraine at the end of 2000 as an Alliance Country Office implementing an international technical assistance project within the Transatlantic HIV Prevention Initiative supported by the US Agency for International Development and the European Union (2000-2004), and, after acquiring organizational and managerial independence, became an independent 'Linking Organization' at the beginning of 2009. Alliance Ukraine became a separate legal entity in March 2003 after the Ministry of Justice

<sup>19</sup> International HIV/AIDS Alliance: <http://www.aidsalliance.org/Pagedetails.aspx?id=234>, accessed 30 June 2013.

registered the ‘International HIV/AIDS Alliance in Ukraine’ as an international charitable foundation<sup>20</sup>. The current structure of Alliance Ukraine can be seen in Fig. 6, below.



**Fig. 6: Organizational Chart of the International HIV/AIDS Alliance in Ukraine, January 2012**

Source: International HIV/AIDS Alliance in Ukraine. Annual Report 2011, Annex 8. Kiev, International HIV/AIDS Alliance, 2012, p144.

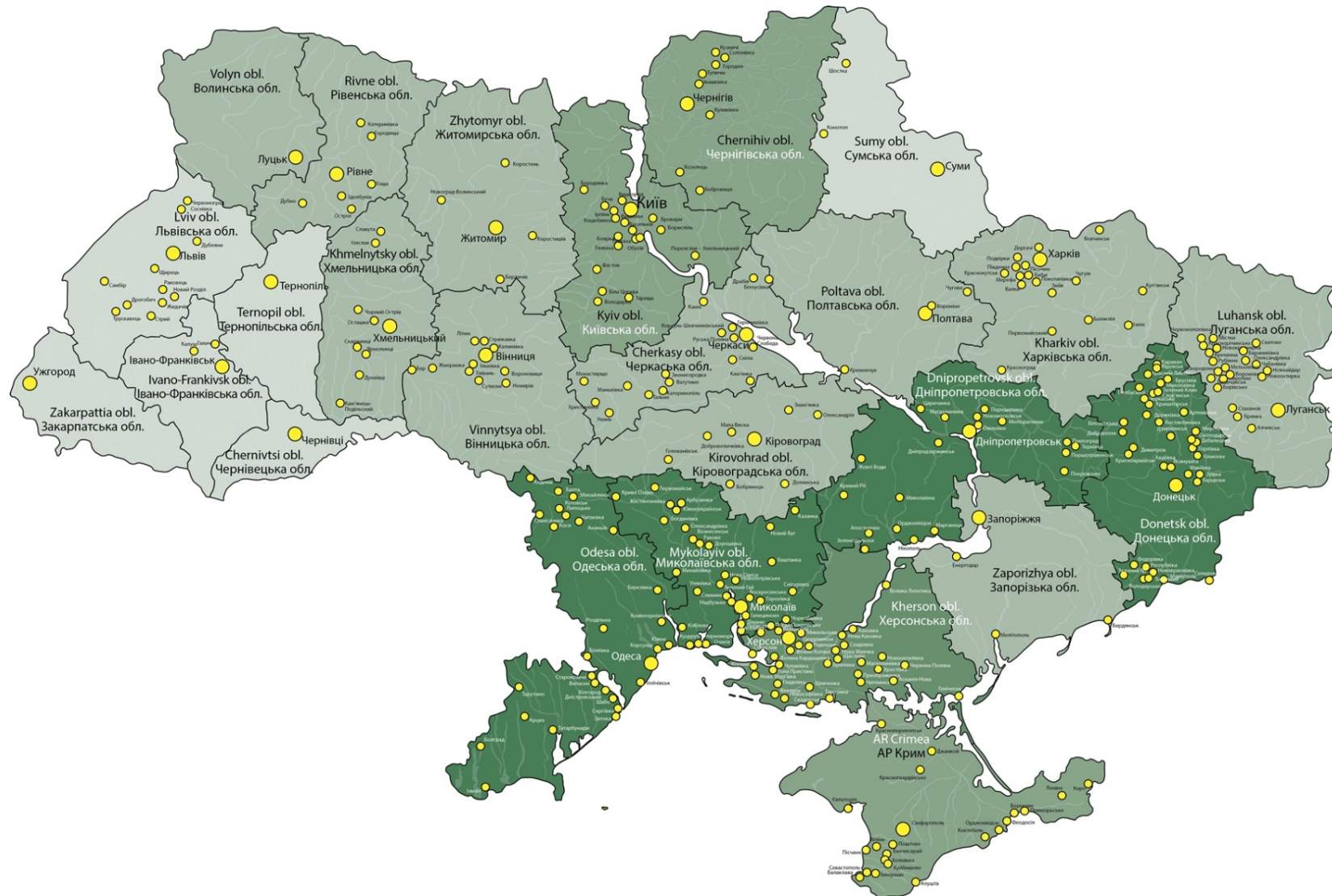
As of July 2013, Alliance Ukraine had 130 partner NGOs in 330 towns and cities throughout the country (see Map 2, below) with annual funding in the region of USD15m, primarily as one of several Principal Recipients of Round 10 of the Global Fund.

<sup>20</sup> International HIV/AIDS Alliance: <http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=6>, accessed 30 June 2013; International HIV/AIDS Alliance in Ukraine: <http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/about/index.htm>, accessed 30 June 2013.

Of the 130 partner NGO's in Ukraine, the Alliance works on an ongoing basis with 76 local NGO's on HIV prevention interventions for PWID and their partners and/or clients that involves more than 500 social workers, more than 100 lawyers and psychologists, more than 200 doctors and nurses, around 100 pharmacists, and approximately 400 staff responsible for administrative and financial management<sup>21</sup>.

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<sup>21</sup> International HIV/AIDS Alliance in Ukraine. Annual Report 2011. Kiev, International HIV/AIDS Alliance in Ukraine, 2012.



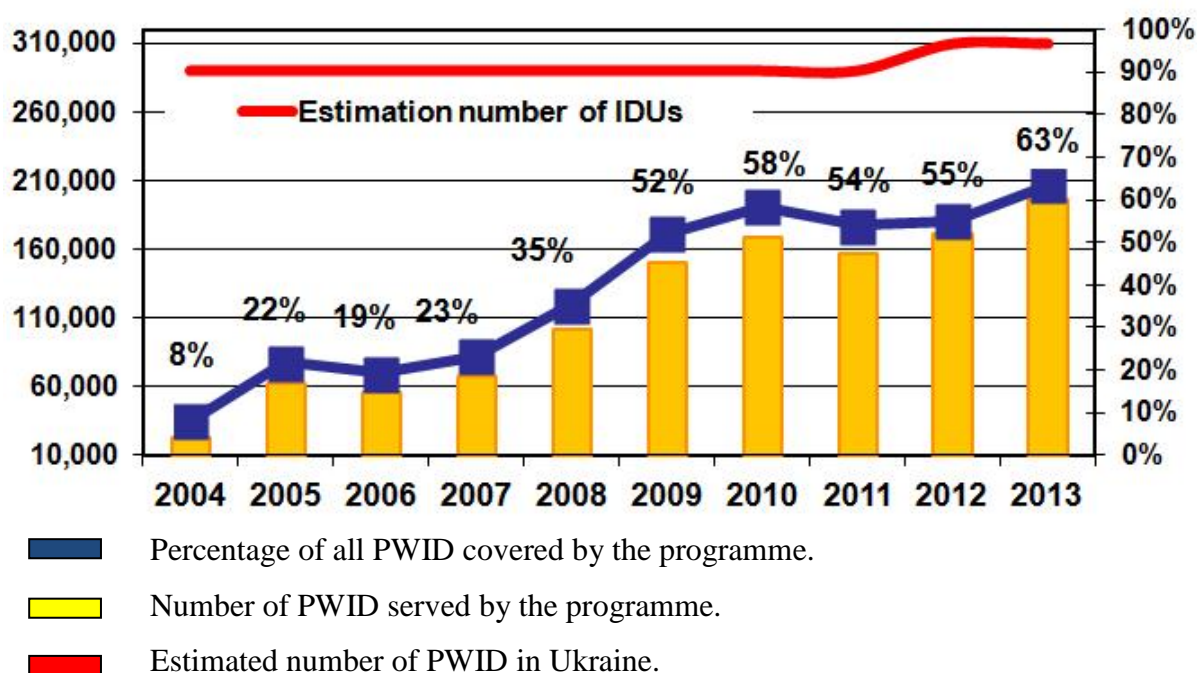
**Map 2: Location of harm reduction interventions in Ukraine supported by the Alliance**

Source: International HIV/AIDS Alliance in Ukraine. Annual Report 2011. Kiev, International HIV/AIDS Alliance, 2012.

#### 4. OVERVIEW OF THE ALLIANCE UKRAINE PROGRAMME

The Alliance Ukraine programme for the prevention of HIV/AIDS amongst People Who Inject Drugs (PWID) has been ongoing since 2004 and is governed by Law No. 1026-VI of Ukraine entitled, the ‘State programme of prevention of HIV infection, treatment, care and support of HIV infected and people living with AIDS for 2009-2013’<sup>22</sup>.

Fig. 7, below, shows the overall increase in the coverage of PWID who receive harm reduction services from the local partners of Alliance Ukraine that correspond to the recommended priority interventions of WHO, UNODC and UNAIDS, respectively<sup>23</sup>.



**Fig. 7: Alliance Ukraine PWID Programme Coverage, 2004-2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2014.

Though, only 29.8% of the number of IBBS respondents reported being registered clients of NGO’s and possessing client cards<sup>24</sup> even though 55% of PWID are served by the HIV/AIDS prevention programme in Ukraine (Fig. 7, above). Alliance Ukraine, through its partners, has the target of reaching 179,800 PWID with its HIV/AIDS prevention programme by the end of 2013<sup>25</sup>.

<sup>22</sup> Op. cit.

<sup>23</sup> WHO, UNODC, UNAIDS, Op. cit., p7.

<sup>24</sup> Balakiryeva, O.M., Bondar, T.V., Sereda, Yu.V., and Sazonova, Ya.O. Analytical Report: Behaviour Monitoring and HIV Prevalence among Injecting Drug Users as a component of Second Generation Sentinel Surveillance (based on results of the 2011 bio-behavioural survey). Kiev, International HIV/AIDS Alliance and the Olexander Yaremenko Ukrainian Institute for Social Research, 2012, p90.

<sup>25</sup> Email correspondence with Igor Matviichuk, International HIV/AIDS Alliance in Ukraine, Kiev, July 23, 2013; this is also the target for Phase II of Global Fund Round 10.

#### **4.1 Availability and accessibility of the Comprehensive Package of nine key interventions recommended by WHO/UNODC/UNAIDS**

Of the nine key interventions that comprise the ‘comprehensive package’ for the prevention, treatment and care for PWID recommended by WHO, UNODC, and UNAIDS, respectively, “countries should prioritize implementing NSPs and evidence-based drug dependence treatment (specifically OST). Countries should also ensure that people who inject drugs are successfully reached by the other interventions of the Comprehensive Package”<sup>26</sup>. Therefore, the following is a review of the availability and accessibility of each of the 9 interventions of the ‘comprehensive package’, with a particular focus on NSPs and OST, respectively.

##### **4.1.1 Needle and Syringe Programmes (NSPs)**

Sterile needles and syringes are available to PWID in 146 regions of Ukraine.

Needle and syringe programmes (NSPs) distribute sterile needles and syringes free of charge to PWID at fixed sites as well as through mobile and outreach services with the objective of facilitating the use of sterile needles and syringes and in reducing the number of injections with used needles and syringes. Article 4.1.8 of the Law on AIDS specifically supports the distribution of injecting equipment through NSPs as do national police guidelines and policy, including client confidentiality<sup>27</sup>. Furthermore, national policy stipulates that NSP services should be “low-threshold” and PWID are not required to meet specific criteria in order to access services or receive injecting equipment and that the return of used injecting equipment is not a prerequisite for clients to receive new injecting equipment. However, legislation does not support the provision of NSP services in prisons and other closed settings and there is no national system to prevent NSP stock-outs. Automated vending machines to dispense injecting equipment are not part of the NSP in Ukraine at present<sup>28</sup>.

The partners of Alliance Ukraine were responsible for 1,667 sterile needle and syringe programme sites in 2011<sup>29</sup>. Approaches to the distribution of sterile needles and syringes include:

- a) Outreach to the community on foot by NGO outreach workers;
- b) Community access through the availability of mobile clinics that visit specific locations at pre-designated days and times that are known to the community;
- c) Small packs of sterile needles/syringes, condoms, and IEC materials are available through pharmacies located nearby areas with a known high prevalence of injecting drug use.

Regular reach by a NSP is defined by Alliance Ukraine as at least once in every 12 month reporting period. The Alliance Ukraine target is to reach 179,800 individual PWID in Ukraine per year with HIV prevention services, including a sterile needle/syringe; this equates to 58% of the estimated number of PWID in Ukraine. However, the Alliance Ukraine

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<sup>26</sup> WHO, UNODC, UNAIDS, Op. cit., p11.

<sup>27</sup> Op. cit.

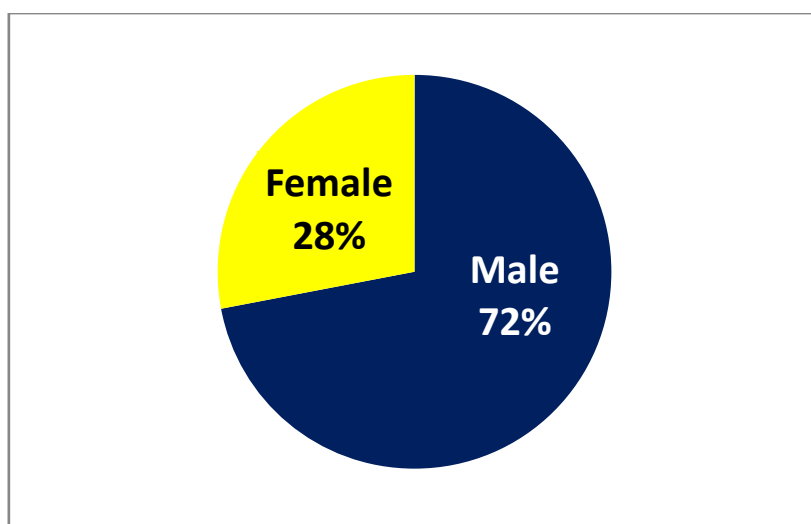
<sup>28</sup> Shaw, G. Harm Reduction Questionnaire, Section 2, NSP. Kiev, WHO, 18 July 2013.

<sup>29</sup> Ukraine harmonized AIDS response progress report, 2012, Op. cit., p47.

target for 2013 of providing each of the 179,800 PWID with 150 sterile needles/syringes<sup>30</sup> falls short of the WHO, UNODC and UNAIDS recommendation of 200 or more sterile needles/syringes to be distributed free of charge to each individual PWID per year<sup>31</sup>.

During 2012, a total of 171,958 PWID received at least one sterile needle/syringe through Alliance Ukraine and its partners, equating to 56% of the estimated total population of PWID in Ukraine. With such a target of 56% of the total estimated PWID population nationwide (i.e. 171,958 PWID), Alliance Ukraine and its partners were able to distribute 121 sterile needles/syringes in 2012 to each PWID<sup>32</sup>. By the end of 2013, this increased to 138 sterile needles/syringes per PWID<sup>33</sup>.

Just over one-quarter of NSP recipients are female (see Fig 8). Females are reported to use drugs less frequently than males during the previous seven days<sup>34</sup>. Furthermore, the use of stimulants is more prevalent among female and young PWID than among males and PWID aged more than 24 years<sup>35</sup>.



**Fig. 8: NSP distribution by gender through Alliance Ukraine partners in the first quarter 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013; Shaw, G. Harm Reduction Questionnaire. Kiev, WHO, July 2013.

As at the end of March 2013, NSP outreach took place at 747 sites throughout Ukraine and fixed site NSPs were implemented by 104 local partners of Alliance Ukraine, totalling 1,606 NSP sites throughout the country; mobile NSP was provided at 143 sites and through 15 mobile clinics<sup>36</sup>.

<sup>30</sup> SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013; Email correspondence with Igor Matviichuk, Op. cit.

<sup>31</sup> WHO, UNODC, UNAIDS technical guide, Op. cit., p53.

<sup>32</sup> Shaw, G. Harm Reduction Questionnaire, Section 2, NSP. Kiev, WHO, 18 July 2013; SYREX programme data, Op. cit. 2014.

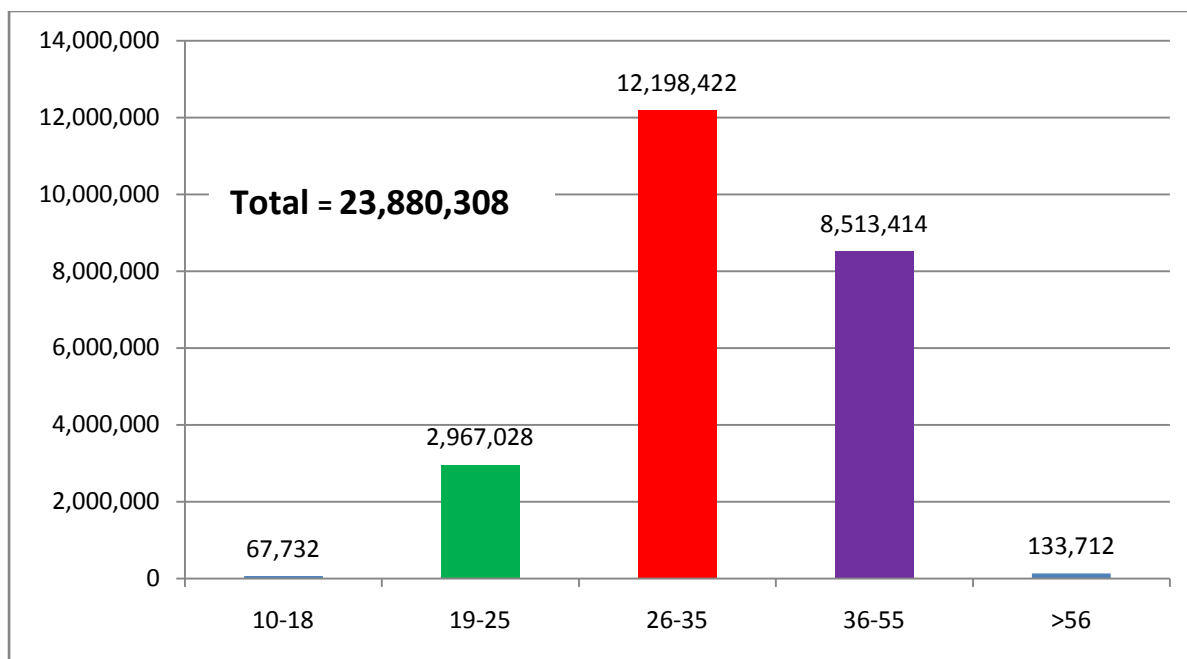
<sup>33</sup> SYREX data. Op. cit 2014.

<sup>34</sup> Balakiryeva, O.M., et al, Op. cit., p40.

<sup>35</sup> Balakiryeva, O.M., et al, Op. cit., p43.

<sup>36</sup> Shaw G. Harm Reduction Questionnaire, Section 2, NSP. Kiev, WHO, 18 July 2013.

Sterile needles/syringes can be purchased in any pharmacy in Ukraine. There are a number of pharmacies which are enrolled in the HIV prevention activities and distribute sterile needles/syringes for clients of harm reduction projects for free. As of the end of March 2013, there were 146 such pharmacies in 13 regions of Ukraine providing PWID with free sterile needles/syringes.



**Fig. 9: NSP distribution by age group through Alliance Ukraine partners in 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2014.

Analysis of the IBBS 2011 data shows that, “the average frequency of drug use over the previous 30 days is 21.7 times, over a week – 5.1 times and over 24 hours – 0.7 times”<sup>37</sup>. This equates to approximately 260 injections per PWID, per year, on average, meaning that for the estimated PWID population of 310,000, a total of 80,724,000 injection events take place each year.

The total number of sterile needles/syringes distributed through the local partners of Alliance Ukraine during 2013 was 23,880,308 (see Fig. 9, above); this equates to approximately 138 sterile needles/syringes per PWID of those targeted by Alliance Ukraine and its partners. However, it is important to note that Alliance Ukraine and its partners **do not attempt to provide NSP to each PWID for each injection event** in Ukraine as many PWID access such commodities by purchasing them from pharmacies without the involvement of any NGO or Government agency. The availability of sterile needles/syringes is high and the price of needles/syringes is very low in comparison with the price of a dose of an opiate drug. IBBS 2011 notes that 68.8% of PWID reported that they bought syringes/needles during the previous month, with male PWID buying such commodities more often than female PWID (72.2% versus 59.5%)<sup>38</sup>. It is important to emphasize here that the overall aim of Alliance Ukraine is to change the behaviour of PWID through the consistent use of sterile needles/syringes and related injecting equipment and access by PWID to sterile

<sup>37</sup> Balakiryeva O.M., et al, Op. cit., p41.

<sup>38</sup> Balakiryeva O.M., et al, Op. cit., p88.



needles/syringes through pharmacies using their own funds is a long-term sustainable modus operandi.

In 2011 in 13 of the 27 administrative regions of Ukraine, 143 pharmacies in cooperation with 25 NGOs serviced 26,973 PWID, including 11,062 new clients, equating to 20.6% of all new PWID brought into prevention programmes by partners of the Alliance in 2011. Services were also provided to 403 FSWs, 32 MSM, and 27 non-injecting drug users. In total, pharmacies distributed 2,121,012 syringes and 123,302 needles in 2011. Needle/Syringe exchange was undertaken in 32 pharmacies during 2011, resulting in the collection of 265,346 used syringes<sup>39</sup>. Follow-up and continuity of care are strengthened through case management instituted by the referring service.

IBBS 2011 also shows that 95.5% of the target population of PWID reported the use of sterile injecting equipment the last time they injected drugs; the data does not provide details, however, as to the source of such sterile injecting equipment<sup>40</sup>. Analysis of data related to needle/syringe sharing from IBBS 2011 also shows that such sharing was not a regular practice during the previous 30 days<sup>41</sup>. However, IBBS 2011 also reports that 56.2% of PWID who never used a used needle/syringe also reported receiving an injection with a 'pre-filled syringe', leaving open the possibility that such PWID were undertaking such injections with contaminated equipment even though they believed that such equipment was unused<sup>42</sup>. For the purpose of this review, coverage is considered to be based on the data provided in the IBBS 2011, i.e. coverage of 95.5% of PWID regardless as to the source of the sterile equipment. However, based on the continued risky injection practices as outlined above, even the high coverage of NSP is insufficient by itself to inhibit HIV transmission amongst the PWID community as a whole.

Fig. 10, below, shows the percentage by age group of PWID reached by an NSP in each of the previous 12 months.

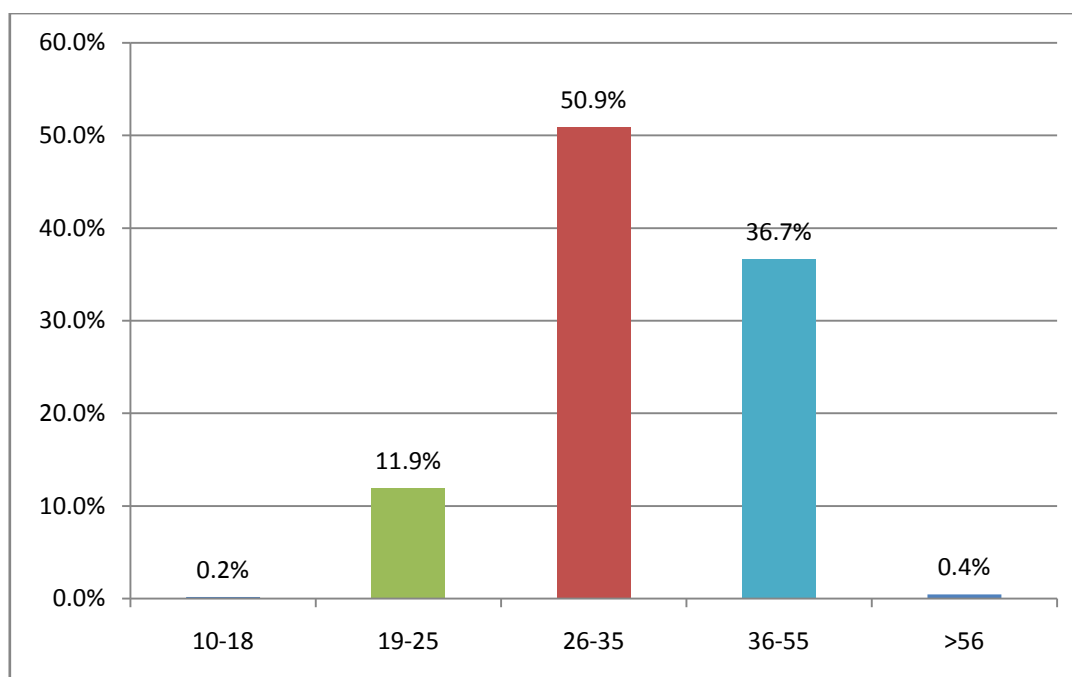
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<sup>39</sup> Alliance Ukraine. Annual Report 2011, Op. cit., p44.

<sup>40</sup> Balakiryeva O.M., et al, Op. cit., p44.

<sup>41</sup> Balakiryeva O.M., et al, Op. cit., p45.

<sup>42</sup> Balakiryeva O.M., et al, Op. cit., p47.



**Fig. 10: Percentage of all PWID reached by an NSP every month in the last 12 months as of 31 December 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013; Shaw G. Harm Reduction Questionnaire. Kiev, WHO, July 2013.

However, since 2010, legislative Order No. 188 has provided heavy sanctions against PWID who are in possession of extremely minute quantities of illicit drugs, such as the residue remaining in a use needle or syringe. This has resulted in many PWID refusing to exchange their used needles/syringes at NSP sites due to fear of police action against them for being in possession of quantities of drugs above those provided for in Order No. 188.

### Recommendations

Assistance should be provided by WHO, UNODC and UNAIDS as one consolidated UN group – and in collaboration with other concerned stakeholders such as Alliance Ukraine – to the Ministry of Health, the Ministry of Interior, the Cabinet of the Council of Ministers and, in particular, to the head of the State Service of Ukraine on Drug Control for the immediate revision of Order No. 188 so that it provides for quantities of drugs that are commensurate with WHO guidance and the norms as used in other countries of the region and beyond.

NSP service delivery is taking place through a wide range of modalities that make it possible for PWID to access such NSP services through one or more of the mechanisms available without undue diversion from their normal daily or weekly lifestyles. Also, whilst not totally attributable to the direct actions of Alliance Ukraine and its partners in all locations at all times, NSP is being implemented throughout Ukraine as part of a broad package of harm reduction interventions. Rather than being considered negatively, the fact that Alliance Ukraine believes in allowing the free market to play a major role in NSP provision is actually allowing limited development partner resources to be focused on those programme areas where the free market is unable, as of yet, to play a role, such as the provision of OST services to PWID and other key populations.

Furthermore, the integration of NSP into other services, such as OST, HTC, TB, and vice-versa, is an effective approach to increase access for PWID and to link PWID with other harm reduction and associated services. Female and younger PWID are being targeted by NSP services which is vital. Greater focus is needed, however, in targeting MSM who inject drugs due to their multiple HIV risk behaviours and apparent lack of reach to such a key population to-date and for research to be conducted on the possible need of NSPs for transgender people, especially transgender women who may also need sterile needles/syringes for hormonal and gender enhancement.

#### **4.1.2 Opioid Substitution Therapy (OST)**

OST is available at no cost to PWID in Ukraine.

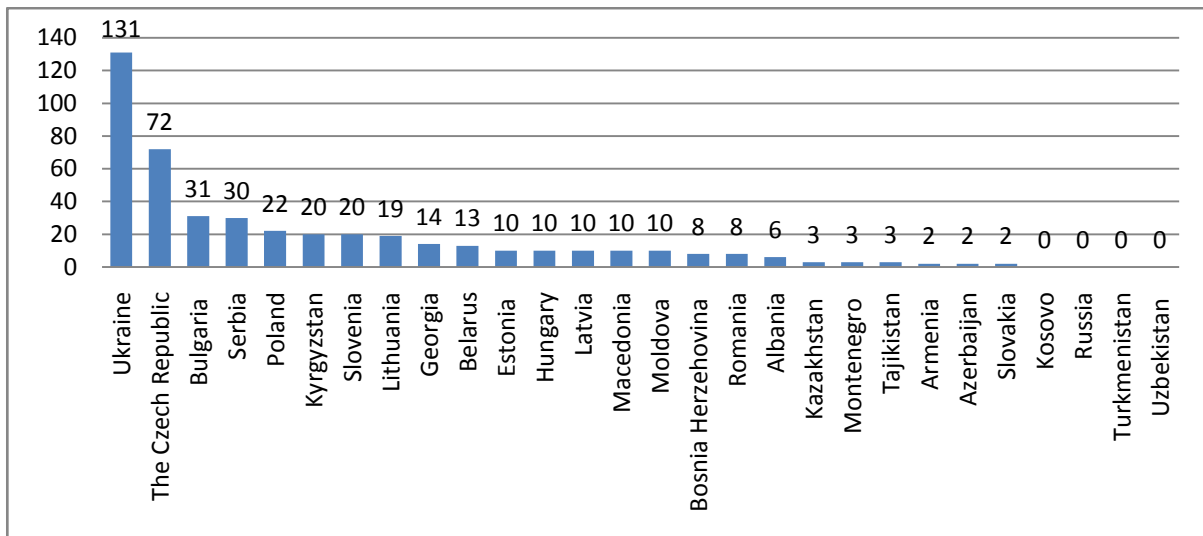
The most recent estimate of the number of PWID in Ukraine is 310,000 (IBBS 2011) of which 62.3% report using only opiates and a further 20.3% report poly drug use, meaning the use of opiates and stimulants. Therefore, the total number of people using opiates is estimated to be 256,060, or 82.6% of the total estimated number of PWID in Ukraine. However, official Government data states that there are 52,913 opiate dependent people in Ukraine<sup>43</sup>. This is a considerably lower number than the IBBS 2011 figure used by Alliance Ukraine, its local NGO partners, and the Global Fund for its Round 10 funding of OST implementation nationwide.

The provision of OST services began in 2005 and is available free-of-charge to patients/clients through Government/NGO partnership services at 156 health care facilities throughout the country as of July 2013, a major increase from the 10 sites established in Ukraine between 2005 and the end of 2007<sup>44</sup>, the largest number of such sites in the Eurasia region (see Fig. 11, below).

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<sup>43</sup> Email correspondence with Sergii Filippovych, Associate Director: Treatment, International HIV/AIDS Alliance in Ukraine, 18 July 2013.

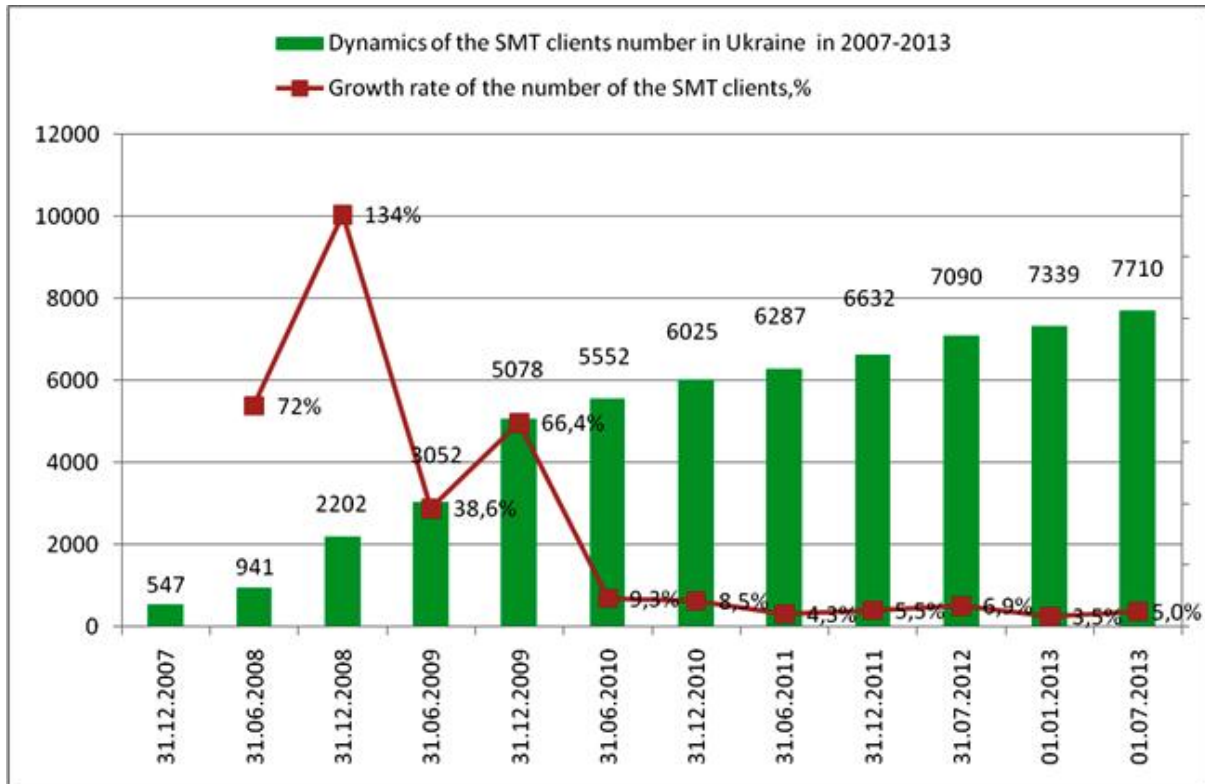
<sup>44</sup> SYREX programme data, Op. cit., 2013; Shaw G. Harm Reduction Questionnaire, Kiev, WHO, July 2013.



**Fig. 11: Number of OST sites in countries of Eurasia, as of 2011**

Source: Alisher Latypov, A. B., Avet Khachatarian. Opioid substitution therapy in Eurasia: how to increase the access and improve the quality, in, International Drug Policy Consortium (Ed.). IDPC briefing series on drug dependence treatment, No. 1. United Kingdom, International Drug Policy Consortium, 2012, p1-19; note: Czech Republic: Subutex is distributed through a network of psychiatrists & general practitioners (N 150-240); Slovakia: Subuxone is distributed through a network of psychiatric outpatient units.

OST sites operate at a range of health care facilities including those at ‘narcological and psychoneurologic’ dispensaries, at AIDS Centres, at hospitals treating communicable diseases, at TB dispensaries, as well as at local and district general hospitals. Grant agreements exist between Alliance Ukraine and 33 local NGOs to support OST implementation, including medical and psychosocial support in collaboration with such health care facilities and government staff. There are approximately 600 staff working on OST implementation nationwide, of which around 75% are medical specialists and 25% are social workers and psychologists. Fig. 12, below, shows the increase in the number of people receiving OST between December 2007 and July 2013 as well as the annual growth rate of the number of OST clients.



**Fig. 12: Cumulative number of people receiving OST and growth rate in new patients/clients in Ukraine, 2007-2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013 and 2014; Email correspondence with Victor Kolomiets, Senior Programme Officer: Substitution Treatment, International HIV/AIDS Alliance in Ukraine, Kiev, 29 July 2013.

As of June 2013, there were 7,594 people receiving OST nationwide, of which 6,773 people (89%) were receiving the tablet form of Methadone, with the remainder of people receiving Buprenorphine (821 people, or 11% of the total). The number of men receiving OST outnumbered women by a factor of 4-to-1<sup>45</sup>.

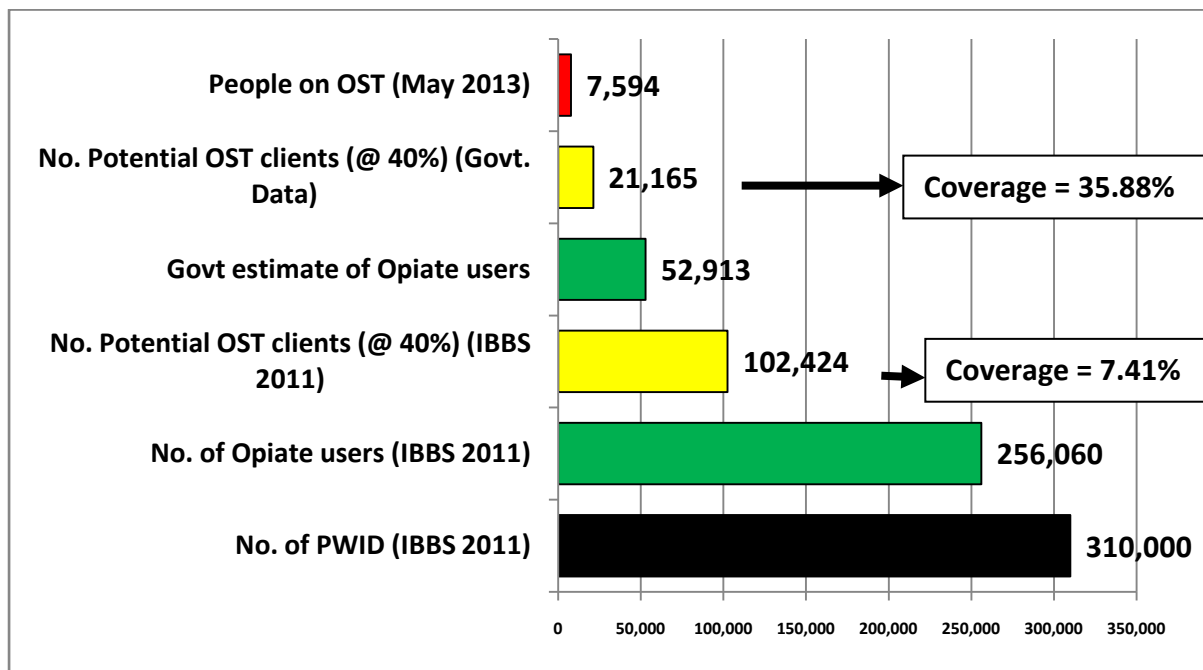
<sup>45</sup> Ukraine harmonized AIDS response progress report, 2012, Op. cit., p47.

Depending on which population size estimate (or denominator) is used, **coverage of OST service delivery nationwide** is either:

**LOW** at 7.41% using the IBBS 2011 population size estimate of all opiate users in Ukraine together with the WHO recommendation of 40% of opiate users will be suitable for OST; or,

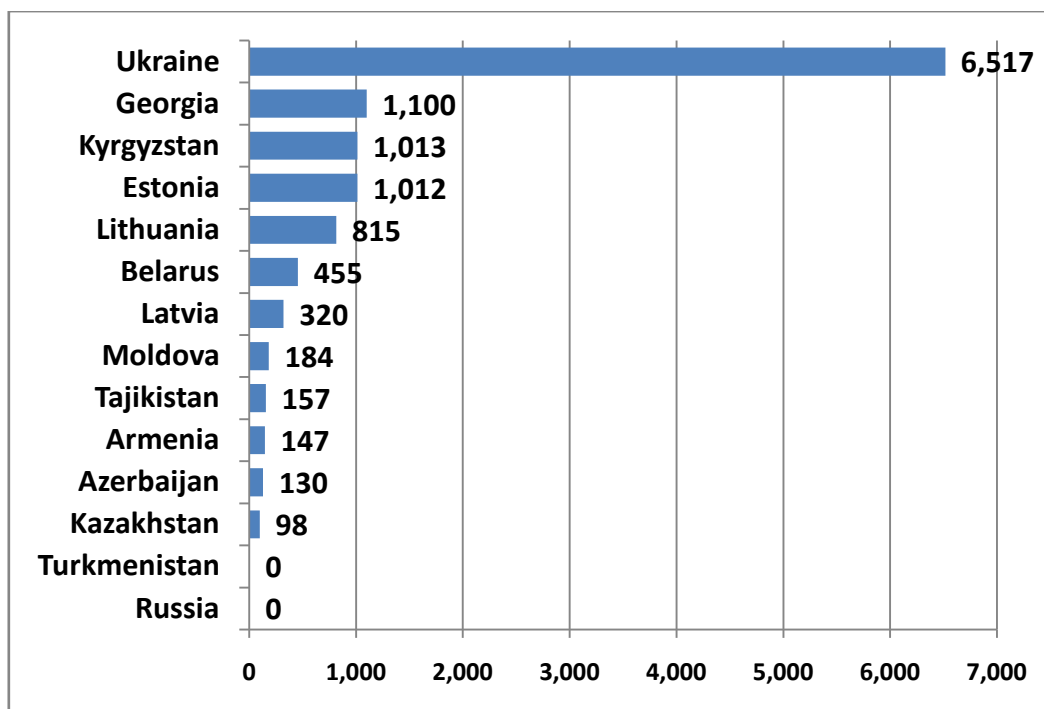
**MEDIUM** at 35.88% using Government data on the estimated opiate using population in Ukraine together with the WHO recommendation of 40% of opiate users will be suitable for OST.

Fig. 13, below, gives the comparison of different estimates of OST coverage in Ukraine as of mid-2013. Therefore, using the data from the IBBS 2011, the coverage of OST amongst PWID in need of it is quite low. However, compared to **ALL** the other countries of the former USSR, Ukraine is far ahead in the absolute number of people receiving OST. Consequently, Ukraine can be considered as a ‘good practice’ in terms of the number of people on OST and also the integrated care centre approach that is being rapidly developed in the country together with active case management to assist OST patients/clients to access ART and related care and support services (see Section 4.5).



**Fig. 13: Comparison of different estimates of OST coverage in Ukraine, mid-2013.**

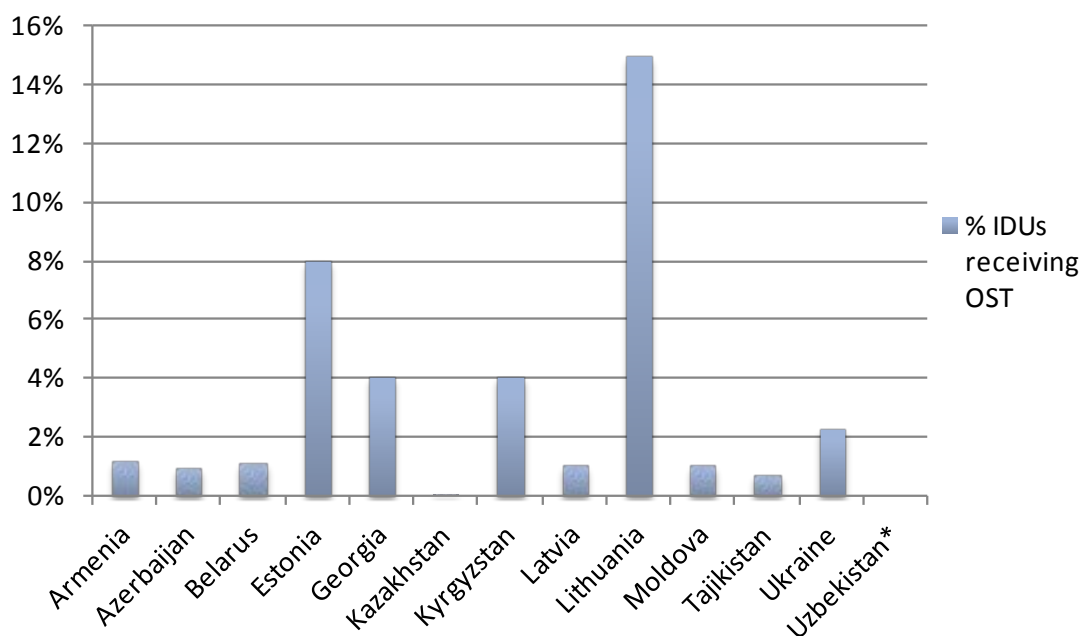
It must be noted, however, that Ukraine currently has more patients on OST than any other country of the former USSR as can be seen in Fig. 14, below.



**Fig. 14: Number of people on OST in countries of the former USSR as of 2011.**

Source: Alisher Latypov, A. B., Avet K. Opioid substitution therapy in Eurasia: how to increase the access and improve the quality, in, International Drug Policy Consortium (Ed.). IDPC briefing series on drug dependence treatment, No. 1. United Kingdom, International Drug Policy Consortium, 2012, p1-19.

Fig. 15, below, gives a comparison of the proportion of PWID on OST in countries of the former USSR as of 2011.



**Fig. 15: Comparison of the Percentage of PWID receiving OST in countries of the former USSR, 2011.**

Source: Donoghoe, M. C. Why is the HIV epidemic in eastern Europe and central Asia the fastest growing in the world and what do we need to do to halt it? Paper presented at the XIX International AIDS Conference, USA, 2012.

Of all those on OST, 3,272 people (43%) are living with HIV, with 1,407 of those people (43%) receiving ART. 307 people (9%) living with HIV and taking OST are on a waiting list to access ART. 1,305 of OST patients/clients (17%) have TB, 1,484 people (20%) have Hepatitis B, and 3,681 people (48%) have Hepatitis C<sup>46</sup>.

Of particular note in Ukraine is the development by the Alliance and its local NGO partners, in close collaboration with the Ministry of Health, of service integration, both of medical and psychosocial support. In reality, this realizes the engagement in programme activities of the respective specialists of key government agencies and NGOs, in particular doctors dealing with drug dependence, the diagnosis and treatment of communicable diseases, as well as nurses, social workers, and psychologists. Wherever possible, all such services are available at one site through what is called an ‘Integrated Care Centre’. This is particularly helpful for OST patients/clients as it is helping to keep adherence levels relatively high. Currently, there are 83 such ‘Integrated Care Centres’ operational throughout Ukraine, or 54% of all OST sites in the country<sup>47</sup>; Section 4.5 provides more detail of this integrated approach to service delivery.

Whether such integrated care services exist or not, OST patients/clients receive counseling, testing and, as needed, treatment for drug dependence, HIV/AIDS, STIs, TB, vaccination against viral Hepatitis B and support for those who have Hepatitis C, respectively. If other medical services are required and not available at the same site as the OST service, referral or assisted referral of patients/clients is made to other medical facilities, such as for surgery, obstetric and gynecologic services, for example. OST is available at some medical facilities where PWID are referred for various services, such as TB diagnostics and treatment, although such an approach is not yet widespread.

Medical follow-up includes support for the individual to adhere to OST as well as to ART, if required, and other treatments such as for TB and Hepatitis B vaccination. A range of psychosocial support services are also available to the OST patient/client. Social support is provided by the collaborating local NGOs to help the person receiving OST to apply for necessary government documentation, such as an identification card, in order to access a broad range of services including ART, and to also support the individual to restore family relations, and for the stabilization of mental and/or emotional conditions, recovery and the forming of safe behaviours of the individual through psychological interventions. Social support and assistance is also given to the OST patient/client with regards to accessing education, finding employment opportunities, and the development of resocialization and reintegration skills to help the individual to become part of mainstream society once again.

“For my way of life, this kind of programme is a panacea!”

A male OST patient/client, Kiev, 5 July 2013

“Because of this OST programme, I have had positive changes with my family; my family trust me now.”

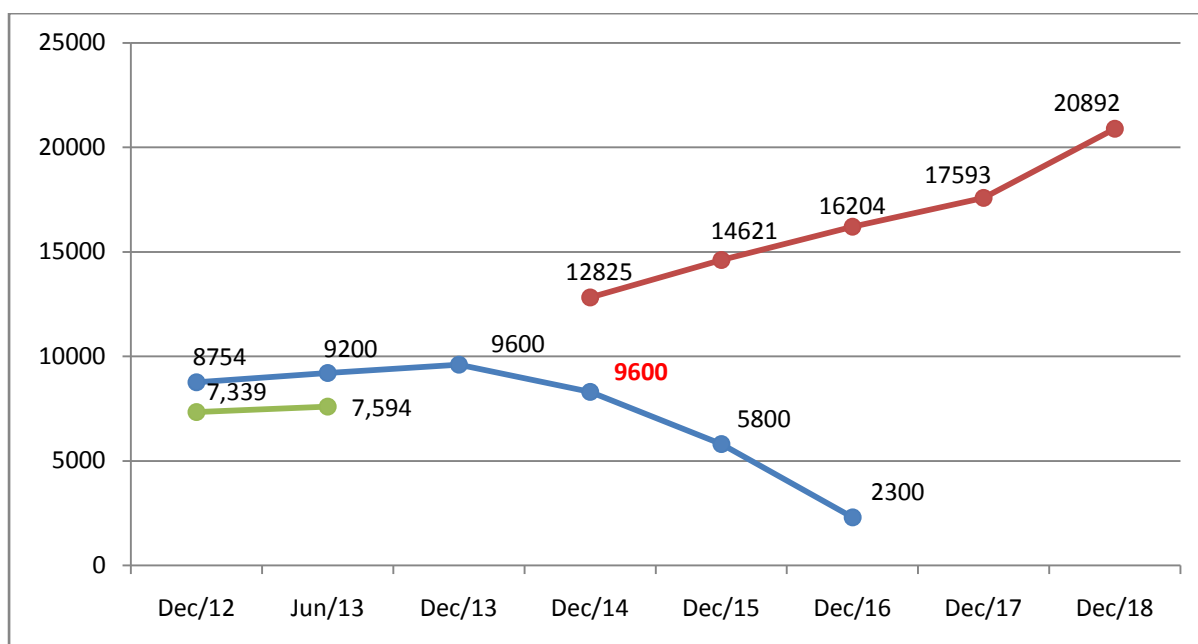
A female OST patient/client, Kiev, 5 July 2013

<sup>46</sup> SYREX programme data. Op. cit., 2013.

<sup>47</sup> SYREX programme data. Op. cit., 2013.



Key achievements of OST include gainful employment by almost 24% of patients/clients on the programme and more than 9% of such people have restored family relations. 5% of OST participants have started families and 2% of patients/clients have become parents. A further 1.6% of patients/clients have started studying for a qualification<sup>48</sup>.



- Global Fund Programme indicator
- National Programme indicator
- Number of patients/clients receiving OST

**NB:** For 2014, the Global Fund indicator was revised to 9,600 patients, indicated in red text.

### Fig. 16: Planned scale-up of OST services in Ukraine, 2012-2018

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013; Shaw G. Harm Reduction Questionnaire. Kiev, WHO, July 2013.

It must be stressed that the work towards implementation, expansion and improving the quality of OST services by Alliance Ukraine has been undertaken within a very rigid health care system and in the context of a lack of state ownership of the OST programme until very recently. In addition, drug treatment doctors have been very reluctant to accept OST as a treatment option for opiate-dependent people. Such challenges have proven the benefit of supporting community-led advocacy by PWID themselves. For example, in 2009 Alliance Ukraine began supporting ASTAU, a community-led advocacy group, that contributed to introducing prescription-based OST in some regions of the country; patients were involved in oversight of the quality of purchased medications and in supporting new clients.

The scale-up of OST services is planned through Phase 2 of Global Fund Round 10 and, most importantly, through the increasing funding that will be made available from the Government budget as from the start of 2015, as shown in Fig. 16, above. Such government investment is a key to sustaining the OST programme in Ukraine when funds from the Global Fund either

<sup>48</sup> SYREX programme data, 2013, Op. cit.; Shaw G, Op cit.

cease or are substantially reduced in the future. However, with a target of 20,892 people on OST by 2018 through 100% Government funding, coverage will be either low at 20.4% (using IBBS 2011 as the denominator) or high at 98.7% (using Government estimates) of the estimated number of opiate-dependent people who could benefit from OST nationwide.

### Recommendations

It is with some urgency that technical assistance should be provided to the relevant agencies of the Government of Ukraine to reconcile the difference between their estimate of the number of opiate users in Ukraine and the estimate generated by IBBS 2011 in order to reach consensus between all stakeholders as to the denominator to be used when calculating coverage of OST services and, crucially, the targets to be set for rapid scale-up of such services throughout the country with the subsequent burden of cost falling upon the Governmental budget. Further efforts should also be expended in motivating female opiate dependent people to enter into OST and for both male and female OST patients/clients to be given socioeconomic support by all current and future OST sites in addition to just the medical intervention of OST itself. Consideration could also be given to introducing different 'streams' for OST clients, such as one stream for stable patients and another for those less stable, in order to make it easier to maintain the progress achieved. Attention should also be given to increasing access to prescription-based OST provision and take away doses, as well as ensuring continuity of OST delivery in cases of in-patient hospitalization. OST in prisons and other closed settings should also be considered as a matter of urgency.

#### **4.1.3 HIV Testing and Counselling (HTC)**

HTC is available free of charge to PWID in Ukraine.

An amendment to the Law, 'On Prevention of Acquired Immune Deficiency Syndrome (AIDS) and Social Protection of the Population', No. 2861-17, of December 23, 2010, provided for the voluntary testing of all persons aged 14 years and older after obtaining informed consent for testing from the individual<sup>49</sup>.

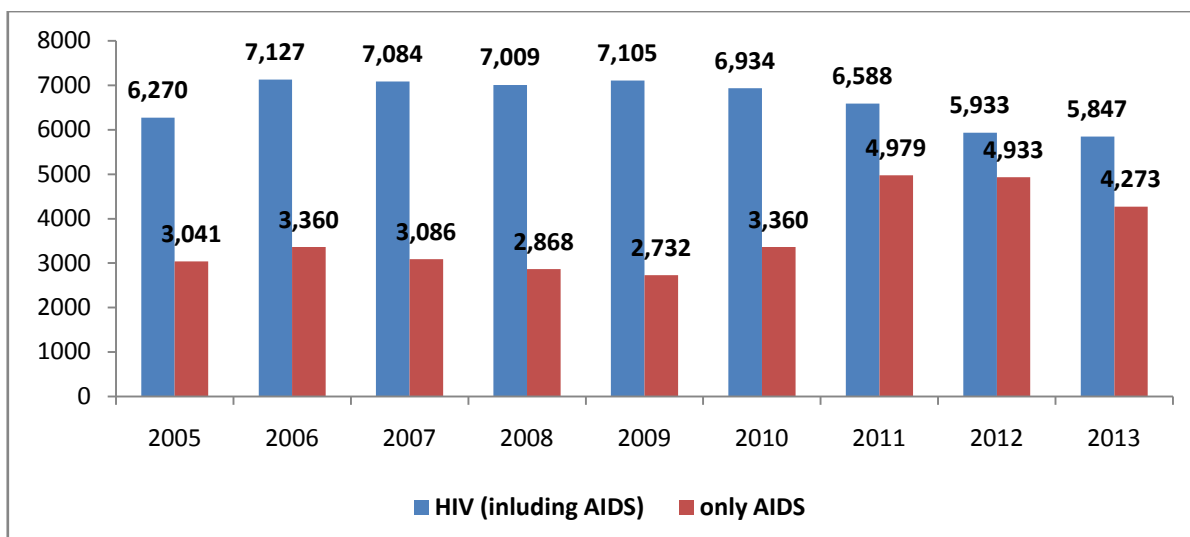
In 2012, a total of 104 NGO partners of Alliance Ukraine implemented 80,089 rapid HIV tests involving PWID at 137 HIV testing and counselling sites throughout the country, of which 15% of such sites also provide NSP. In addition, all 153 OST sites in Ukraine also provide HTC services. Outreach services targeting PWID also provide HTC and linkages with care and treatment services where needed, on a voluntary basis, as do 15 mobile clinics<sup>50</sup>. HTC targeting PWID is also available at regional and city AIDS Centres, as well as at TB clinics and dispensaries nationwide. 45,105 ELISA HIV tests were funded by Alliance Ukraine in 2012 and 28,473 during the first quarter of 2013; such tests were only undertaken at health care facilities<sup>51</sup>.

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<sup>49</sup> Balakiryeva O.M., et al, Op. cit., p76.

<sup>50</sup> Shaw G. Harm Reduction Questionnaire, Section 4, HTC & ART. Kiev, WHO, 18 July 2013.

<sup>51</sup> Ibid.



**Fig. 17: Number of HIV and AIDS cases by year among PWID, 2005-2013**

Source: Shaw G. Harm Reduction Questionnaire. Kiev, WHO, July 2013. HIV (including AIDS) is the total number of HIV-positive cases regardless of CD4 count; AIDS is the number of HIV-positive cases with a CD4 count of less than 200 cells/mm<sup>3</sup> or with opportunistic infections (data for 2005-2012); L.V. Gromashevsky Institute for Epidemiology and Infectious Diseases of the National Academy of Medical Sciences of Ukraine, HIV infection in Ukraine, Newsletter No. 41, Ukrainian Centre for AIDS Prevention and Control, Ministry of Health, Kiev, 2014, p52 (data for 2013).

However, according to IBBS 2011, only 35.7% of PWID undertook testing for HIV over the previous 12 months with the unwillingness to undergo such testing or lack of information on where to go to get tested as the main reasons why more PWID did not undertake such testing<sup>52</sup>. But compared to 2008/2009, the share of PWID who did get tested for HIV in the previous 12 months and also received their results increased significantly from 27.9% to 35.7%<sup>53</sup>.

A comparison of the number of HIV and AIDS cases by year among PWID from 2005 to 2013 can be seen at Fig. 17, above.

If a rapid test result is positive, a PWID is referred to an AIDS Centre for a confirmatory HIV test; increasingly, Alliance Ukraine and its partners are providing assisted referral and case management support to such PWID who have a positive HIV rapid test result in order to assist them through the somewhat complex paperwork required to access ART.

In 2011, 7,660 MSM were tested for HIV using rapid tests, of which 237 were positive (3%)<sup>54</sup>.

HTC training is delivered to NGO partners by Alliance Ukraine with a certificate issued to each trainee once they have successfully completed the training course. However, no independent agency certifies the Alliance Ukraine master trainers regarding HTC.

<sup>52</sup> Balakiryeva O.M., et al, Op. cit., p83.

<sup>53</sup> Balakiryeva O.M., et al, Op. cit., p79.

<sup>54</sup> Alliance Ukraine. Annual Report 2011, Op. cit., p50.

## Recommendations

In summary, far more PWID need to be encouraged to undergo HTC than is currently the case. A range of awareness and advocacy approaches are needed so that far more than 35.7% of PWID will undertake testing for HIV in the future. Ongoing research should be considered so as to learn as to the reasons why PWID are reluctant to access HTC services and to revise advocacy and service delivery approaches accordingly. Periodic certification and recertification of Alliance Ukraine master trainers by an independent agency would help to maintain high quality and up-to-date approaches. Furthermore, those testing positive for HIV should be linked to ongoing care and, if needed, treatment.

### **4.1.4 Antiretroviral Therapy (ART)**

ART is available to PWID in Ukraine at no cost to the patient.

In 2013, 0.62% of the general population aged 15 to 49 years were reportedly living with HIV in Ukraine<sup>55</sup>. Of the estimated 220,000 PLHA, 101,222 are believed to be in need of ART<sup>56</sup>.

The Government pays for some of the ARVs required and also for laboratory diagnostic kits for HIV testing. The stated goal of the Government is to decentralize the management and scale-up of ART provision to the regional level and below. However, due to the difficult economic conditions faced by the Government, no funding is yet available for such support<sup>57</sup>.

The All-Ukrainian Network of People Living with HIV/AIDS is responsible for the provision of care and treatment for all people who are HIV-positive in Ukraine, including members of key populations, and use their own Unique Identifier Code (UIC) system. Alliance Ukraine is officially only responsible for HIV prevention. The first phase of Global Fund Round 10 has distributed funds on this basis.

One-in-five PWID (21.6%) are HIV-positive, a status that has been relatively stable since 2009<sup>58</sup>, and HIV is slightly more prevalent among female PWID (24%) than it is among male PWID (21%)<sup>59</sup>.

As of the end of 2012, there were 3,811 PWID receiving ART out of 5,935 registered HIV cases among PWID, i.e. 64%<sup>60</sup>. As of May 1, 2013, this number had increased to 4,689 active PWID, or 10.5% of the 44,525 people who received ART in Ukraine. Of the 154 drug treatment sites in Ukraine, 129 of them (84%) provide ART<sup>61</sup>.

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<sup>55</sup> Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). National HIV/AIDS estimates. Kiev, UCSDDC, 2013; Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). HIV Infection in Ukraine. Bulletin No. 41, Kiev, UCSDDC, March 2014.

<sup>56</sup> Ukrainian Centre for AIDS Prevention and Control. HIV infection in Ukraine, Newsletter No. 40. Kiev, Ministry of Health of Ukraine, 2013.

<sup>57</sup> Meeting with Aleksandrina Tetiana, Head, State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases, Kiev, 9 July 2013; Meeting with Natalia Nizova, Director, Ukrainian Center for Disease Control, Ministry of Health of Ukraine, Kiev, 10 July 2013.

<sup>58</sup> Balakiryeva O.M., et al, Op. cit., p97.

<sup>59</sup> Balakiryeva O.M., et al, Op. cit., p95.

<sup>60</sup> Shaw G. Harm Reduction Questionnaire, Section 4, Op. cit.

<sup>61</sup> Shaw G. Harm Reduction Questionnaire, Section 4, Op. cit.

A multidisciplinary team provides HIV treatment and care at health care facilities, primarily AIDS Centres, involving nurses, social workers, psychologists, doctors specializing in communicable diseases, and other medical specialists as required, such as TB and STI doctors.

However, access by PWID to ART services has, until recently, been restricted due to insufficient referral and linkages from, and between, NGOs and health care facilities, resulting in PWID ‘dropping out’ of the HIV/AIDS continuum of care. This issue is being addressed through the rapid introduction and scale-up of assisted referral by Alliance Ukraine and its partners and, most importantly, of case management to support the individual PWID, if needed, to access all relevant health and social services, especially ART for those PWID who are HIV-positive. Other reasons why PWID may be dropping out of the continuum of care could include poor quality OST provision whilst they are hospitalised and also improper care for stimulant users.

As a result, since early 2013, 27 NGO partners of Alliance Ukraine in 11 regions of Ukraine are involved in supporting the provision of ART to PWID case management owing to the apparent poor performance of other agencies to support treatment and care services to PWID under Phase 1 of the Global Fund Round 10 grant.

Alliance Ukraine plans to reach 5,000 PWID by the end of 2013 through the case management approach in which outreach workers (locally referred to as Social Workers) support PWID, as needed, throughout the continuum of prevention to care and treatment (CoPCT). As of 11 June 2013, a total of 1,057 PWID had been enrolled in case management with 387 PWID officially registered with an AIDS Centre and 234 PWID initiated into ART<sup>62</sup>.

Confidentiality of PWID personal data, as well as the need for informed consent, is regulated by Order No. 110 of the Ministry of Health on keeping primary accounting/reporting documentation at health care facilities. Comprehensive patient assessment protocols are part of the national, ‘Clinical Guidelines on Antiretroviral Treatment in HIV-positive Adults and Adolescents’, approved by Order No.551 of the Ministry of Health on 12 July 2010, as well as by the, ‘Procedure of Treatment of HIV-positive Individuals Who Are Injecting Drug Users’, approved by Order No. 476 on 19 August 2008, respectively<sup>63</sup>.

Restrictions to accessing ART for PWID include the large number of tests and laboratory analyses required before the administration and initiation of ART. In addition, PWID must provide personal identification documents, such as a passport, in order to register with an ART site; most PWID do not have such papers and, consequently, are unable to access ART. Such requirements are included in the, ‘Procedure of Treatment of HIV-positive Individuals Who Are Injecting Drug Users’, that was approved by Order No. 476 on 19 August 2008.

#### OST client access to ART

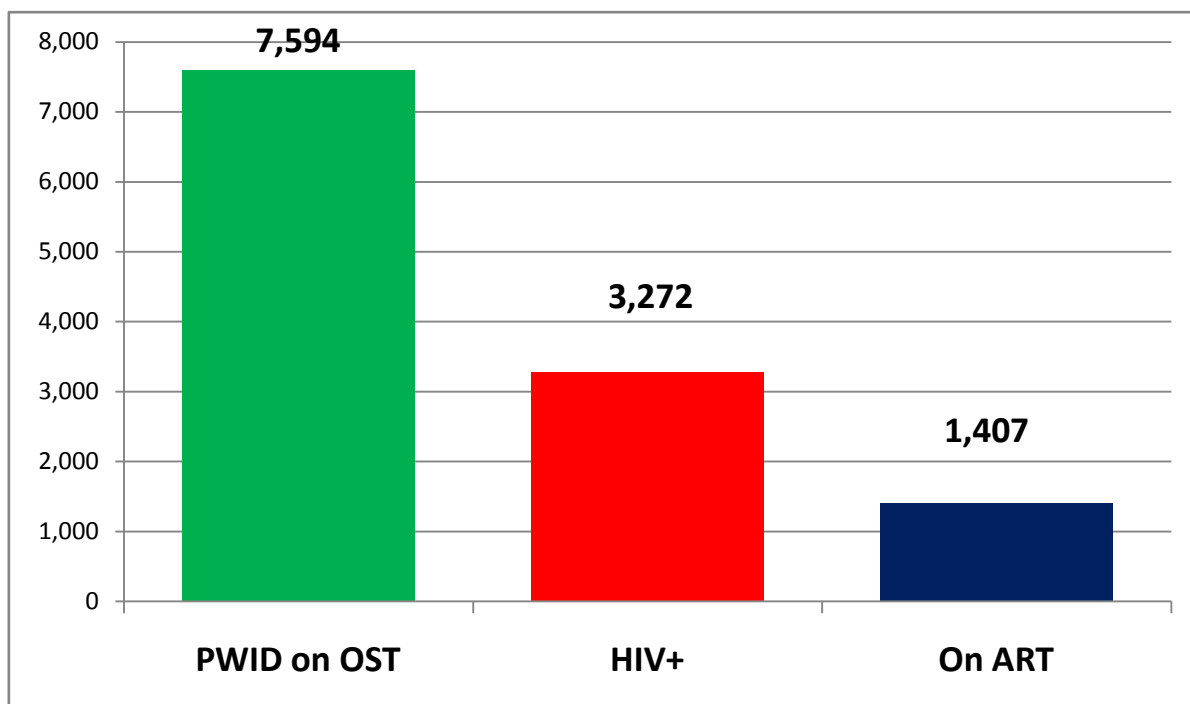
Of the 7,594 OST clients in May 2013, 3,272 of them (43%) were HIV-positive but only 1,407 HIV-positive OST clients were receiving ART (43%); see Fig. 18, below. A total of

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<sup>62</sup> SYREX programme data. Op. cit., 2013; Op. cit.; Shaw G. Harm Reduction Questionnaire, Op. cit.

<sup>63</sup> Shaw G. Harm Reduction Questionnaire, Section 4, Op. cit.

307 OST clients (9% of all OST clients living with HIV) are on a waiting list to get access to ART<sup>64</sup>. If treatment as prevention were introduced – meaning all those with a CD4 count ≤500 cells/mm<sup>3</sup> – the number of OST clients waiting to access ART would rise dramatically to 1,865 people (57% of all HIV-positive OST clients). But such data only refers to people currently receiving OST. There are many opiate dependent PWID who are HIV-positive but are not yet receiving OST.



**Fig. 18: Cascade of PWID on OST, HIV-positive and receiving ART as of May 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013 and 2014; Shaw G. Harm Reduction Questionnaire. Kiev, WHO, July 2013.

### Recommendations

In summary, the main obstacles to PWID access to ART appear to have been identified and actions are now being implemented to overcome those obstacles through the provision of a case manager for each PWID who requires assistance in gaining the necessary personal documentation to enrol for ART, as well as plans by Alliance Ukraine to support PWID adherence to ART. It is anticipated that such actions will result in a rapid increase in the number of PWID accessing ART in the very near future and in adhering to their treatment regimen in the medium to long term. Strong linkages between OST and ART sites have been established in some geographic areas of Ukraine and this model of ‘integrated care’ should be rapidly scaled-up at the earliest opportunity, especially with regards to supporting adherence to both OST and ART, respectively.

It is recommended that for Phase 2 of the Global Fund Round 10 grant that Alliance Ukraine be given the responsibility and funding for the provision of OI/ART to key populations as such people are most in need of case management throughout the continuum of prevention to care and treatment of HIV/AIDS and have established the trusting relationships needed for

<sup>64</sup> Shaw G. Harm Reduction Questionnaire, Section 4, Op. cit.

many members of key populations to be assisted in accessing, and maintaining adhere to, ART.

In addition, it is recommended that the same UIC used for HIV prevention be continued for those key populations who require OI/ART services in order to minimise the bureaucracy in accessing such treatment and care services for the individual patient.

#### **4.1.5 Prevention and treatment of Sexually Transmitted Infections (STIs)**

STI prevention, diagnosis and treatment services are available to PWID in Ukraine at no cost.

Between July 2012 and May 2013, Alliance Ukraine and its partners conducted a total of 10,018 complete STI treatment courses among key populations, including PWID. During 2012, a total of 44,028 syphilis, 12,830 chlamydia, and 12,521 gonorrhoea tests were conducted in 109 health care facilities throughout Ukraine.

During the first quarter of 2013, 20,858 STI diagnostic tests were undertaken with key populations at 109 health care facilities in Ukraine, of which 29% were for women and 71% for men. Approximately 17% of male and 19% of female STI tests were conducted at NSP sites.

The Ministry of Health usually pays for STI diagnostics but when not available, Global Fund is used to purchase such supplies. STI treatment costs are covered in full by Global Fund as no state budget is available to cover such expenditures.

#### **Recommendations**

In summary, greater attention needs to be paid in the future to the needs of the MSM community in all aspects of the prevention to care and treatment of all STIs including HIV/AIDS as well as viral Hepatitis. Further research is also needed to learn how to develop cost-effective and efficient prevention and treatment services for this community as is an understanding of the needs of transgender people in this regard.

#### **4.1.6 Condom programmes for people who inject drugs and their sexual partners**

Condoms are available at no cost to PWID in Ukraine.

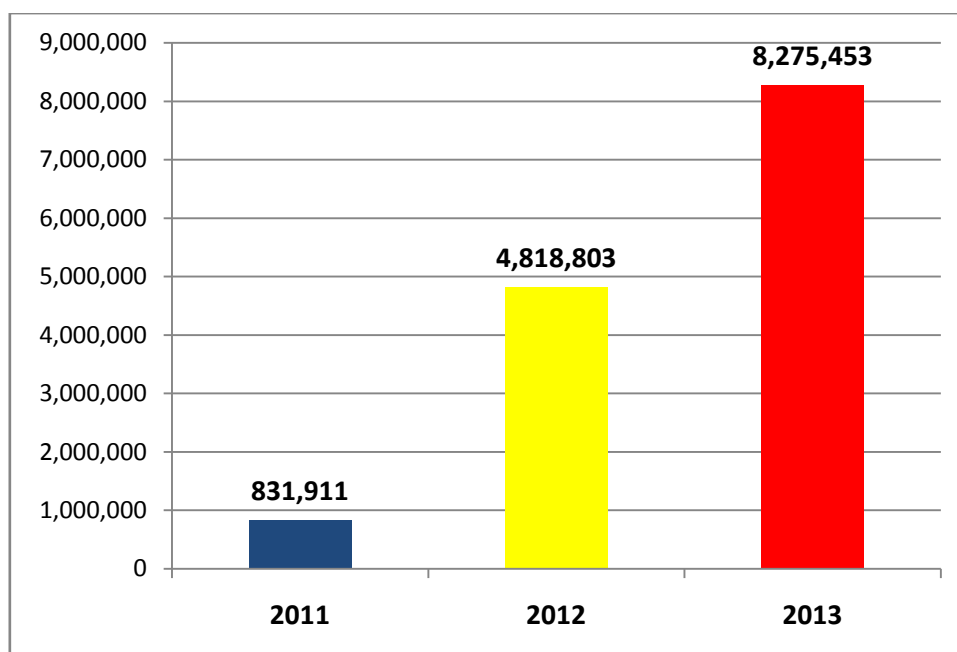
As can be seen in Fig. 19, an estimated 831,911 condoms (828,281 male, 3,630 female) were distributed by the partners of Alliance Ukraine during 2011<sup>65</sup>. In addition, a total of 14,514 female condoms ('femidoms') were distributed among MSM by 8 HIV prevention projects<sup>66</sup>. During 2012, the total number of condoms distributed rose to 4,818,803 to all key populations, including to 171,958 PWID, a major increase over the number distributed in 2011, with the total rising substantially in 2013 to 8,275,453<sup>67</sup>.

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<sup>65</sup> Alliance Ukraine. Annual Report 2011, Op. cit., p44.

<sup>66</sup> Alliance Ukraine. Annual Report 2011, Op. cit., p50.

<sup>67</sup> SYREX programme data. Op. cit. 2013 and 2014; Shaw G. Harm Reduction Questionnaire, Op. cit.



**Fig. 19: Number of Condoms distributed to PWID through Alliance Ukraine partners**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, 2013; Shaw G. Harm Reduction Questionnaire. Kiev, WHO, July 2013.

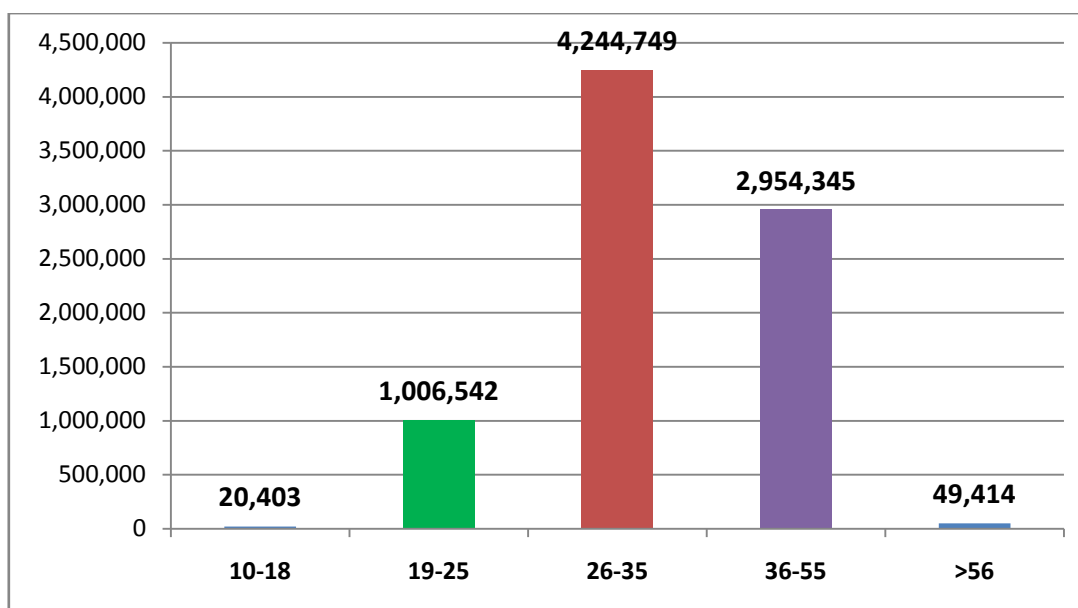
Coverage of key populations, including PWID, with condoms is, therefore, rapidly increasing. The number of condoms distributed to PWID by age group through Alliance Ukraine partners in the first quarter 2013 can be seen at Fig. 20. However, the number of condoms distributed per PWID, per year, in 2011 and 2012 was relatively low.

With an estimated 30 condoms per PWID as the target by Alliance Ukraine through its partners by the end of 2013<sup>68</sup>, the number of condoms received by PWID remains relatively low based on the recommended coverage of WHO, UNODC and UNAIDS, respectively, even though the coverage of the number of PWID with such services is in the ‘mid-to-high’ category at 67%<sup>69</sup>.

<sup>68</sup> Email correspondence with Igor Matviichuk, Op. cit.

<sup>69</sup> WHO, UNODC, UNAIDS. Technical Guide, Op. cit., p83.





**Fig. 20: Number of Condoms distributed to PWID by age group through Alliance Ukraine partners in 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, April 2014.

The IBBS 2011 reports that 47% of all PWID received condoms over the previous 12 months within the framework of awareness-raising programmes at NSP and HTC sites, and through NGO activities throughout Ukraine<sup>70</sup>. PWID who have contact with local NGOs used a condom 53% of the time during the most recent sexual contact, whereas it was 45% among PWID who had no such contact with a NGO. As noted by the IBBS 2011 analysis report, “this suggests that regular work with IDU clients is more effective in terms of developing safe sexual behaviours, including distribution of condoms and motivation of their use”<sup>71</sup>. Worryingly, however, is that 51% of all PWID – meaning a combination of PWID who do, and do not, have interactions with NGOs – are potentially at risk of HIV because of not using a condom during the most recent sexual contact<sup>72</sup>.

### Recommendations

In summary, not enough condoms are being made available to each individual PWID per year. In addition, more innovative approaches are required to try to motivate far more PWID to consistently use a condom every time they have sex. Lessons learnt from 100% condom use programmes (CUP) from around the world might be of particular use to key programme personnel of the Government, Alliance Ukraine and its larger NGO partners around the country. Research should also be undertaken to ascertain the extent to which PWID who have no contact with NGO services are purchasing condoms from pharmacies and/or elsewhere.

### **4.1.7 Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners**

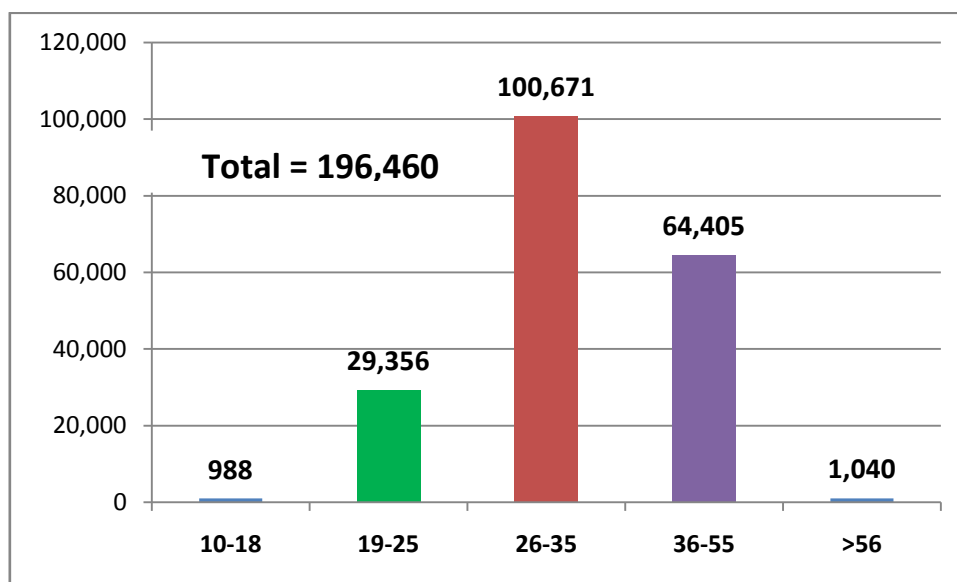
<sup>70</sup> Balakiryeva O.M., et al, Op. cit., p84.

<sup>71</sup> Balakiryeva O.M., et al, Op. cit., p67.

<sup>72</sup> Balakiryeva O.M., et al, Op. cit., p113.

Targeted IEC for PWID is available and distributed to PWID in Ukraine.

During 2013, a total of 196,460 PWID received targeted IEC materials through a sterile needle/syringe programme (NSP) activity or site (see Fig. 21), surpassing the total number of PWID targeted by Alliance Ukraine and its partners for 2013.



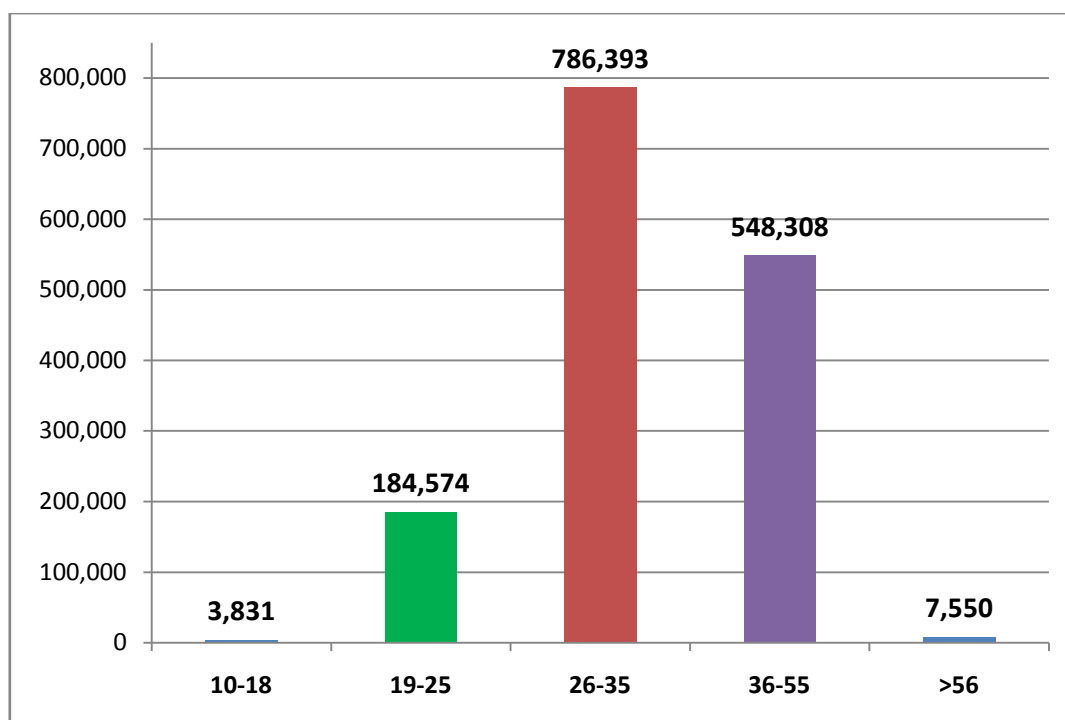
**Fig. 21: Number of PWID by age group receiving targeted IEC provided by NSPs during 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance. April 2014.

Many male and female PWID had more than one opportunity to receive targeted IEC materials through NSP activities and sites during 2013 as can be seen in Fig. 22 that shows the number of NSP occasions in which PWID were provided with targeted IEC materials.

However, it remains unclear the extent to which such targeted IEC materials result in actual behaviour change by PWID, as, for example, the lack of consistent condom use by PWID indicates that targeted IEC materials have been insufficient to make any change in such high risk behaviour<sup>73</sup>.

<sup>73</sup> Balakiryeva O.M., et al, Op. cit., p113.



**Fig. 22: Number of NSP occasions of service in which PWID were provided with targeted IEC during 2013**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, April 2014.

### Recommendations

Coverage of PWID with targeted IEC materials on HIV prevention is very high but the number of PWID engaging in safer HIV practices does not appear to be occurring at a similar high level. Operational research could help to identify the obstacles to such behaviour change by PWID and thereby inform developers of IEC materials as to what approach and content is required to make future targeted IEC materials more effective.

### **4.1.8 Prevention, vaccination, diagnosis and treatment for viral hepatitis**

Vaccination for, as well as diagnosis and treatment of, Hepatitis B is available free of charge to PWID in Ukraine but coverage of PWID by such services appears to be low. Hepatitis C diagnosis is available to PWID in Ukraine but treatment is not available due to the high cost per patient for the existing 48-week course.

### Hepatitis B

Alliance Ukraine, through 19 of its local NGO partners, provides free vaccination for key populations against viral Hepatitis B through Round 6 support from the Global Fund.

From 2010 until March 31, 2013, the partners of Alliance Ukraine carried out 14,145 vaccinations and revaccinations against viral Hepatitis B in key population groups, including 8,999 with PWID, a coverage of 4.3% of all PWID targeted. Hepatitis B vaccination at NSP sites totalled 699 PWID between 1 August 2012 and 31 March 2013, with male PWID accounting for 66% of such vaccinations and female PWID 34%, respectively<sup>74</sup>. During

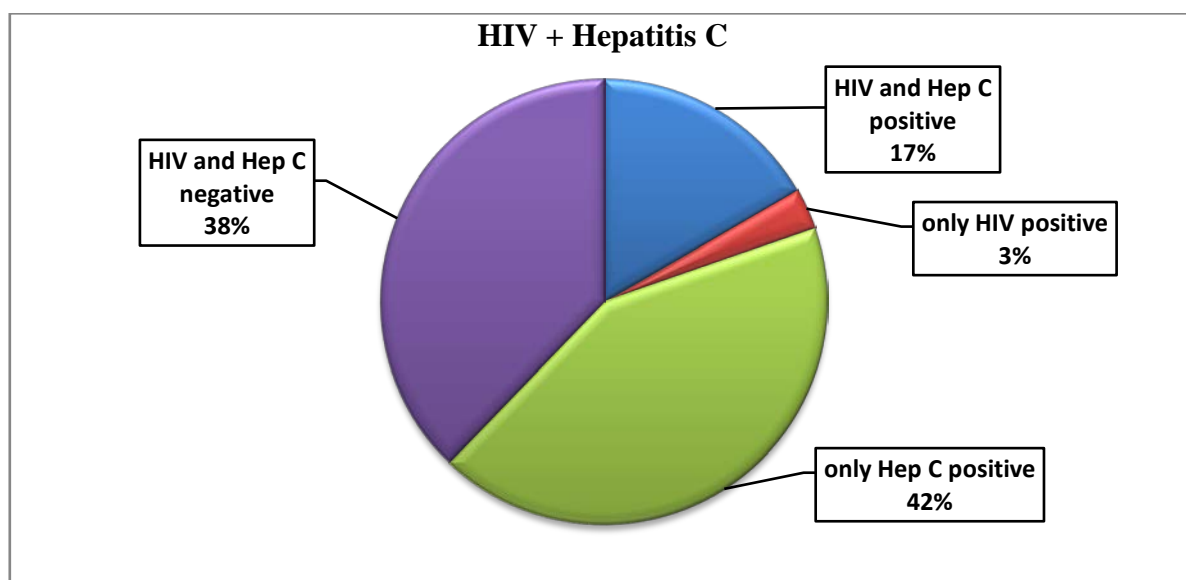
<sup>74</sup> Shaw G. Harm Reduction Questionnaire, Section 6, IEC, Hep & TB. Kiev, WHO, 18 July 2013.

2011, 3,937 MSM were tested for Hepatitis B with 431 MSM clients vaccinated against Hepatitis B; a total of 2,773 MSM were tested for Hepatitis C during the same year<sup>75</sup>. Since the delivery of the Hepatitis B vaccination regime began, Alliance Ukraine estimate that adherence to the three-shots required has been approximately 99%<sup>76</sup>.

Due to the centralized supply and distribution mechanism used for the Hepatitis B vaccine which involves Alliance Ukraine, its NGO partners and Governmental health care facilities, it has been possible to reduce the cost of providing Hepatitis B vaccinations to key populations by four times on condition by the supplier, GlaxoSmithKline, Belgium, that the vaccinations are procured by Alliance Ukraine. The vaccination schedule is the provision of three injections, the second of which takes place after 1 month and the final vaccination after 6 months. Such vaccinations are carried out at government health care facilities in cooperation with local NGOs<sup>77</sup>.

### Hepatitis C

There is in the region of 2 million people in Ukraine in need of Hepatitis C treatment<sup>78</sup>. There is no national guideline on Hepatitis treatment but there is a clinical protocol on viral Hepatitis C screening and treatment for HIV-positive adults that was approved by the Ministry of Health through Order No. 826 on 30 December 2008<sup>79</sup>.



**Fig. 23: Percentage of PWID co-infection with HIV and Hepatitis C**

Source: IBBS among PWID conducted in Ukraine in 2013.

The percentage of PWID co-infected with HIV and Hepatitis C can be seen in Fig. 23, above. Access to Hepatitis C treatment is limited by its extremely high price with a 48 week course costing in the region of USD15,000 per person at present. Although a breakthrough agreement was made in September 2013 with a pharmaceutical company to provide the

<sup>75</sup> Alliance Ukraine. Annual Report 2011, Op. cit., p50.

<sup>76</sup> SYREX programme data. Op. cit., 2014.

<sup>77</sup> Shaw G. Harm Reduction Questionnaire, Section 6, Op. cit.

<sup>78</sup> SYREX programme data. Op. cit.,.

<sup>79</sup> Shaw G. Harm Reduction Questionnaire, Section 6, Op. cit.

course of treatment at USD5,000 per person, only 100 highly vulnerable patients with HIV/HCV co-infection will benefit through support from the Global Fund, far fewer than the number of people in need of such life-saving treatment<sup>80</sup>. There is also a lack of a national treatment guideline solely for Hepatitis C, with the only existing guideline being for people co-infected with HIV and Hepatitis C, respectively. A brochure was published by Alliance Ukraine concerning viral Hepatitis B and viral Hepatitis C prevention for key populations in the form of a specially adapted pocket book format. WHO guidelines launched in April 2014 for the screening, care and treatment of persons with hepatitis C infection should also assist human resource capacity building in this area in Ukraine<sup>81</sup>.

### Recommendations

In summary, Hepatitis B vaccinations are not being provided to a large enough number of PWID to have an impact on the prevalence of Hepatitis B among PWID in Ukraine and needs to be dramatically scaled-up. Greater involvement of WHO is needed in supporting the scaling-up of treatment of Hepatitis C through dissemination of WHO recommendations and technical assistance to the Government and its civil society partners, including support to identify new or generic Hepatitis C medications that are cheaper and therefore more accessible to the many PWID who are in desperate need of such treatment. It is also suggested that WHO take a more direct role in assisting concerned partners in the development of a national treatment guideline for Hepatitis C for people who are not co-infected with HIV.

#### **4.1.9 Prevention, diagnosis and treatment of tuberculosis (TB)**

TB prevention, diagnosis and treatment services are available to PWID in Ukraine.

Ukraine has the seventh highest prevalence of TB in Europe. The response to TB has been integrated by Alliance Ukraine into the other key components of the comprehensive package for HIV prevention, treatment and care for PWID, such as 1,200 TB patients receiving OST, and the number of OST sites that can arrange HIV/AIDS and TB diagnostics and treatment activities rising in 2011 from 8 to 34<sup>82</sup>. Stand alone services of early TB detection for key populations were only introduced by Alliance Ukraine through its partner NGOs in April 2013. The new component includes coordination of work with medical staff of TB facilities in order to organize counseling and diagnostic services through NGOs and further referral of clients to TB clinics and the introduction of an infection control system at NGO facilities. In addition, the component supports NGO coordination with medical staff of TB facilities regarding assistance in treatment, such as establishing contact with clients upon the doctor's request, etc. Furthermore, Alliance Ukraine has supported its local partners to develop and deliver IEC materials for prevention of TB and to also ensure that Isoniazid Preventive Therapy (IPT) is provided to PWID if they are HIV-positive and do not have active TB<sup>83</sup>.

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<sup>80</sup> International HIV/AIDS Alliance in Ukraine. Alliance Ukraine secures affordable life-saving Hepatitis C treatment for people living with HIV. Kiev, International HIV/AIDS Alliance, 10 September 2013.

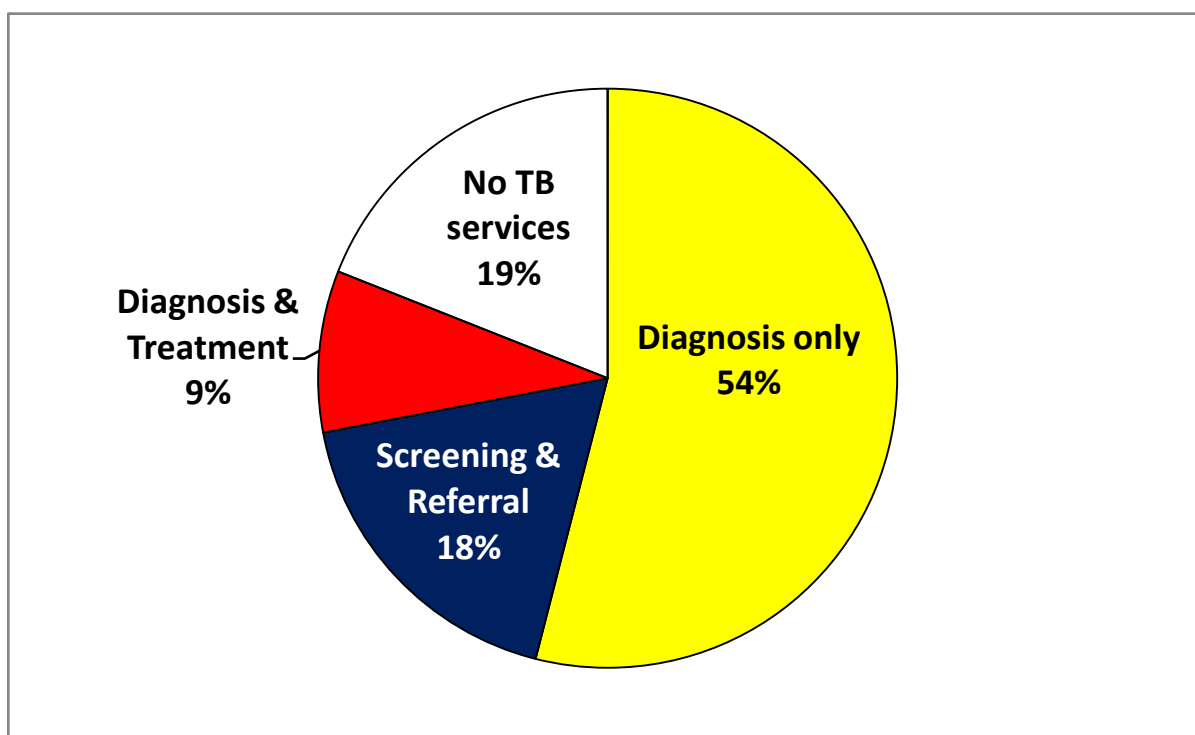
<sup>81</sup> WHO. Guidelines for the screening, care and treatment of persons with hepatitis C infection. Geneva, WHO, 2014; [http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755_eng.pdf), accessed 28 April 2014.

<sup>82</sup> Alliance Ukraine. Annual Report 2011, Op. cit. p11.

<sup>83</sup> Mburu G and Richardson D. Community-based TB and HIV integration. Good Practice Guide. Hove, International HIV/AIDS Alliance and PATH, 2013, p47, <http://www.aidsalliance.org/Publicationsdetails.aspx?Id=90632>, accessed 14 April 2014; [http://www.aidsalliance.org.ua/ru/library/our/2012/dec/izo\\_for\\_print.pdf](http://www.aidsalliance.org.ua/ru/library/our/2012/dec/izo_for_print.pdf), accessed 14 April 2014.

Between April and July 2013, a total of 37 local NGO's supported the provision of TB screening to 15,814 people, with diagnostic tests being performed with 1,436 people (9% of those screened); 140 people tested positive for TB with 122 of those people receiving treatment (87%). Consequently, of the 15,814 people screened for TB, the prevalence of TB was 0.89%<sup>84</sup>.

TB diagnosis and treatment services for PWID are available at 14 of the 153 drug treatment/OST sites nationwide; TB diagnosis is available at 83 drug treatment/OST sites and TB screening and referral is available at 27 such sites; see Fig. 24. In addition, 36 NSP sites (45% of the total number of such sites in the country) provide TB screening and referral – often assisted by a case manager – of suspected TB cases to appropriate health care facilities for diagnosis and treatment. PWID with HIV/TB co-infection are simultaneously provided TB treatment with initiation of ART<sup>85</sup>.



**Fig. 24: Types of TB services available at the 153 drug treatment/OST sites in Ukraine**

Source: Shaw G. Harm Reduction Questionnaire, Section 6, IEC, Hep & TB. Kiev, WHO, 18 July 2013.

### Recommendations

More action is needed to integrate TB diagnosis and treatment into the integrated care model (see Section 4.5, below, for more details) and to increase the number of male, female and adolescent PWID who receive periodic TB screening, diagnosis and treatment. Effective drug dependence care and treatment in hospital settings that allows a full course of evidence-based interventions to be undertaken without stigma or discrimination will also significantly enhance TB treatment for PWID.

<sup>84</sup> Email correspondence with Irina Zharuk, Technical Support Manager, Most At-Risk Adolescents (MARA), International HIV/AIDS Alliance in Ukraine, Kiev, 24 July 2013.

<sup>85</sup> Shaw G. Harm Reduction Questionnaire, Section 6, Op. cit.

## **4.2 The prevention of co-infection of TB/HIV**

Alliance Ukraine is a subrecipient of the Rinat Akhmetov Charitable Foundation for Development of Ukraine in relation to the Global Fund Round 9 component entitled, 'Improving access to high quality services for patients having TB/HIV co-infection'. Through this mechanism, a total of 10 grants were given in 2011 to local NGOs that resulted in 2,170 TB patients receiving HIV and STI prevention interventions. PWID with HIV/TB co-infection are provided TB treatment simultaneously with their initiation onto ART.

This component of the comprehensive programme appears to be functioning well; the introduction of case management is an opportunity to provide additional support to people who need it so that they can simultaneously access both the TB and ART treatments that they need.

## **4.3 Human Rights**

One of the five strategic objectives of Alliance Ukraine is to make a positive impact on policy-making for HIV/AIDS, tuberculosis and drug use in order to reduce stigma and discrimination, and to protect human rights<sup>86</sup>.

The rights of all people in Ukraine to a basic level of quality health care forms the basis of the approach taken by Alliance Ukraine and its partners to advocating for the rights of key populations most at-risk of HIV/AIDS. However, much of the human rights work undertaken by Alliance Ukraine benefits the general population as well as PWID, FSW, MSM, and most at-risk children and adolescents.

For example, a draft law in 2005 sought to give medical staff the authority to disclose the HIV-positive status of a person to their relatives, partners and others who reside with the person without the prior consent of the individual. This is contrary to the key principles of the right to protection of the individual and patient confidentiality. Such a law would affect all Ukrainians, not just people from key populations. As a result of considerable advocacy work by Alliance Ukraine, the draft law was excluded from further consideration in September 2005.

Specific efforts are made, however, to protect the rights of those most at-risk of HIV/AIDS and, in particular, of people living with HIV/AIDS (PLHA). As a result of its advocacy work, Alliance Ukraine was instrumental in the formation of an Advocacy Committee for the protection of the rights of PLHA and vulnerable groups with the involvement of Government agencies that has become a generator of ideas to change policy to overcome stigma and discrimination, to make changes to the drug control policy, and to address regulatory problems faced by PLHA and vulnerable people on a daily basis.

The lack of state funding for HIV/AIDS prevention and treatment programmes has undermined the right of people to access such health services. As a result, a powerful information and advocacy campaign was undertaken by Alliance Ukraine and its partners targeting senior government officials, members of parliament and the Cabinet of Ministers, and including the involvement of the mass media. This resulted in an increase of the state

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<sup>86</sup> Alliance Ukraine. Annual Report 2011, Op. cit. p14.

budget for such services from 21m UAH [approximately USD2.6m] in 2006 to 98m UAH [approximately USD12m] in 2007, an almost five-fold increase.

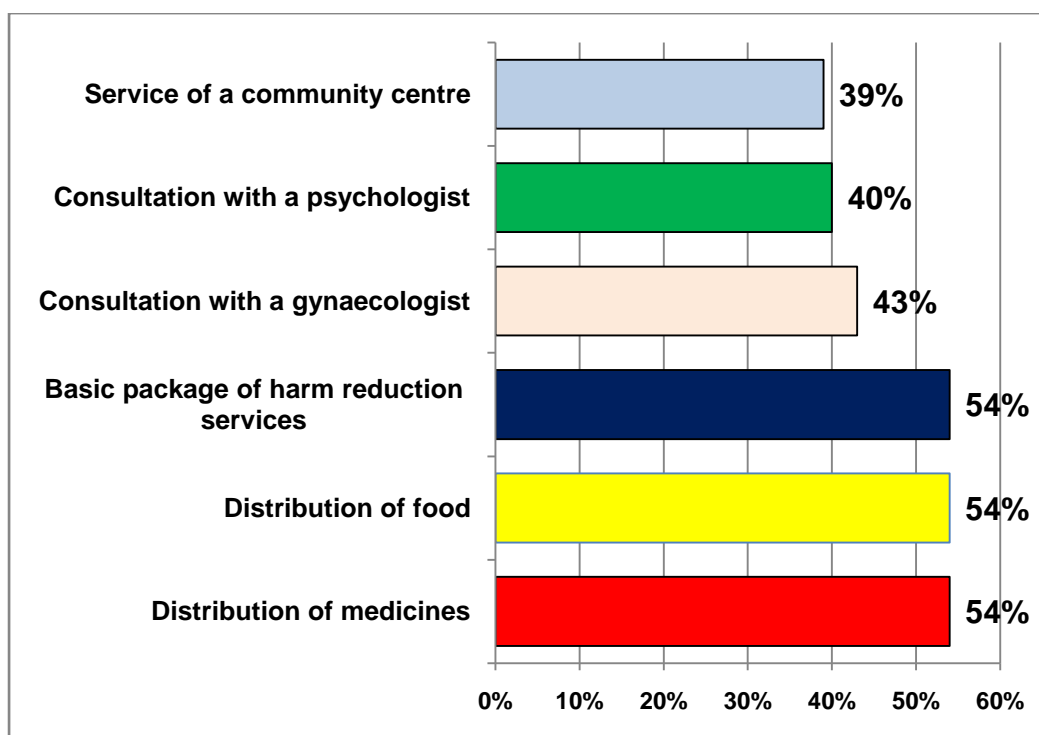
Some NGO's – such as Svitlo Nadiyi (Light of Hope) in Poltava Oblast – with the assistance of Alliance Ukraine, are now able to issue identification documents to PWID in order for them to be able to access a range of health and social services, including ART. The lack of identification papers in Ukraine inhibits access to most government services. But through partnership, and developing a trusting working relationship, some NGO's have been very effective in overcoming the obstacles to health service access, a fundamental right of all people.

Alliance Ukraine continues to take a pro-active position on the protection of rights of all people, especially those from key populations. All staff of Alliance Ukraine have a role to play in this cross-cutting work. The high regard in which the Alliance is viewed by central and regional Government officials bodes well for the continued ability of the organization to play a central advocacy and technical role to ensure that PWID, FSW, MSM, prisoners, people on probation, as well as most at-risk children and adolescents, are afforded protections and access to services when and where they need them.

#### **4.4 Gender Sensitivity & Integration**

Alliance Ukraine is cognizant of the importance of integrating gender needs into all components of the harm reduction programme throughout the country. An evaluation was undertaken in 2009 by Alliance Ukraine of gender sensitive approaches to HIV prevention and harm reduction interventions among PWID. The evaluation identified a range of services of most interest to female injecting drug users as shown in Fig. 25. The basic package of harm reduction services, of which 54% of the female IDU participants in the evaluation wanted to receive, includes sterile needles/syringes, condoms and lubricant, information materials, and peer counselling.





**Fig. 25: Services of most interest to female injecting drug users, Ukraine, 2009**

Source: International HIV/AIDS Alliance in Ukraine. Evaluation of Gender Sensitive Approaches to HIV Prevention & Harm Reduction Interventions Among IDUs. Kiev, International HIV/AIDS Alliance, 2009, p90.

With regards to information needs, female IDU expressed interest in issues such as relations with the police, employment, and the safe use of drugs, as well as living with HIV and viral hepatitis; such views are similar to those of male IDU<sup>87</sup>.

In 2009, Alliance Ukraine undertook an evaluation of gender sensitivity related to harm reduction services in the country. As a result of the evaluation, Alliance Ukraine has been providing ongoing assistance to its local NGO partners to increase service utilization by female IDU. The specific gender-sensitive approaches and actions are as follows:

- Structured Training Activities for female harm reduction staff;
- Creating an Emotionally and Physically Safe Environment;
- Changing Policies and Procedures for Service Delivery;
- Gender Sensitivity Indicators;
- Secondary Syringe Exchange (SSE);
- Women-focused Outreach;
- Short-term Childcare;
- Case Management for Female IDUs; and,
- Addressing violence against females.

<sup>87</sup> International HIV/AIDS Alliance in Ukraine. Evaluation of Gender Sensitive Approaches to HIV Prevention & Harm Reduction Interventions Among IDUs. Kiev, International HIV/AIDS Alliance, 2009, p90.

## 4.5 Efficiency of Services

The efficiency of services is based on the availability and accessibility of needed health and social services for the individual PWID and relevant family and friends, as appropriate, as well as the financial cost of each service delivered, and the avoidance of duplication in service delivery.

Wherever possible, all harm reduction services in Ukraine are available at one site through an ‘Integrated Care Centre’, i.e. a ‘one-stop-shop’ for PWID. A comprehensive definition of integrated care is given by Kodner and Spreeuwenberg:

‘Integration is a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings. The result of such multipronged efforts to promote integration for the benefit of these special patient groups is called ‘integrated care’<sup>88</sup>.

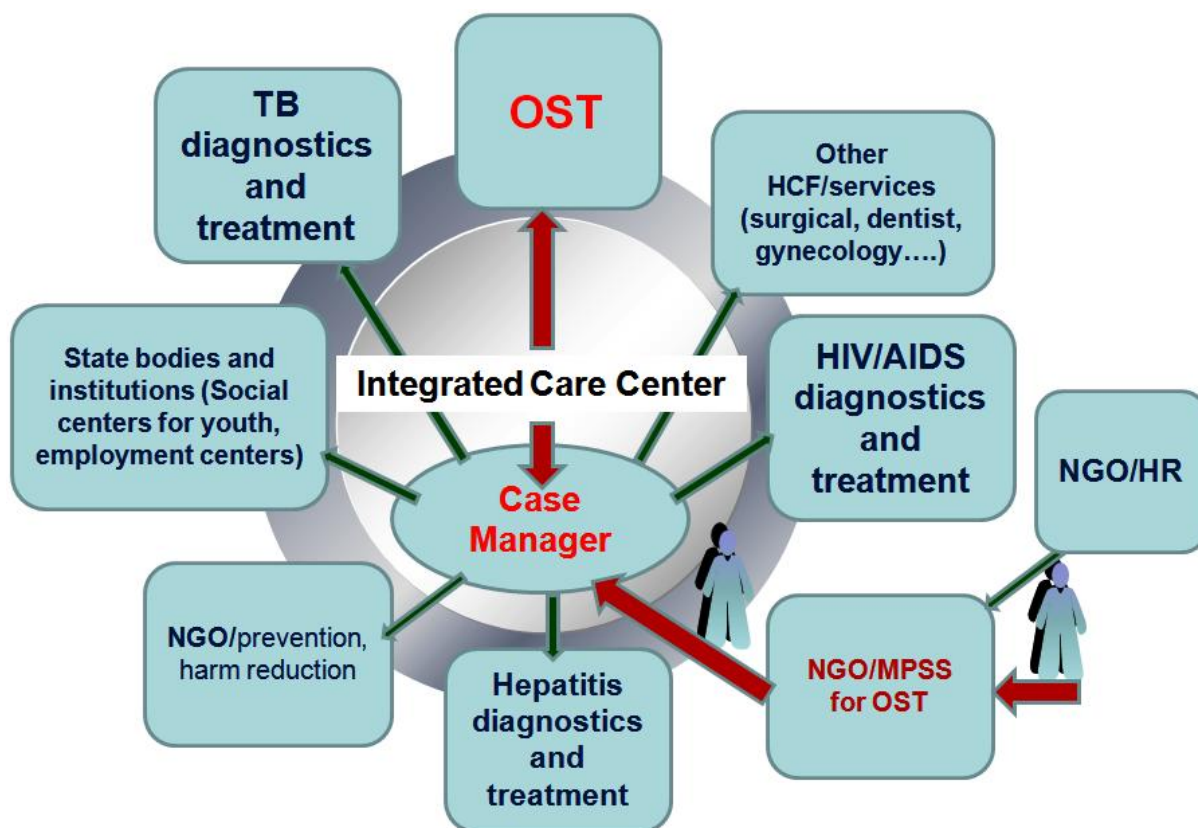
Alliance Ukraine and its local NGO partners, and in close collaboration with the Ministry of Health, has developed service integration, both of medical and psychosocial services and related support/follow-up; see Fig. 26, below.

In reality, this realizes the engagement in programme activities of the respective specialists of key government agencies and NGOs, in particular doctors dealing with drug dependence, the diagnosis and treatment of communicable diseases, as well as nurses, social workers, and psychologists. Currently, there are 83 such ‘Integrated Care Centres’ operational throughout Ukraine, including 54% of all OST sites in the country<sup>89</sup>.

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<sup>88</sup> Kodner D.L., Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications - a discussion paper. *International Journal of Integrated Care*, Vol. 2, 14 November 2002, in, WHO, International HIV/AIDS Alliance in Ukraine, USAID, Clinton Health Access Initiative. Providing integrated services at health care facilities for people who use drugs in Ukraine, Guidelines. Copenhagen, WHO, 2012, p9.

<sup>89</sup> SYREX programme data. Op. cit., 2014.



**Fig. 26: The model of the Integrated Care Centre in Ukraine**

Source: WHO, International HIV/AIDS Alliance in Ukraine, USAID, Clinton Health Access Initiative, Providing integrated services at health care facilities for people who use drugs in Ukraine, Guidelines. Copenhagen, WHO, 2012.

The integrated care centre model thereby provides a range of approaches to organizing health and social services into health care facilities in order to improve the accessibility of health care services for PWID. Integrated care programmes are based on the concept of equal access to a complete range of services that should be free of stigma and discrimination towards the individual PWID as well as being flexible and responsive to the needs and issues of the patient, including the family and friends of each PWID. This integrated care model in Ukraine led to the development of a guideline published in 2012 by WHO that details the steps needed to establish and operate such integrated services<sup>90</sup>.

#### Financial Cost

Most of the financial resources available to Alliance Ukraine and its partners for service delivery comes from Round 10 of the Global Fund through a grant entitled, ‘Building a sustainable system of comprehensive services on HIV prevention, treatment, care and support for MARPs and PLWH in Ukraine’, for which the treatment, care and support component during Phase 1 was implemented by the Network of PLHA in Ukraine.

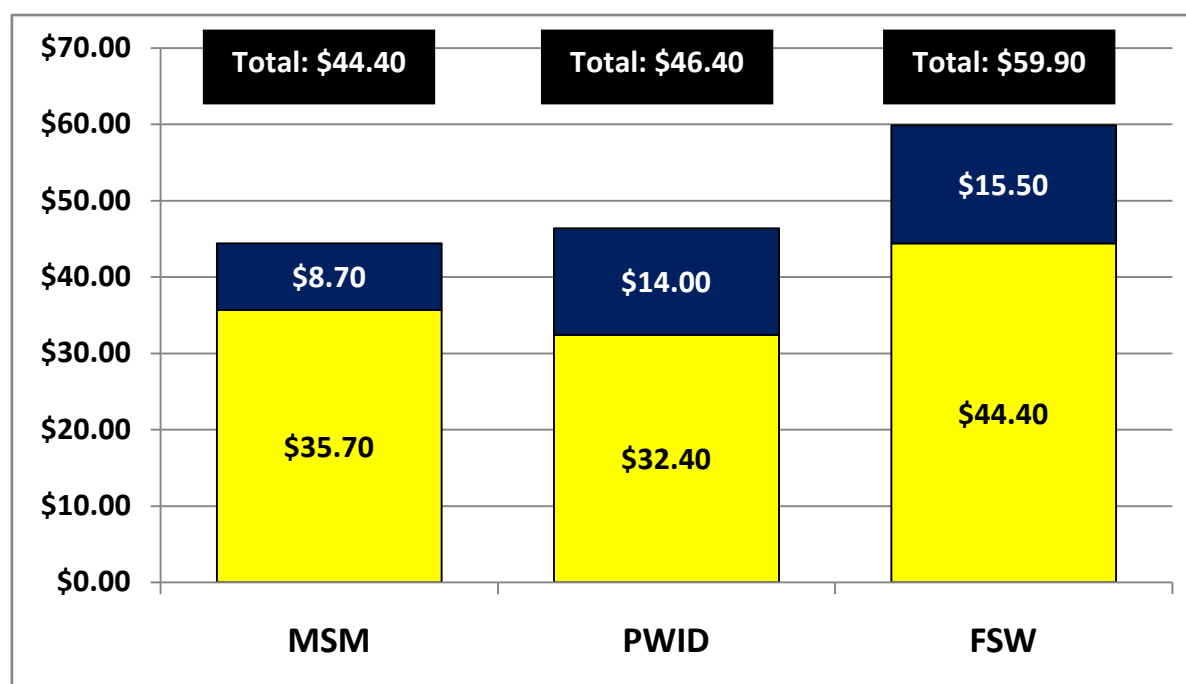
Alliance Ukraine expenditures during 2012 were split into the components as outlined in Table 2.

<sup>90</sup> WHO, et al. Providing integrated services at health care facilities for people who use drugs in Ukraine. Op. cit.; see also, [http://www.euro.who.int/data/assets/pdf\\_file/0005/167315/e96608-update.pdf](http://www.euro.who.int/data/assets/pdf_file/0005/167315/e96608-update.pdf), accessed 30 June 2013.

| Cost Category                               | USD ('000)    | %           |
|---|---------------|-------------|
| Grants and SubAwards                        | 14,571        | 42.20%      |
| Health Products and Health Equipment        | 8,442         | 24.45%      |
| Human Resources                             | 3,492         | 10.11%      |
| Medicines and Pharmaceutical Products       | 2,414         | 6.99%       |
| Training                                    | 1,315         | 3.81%       |
| Technical Assistance                        | 1,134         | 3.28%       |
| Procurement and Supply Management Costs     | 949           | 2.75%       |
| Overheads                                   | 671           | 1.94%       |
| Monitoring and Evaluation                   | 454           | 1.32%       |
| Communication Materials                     | 434           | 1.26%       |
| Planning and Administration                 | 405           | 1.17%       |
| Infrastructure and Other Equipment          | 196           | 0.57%       |
| Living Support to Clients/Target Population | 54            | 0.16%       |
| <b>Total</b>                                | <b>34,529</b> | <b>100%</b> |

**Table 2: Alliance Ukraine Expenditure Structure in 2012**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, July 2013.



■ Annual cost per person (in US Dollars) of the comprehensive package, excluding commodities\*

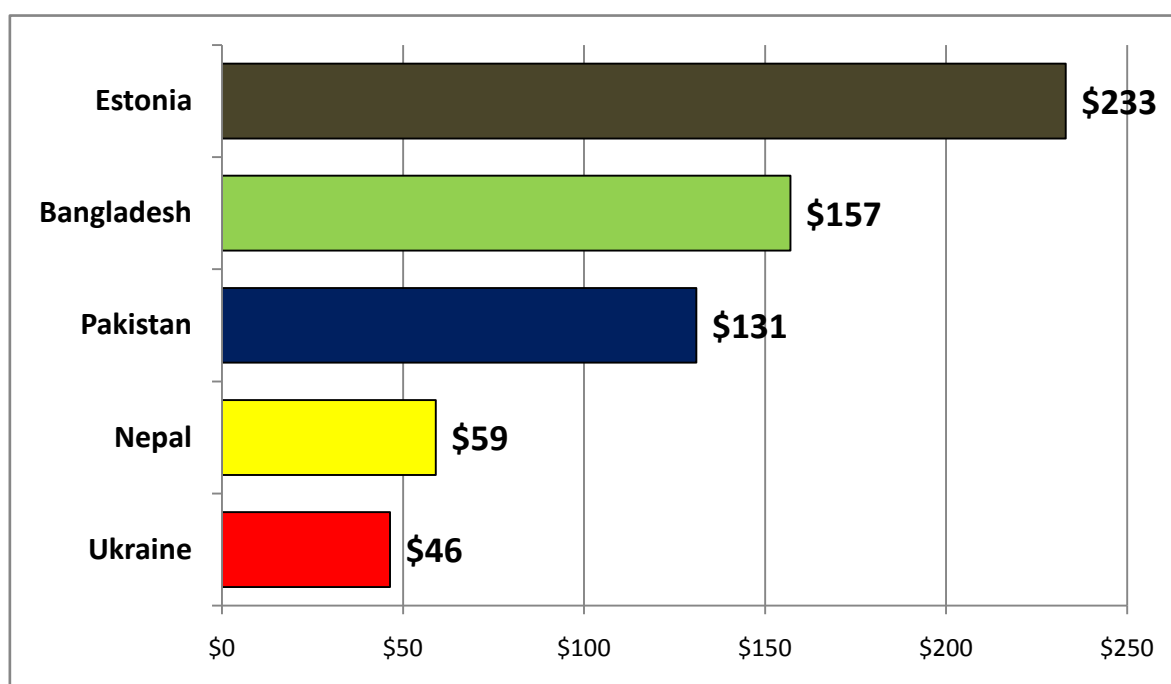
■ Additional annual cost for purchase of commodities per person (in US Dollars)^

**Fig. 27: Annual individual cost to deliver the comprehensive package of HIV prevention services to key populations in Ukraine, 2013 (in US Dollars)**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, July 2013; Email correspondence with Myroslava Debeliuk, Technical Support Manager, International HIV/AIDS Alliance in Ukraine, Kiev, July 25, 2013.

- \* Costs include the distribution of commodities to each person, development of IEC materials and their distribution, and costs for HTC and STI services.
- ^ Commodities include 170 sterile needles/syringes and alcoholic wipes per person at USD12 per person, per year; 25 (for PWID)/350 (for FSW) condoms per person at USD1/14 per person, per year; 40% of key population annual coverage of HTC costs at USD0.30 per person, per year; and, 40 (for PWID)/80 (for FSW) of annual coverage cost of STI at USD0.6/1.2 per person, per year.

The cost per person for each of the three key populations shown in Fig. 27, above, compares very favourably to the costs of many other countries, both economically developed and less developed, as can be seen in Fig. 28, below.



**Fig. 28: Comparison of annual cost per person for the implementation of HIV prevention services for PWID in randomly selected countries (in US Dollars)**

Sources: Email correspondence with Myroslava Debeliuk, Technical Support Manager, International HIV/AIDS Alliance in Ukraine, Kiev, July 25, 2013; Alban, A., and Manuel, C. Background Report: Cost-effectiveness of Injecting Drug User Interventions to prevent HIV in Nepal. ADB/UNAIDS, 2007, p1; Stimson, G.V., Cook, C., Bridge, J., Rio-Navarro, J., Lines, R., and Barrett, D. Three cents a day is not enough: Resourcing HIV-related Harm Reduction on a Global Basis. London, International Harm Reduction Association, 2010, p37.

In Asia overall, the general cost of HIV interventions range from USD69–157 at 2006 prices per PWID, per year, for a mix of drop-in centre and outreach services<sup>91</sup>. Therefore, Ukraine is showing a relatively cost-effective model for HIV prevention among PWID, especially in light of its relative economic development as compared to many other countries of the world with higher comparative costs.

<sup>91</sup> Alban, A., and Manuel, C. Background Report: Cost-effectiveness of Injecting Drug User Interventions to prevent HIV in Nepal. ADB/UNAIDS, 2007.

### Duplication of Service Delivery

A Unique Identifier Code (UIC) is recommended by WHO, UNODC and UNAIDS, respectively, based on a range of numbers and/or letters that keeps the name, address and other key personal information of the individual PWID confidential whilst allowing service providers to identify an individual for which interventions are being delivered. In Ukraine, there are currently three UIC systems in operation:

- a) for registration of clients of **HIV prevention** programmes, a system used by Alliance Ukraine and its partners uses 8 symbols based on a clients' personal information;
- b) for registration of clients of **treatment, care and support** programmes, a system used by the 'All-Ukrainian Network of People Living with HIV/AIDS' (referred to as 'the Network') is automatically generated from the clients' full name; and,
- c) for registration of a HIV-positive person **at an AIDS Centre for receipt of ART** in which the clients' full name is utilized based on the data in their Ukrainian passport.

An overview of the main agencies responsible for each key component in the HIV/AIDS sector in Ukraine is at Table 3. This overview highlights the current lack of a continuum of support for key populations from an individual's first contact with an outreach worker or health care facility – whether it is run by a NGO or a Government agency, or a combination of the two – through to adherence to ART and, for some, the multiadherence requirements of OST and ART, respectively. The relative lack of access by PWID to ART is one key indicator as to the inability of the current division of labour to assist such a key population in accessing this crucially important component of the continuum of care for HIV/AIDS prevention, treatment and care in Ukraine. A recommended revised approach to the entire sector is shown at Table 4 in Section 10.2, Conclusions and Recommendations.

| <b>HIV/AIDS Sector</b>   |   |  |
|--|---|--|
| <b>Prevention</b>  | <b>Care &amp; Support</b>                     | <b>Treatment</b>                         |
| Alliance Ukraine   | The All-Ukrainian Network of PLHA             | Government of Ukraine                    |
| Key Populations  | PLHA<br>(general + key populations)           | PLHA<br>(general + key populations)      |
| Outreach, Drop-In Centres, Health care Facilities, NSP sites, pharmacies, drug treatment sites | AIDS Centres                                  | AIDS Centres                             |
| UIC = anonymity  | UIC = more formal disclosure of personal data | No coding system; no electronic register |
| Prevention   | -   | -  |

|   |                             |   |
|---|-----------------------------|---|
| Rapid Test  | Registration support        | Confirmation test                                     |
| -   | -                           | Dispensing of ART                                     |
| Adherence support through case managers           | Adherence support           | Dispensing of treatments for Opportunistic Infections |
| TB/HIV co-infection support through case managers | TB/HIV co-infection support | -   |
| OST + ART support                                 | -                           | OST + ART support                                     |
| Viral Hepatitis support                           | Viral Hepatitis support     | -   |

**Table 3: Overview of current key activities and division of roles and responsibilities in the response to HIV/AIDS in Ukraine.**

#### 4.6 Sustainability

The issue of sustainability is primarily a question of where future funding will come from to pay for service delivery; Section 4.5, above, provides details of the costs and related efficiencies in delivering the HIV prevention programme through Alliance Ukraine. It is clear from senior, mid-level and low-level Government personnel and their NGO counterparts that the systems being put in place with the assistance of Alliance Ukraine are effective and of relatively low cost to implement.

However, it is the current dependence on external development partner funding – from GFATM in particular – that concerns all key stakeholders in the HIV/AIDS sector. All are cognisant of the need to move away from sole reliance on external sources of funding. The current situation does not provide for sustainable HIV prevention services for key populations in the long term in Ukraine, other than the provision of OST for which the Government has approved future funding to fully take over the costs of the medications involved in the provision of treatment. The Government does pay for some ARV medications<sup>92</sup> and it is hoped that this will increase substantially in the medium to long term. Efforts by Alliance Ukraine, and others, continue for an increase in national and regional government funding to all components of the comprehensive harm reduction package as well as to the entire continuum of prevention to care and treatment for key populations. Some success has been achieved by Alliance Ukraine to-date with 9 of the 12 Regional Governments currently targeted by Alliance Ukraine agreeing to contribute between 5-10% of the HIV programme costs<sup>93</sup>.

Efforts to advocate for increased central Government funding has also been successful over recent years through the use of mass media and advocacy with Members of Parliament, and others. Further efforts will need to be made in this regard.

<sup>92</sup> Meeting with Aleksandrina Tetiana, Head, State Service of Ukraine on HIV/AIDS and Other Socially Dangerous Diseases, Kiev, 9 July 2013; Meeting with Natalia Nizova, Director, Ukrainian Center for Disease Control, Ministry of Health of Ukraine, Kiev, 10 July 2013.

<sup>93</sup> SYREX programme data. Op. cit., 2013.

Further efforts are also needed to negotiate better pricing for the purchase of key medications so as to reduce unit costs still further. There is a potential role for WHO to undertake more facilitation activities in this regard between manufacturers, the Government of Ukraine, and key NGOs, such as Alliance Ukraine. The current difficult negotiations related to the purchase of medications to treat Hepatitis C is a case in point.



## **5. INCREASE IN AVAILABILITY AND ACCESSABILITY OF HARM REDUCTION SERVICES**

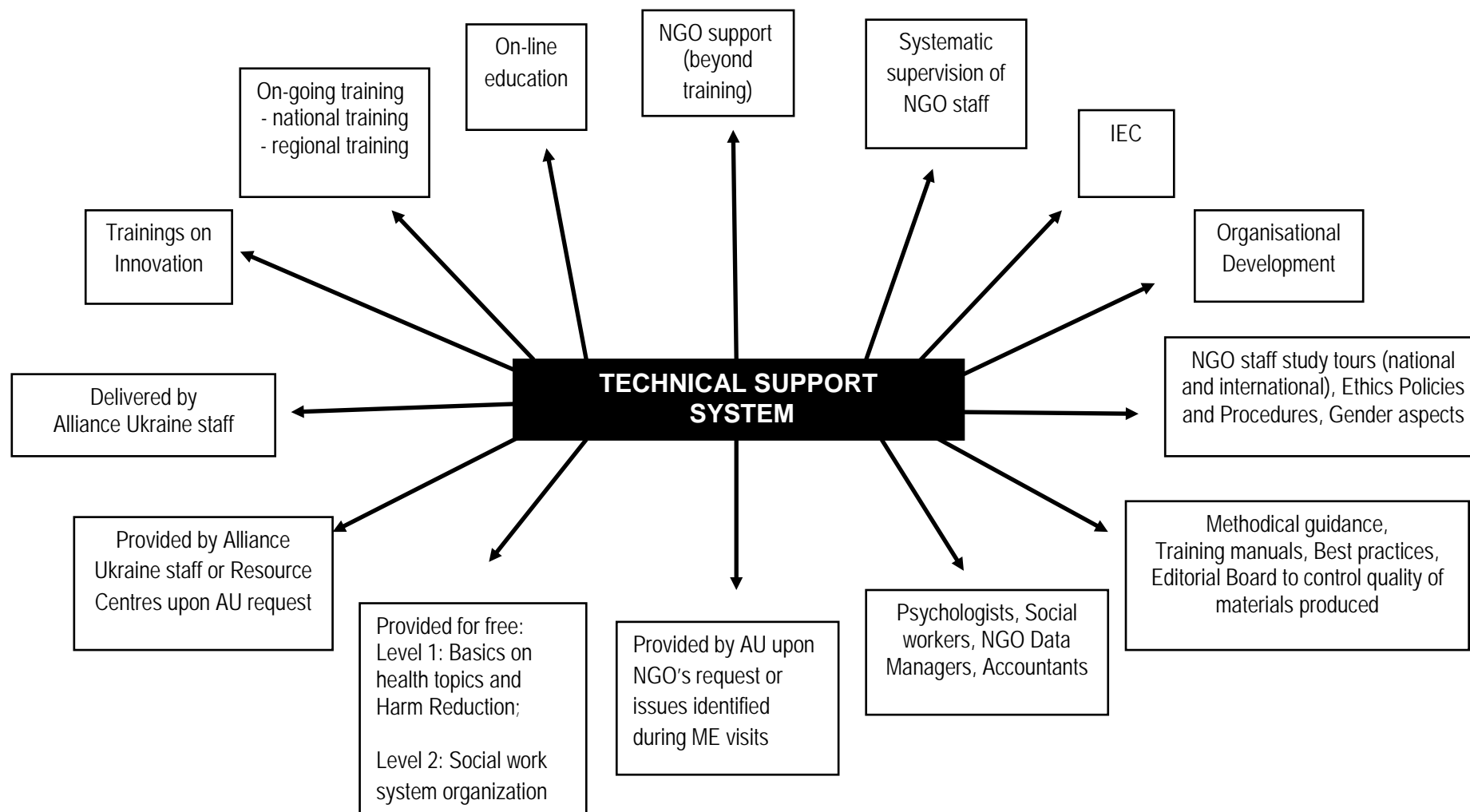
### **5.1 The role of technical support provided by Alliance Ukraine**

The technical assistance provided by Alliance Ukraine to its partners is crucial. Alliance Ukraine acts as both a quality assurance and a quality improvement mechanism for their local partners through certification in a range of harm reduction, human and financial resource, and strategic management components of the overall national harm reduction programme.

Such ongoing support to local NGO's allows for the greater availability of a comprehensive package of services to PWID in many parts of Ukraine, especially those with limited experience of service delivery, the management of donor funding, and in the development of partnerships with local government agencies.

The quality of the training and back-up from Alliance Ukraine also allows for greater accessibility to harm reduction services for all key populations as such guidance from Alliance Ukraine is based on both the nine recommended interventions of WHO, UNODC and UNAIDS for PWID and also on a range of good practice approaches to helping marginalized people to access health, social and other needed services in a cost-effective manner.

Components of the Alliance Ukraine technical support system is shown at Fig. 29.



**Fig. 29: Components of the Alliance Ukraine technical support system**

Source: Interviews with staff of the International HIV/AIDS Alliance in Ukraine, Kiev, July 2013; SYREX programme data. Kiev, International HIV/AIDS Alliance, July 2013.

During 2012, Alliance Ukraine delivered a total of 190 trainings to its local partners within Ukraine; some of the trainings were of a general nature and others were specific to an issue. In addition, 11 resource centres have been established throughout Ukraine with the support of Alliance Ukraine<sup>94</sup>. The objective of the resource centres is to increase the capacity of local NGO staff in a range of harm reduction services and approaches and to also increase the responsibility taken by each of the centres to cater to the needs of the organizations and people whom they serve; this is a form of decentralization to address the specific needs of specific geographic areas of the country and to reduce their dependence upon Alliance Ukraine in Kiev. Often, resource centres are located within existing NGO partner organizations implementing harm reduction services.

Basic and more advanced harm reduction training by Alliance Ukraine is also available online and provides both a certified foundation course as well as a more advanced course; a hard-copy version is also available.

The technical support unit of Alliance Ukraine also assists its partners through the functioning of an editorial board comprising a range of people from different specialisms both within and outside of Alliance Ukraine who give their time to review materials collected from partner NGOs, as well as the materials developed by Alliance Ukraine itself. The review looks at both the substantive content and technical accuracy of the materials, as well as reviewing the feedback from focus group discussions used to assess draft versions of the material. This approach assists in the production of targeted, accurate and quality-based information on a wide range of harm reduction related issues.

## **5.2 Sexual and Reproductive Health and Rights**

Alliance Ukraine includes a range of issues under its component for sexual and reproduction health and rights, including the right to:

- exercise control over one's own body, reproductive health and sexuality;
- services for the prevention and treatment of STIs, including HIV/AIDS; and,
- freedom from Gender Based Violence (GBV) in all its forms and the right of access to appropriate medical, counselling and legal services.

Since 2010, the organization has developed a training module on SRH that includes training-of-trainers (TOT) who then deliver SRH training through resource centres. At the regional level, resource centres have provided trainings to NGO staff with the support of Alliance Ukraine. The organization has also delivered trainings on SRH to social workers and psychologists, thereby increasing the availability of, and FSW accessibility to, SRH interventions.

With regards to GBV, please see Section 5.3.

Alliance Ukraine has published several materials (in Russian) for NGO staff and clients related to some aspects of SRH including the following:

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<sup>94</sup> SYREX programme data. Op. cit., 2013.

Reproductive Health:

[http://www.aidsalliance.org.ua/ru/library/our/2012/reprod\\_zdorovie\\_preview.pdf](http://www.aidsalliance.org.ua/ru/library/our/2012/reprod_zdorovie_preview.pdf)

Women's Personal Hygiene:

[http://www.aidsalliance.org.ua/ru/library/our/2013/07/WomanHealth\\_PRINT.pdf](http://www.aidsalliance.org.ua/ru/library/our/2013/07/WomanHealth_PRINT.pdf)

### **5.3 Prevention of Violence and the response to it**

Violence as defined by WHO is an action of any persons, or groups of persons, with regard to female sex workers (FSW) if such actions bring about (or can bring about) physical, psychological, economic damage or anguish to FSW, including threats of taking such actions, compulsion or deprivation of liberty in all life spheres<sup>95</sup>.

Hence, violence is often associated with physical force, such as beatings, physical trauma, and bodily injuries that heighten the risk of exposure to HIV and STIs from unprotected sexual contact. Other forms of violence include economic, psychological and emotional trauma, as well as post-traumatic stress disorder (PTSD).

Both aspects of violence and its aftermath can provoke marginalization and stigmatization of people from vulnerable populations, especially FSW, that can lead to their inability to access information and support for health and social services that such people are in desperate need of, including services to prevent, treat and care for HIV/AIDS, STIs, and drug dependence.

Violence can be perpetrated against people from vulnerable populations, especially FSW, by a wide range of people including law enforcement officers, commercial sex clients, the permanent partners of FSW, and others, who hinder access by vulnerable people to HIV/AIDS prevention, diagnostic and treatment services due to a disregard for the rights of the individual and their social protection<sup>96</sup>.

In 2012, Alliance Ukraine published the findings of research undertaken in Ukraine in mid-2011 on various types and sources of violence against FSW, and factors increasing the risk of FSW becoming infected with HIV in situations involving violence; 36% of the FSW involved in the research also injected drugs during the last 12 months<sup>97</sup>.

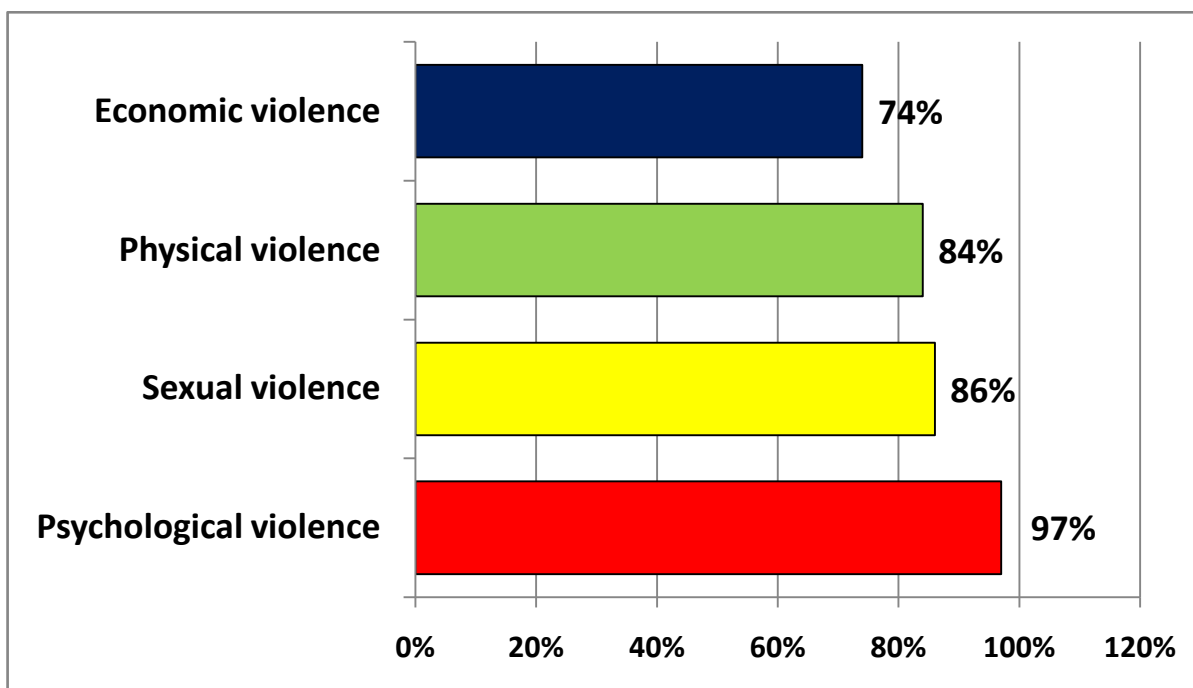
It was found that all forms of violence are an inevitable and permanent part of the life of FSW's in Ukraine. The main forms of violence experienced by FSW are outlined in Fig. 30, below, together with the percentage of FSW respondents to whom such violence occurred.

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<sup>95</sup> WHO. Violence against Women. Newsletter, Issue No. 239 (as revised in October 2013); see, <http://www.who.int/mediacentre/factsheets/fs239/ru/index.html>, accessed 25 April 2014.

<sup>96</sup> Artiuh, O., Belonosova, N., Varban, M., Demchenko, I., Kostiuchok, M., Matiyash, O., Pivovarova, N., and Plusch, A. Investigating Causes Influencing Manifestations of Violence against FSW as a Factor of Increased Risk of Exposure to HIV, Operational Survey, Brief Results. Kiev, International HIV/AIDS Alliance, 2012, p3.

<sup>97</sup> Artiuh, O., et al, Ibid., p11.



**Fig. 30: Main forms of violence experienced by FSW in Ukraine, 2011**

Source: Artiuh, O., Belonosova, N., Varban, M., Demchenko, I., Kostiuchok, M., Matiyash, O., Pivovarova, N., and Plusch, A.. Investigating Causes Influencing Manifestations of Violence against FSW as a Factor of Increased Risk of Exposure to HIV, Operational Survey, Brief Results. Kiev, International HIV/AIDS Alliance, 2012, p6-7.

Physical violence refers to physical pain or bodily injuries caused to the FSW. Economic violence includes the provision by FSW of ‘free sex’ and not receiving money or food, etc., as payment for sexual services delivered. The research also found that there was a significant and strong interrelationship among each indicator, meaning that FSW were often subjected to multiple forms of violence<sup>98</sup>.

Factors affecting FSW vulnerability to violence include:

- their illegal status from working in the sex industry;
- the conditions in which they often work, such as on a road, in a car, or in an apartment;
- the lack of any supporting environment from which to seek assistance when subjected to violence;
- social factors, such as drug and alcohol dependence; and,
- the psychology of the ‘inner world’ of a typical FSW in ‘the industry’<sup>99</sup>.

There is also a range of ‘risk levels’ dependent on the site at which the sexual services are performed<sup>100</sup>.

Risk of increased HIV infection among such FSW is attributable to several factors. 70% of those surveyed said that they had been forced to provide sexual services without the use of a

<sup>98</sup> Artiuh, O., et al, Ibid., p6-7.

<sup>99</sup> Artiuh, O., et al, Ibid., p8-9.

<sup>100</sup> Artiuh, O., et al, Ibid., p9.

condom over the previous 12 months. A further 45% of respondents said that they had had sex without using a condom voluntarily. In addition, 7% of FSW who were forced to have sex without the use of a condom said the clients were known to have been infected with STI/HIV and/or viral hepatitis<sup>101</sup>

As the report notes,

“Activities of sex workers are often times come together with stigma, including self-stigma and marginalization. When a person incurring stigma or marginalization becomes a victim of violence, often times s/he is the one accused of being guilty in it, which causes an internal feeling of guilt or self-condemnation. In many cases a person who suffered from violence or a threat of violence has understated self-assessment; as a result, often times s/he doesn’t take all the necessary actions in order to protect him/herself (in particular, to protect oneself from HIV).”<sup>102</sup>

The following strategies for the prevention of violence against FSW in the context of HIV/STI prevention and the formation of self-defending behaviour of FSWs are recommended by Alliance Ukraine to be jointly implemented by local NGOs and relevant governmental authorities, such as social services, health care institutions, and law enforcement bodies<sup>103</sup>:

- promoting a healthy lifestyle and values of health;
- promoting safe sexual behaviours among FSW, their clients, employers/intermediaries;
- ensuring accessibility and training in correct use of barrier means of contraception (condoms, femidoms);
- holding target activities for FSW who inject drugs, including approaches to harm reduction;
- training “know how to negotiate with a client” and “self-defending behaviour in a violent situation” techniques;
- promoting and ensuring accessibility of services on STI/HIV diagnostics and treatment;
- making available a “crisis counseling hotline” with short and easy-to-remember phone numbers;
- outreach and peer-to-peer techniques in the field to provide medical, social and legal services;
- ensuring FSW’s access to services targeted at solving psychological and emotional problems in conjunction with political-level efforts to tackle social, cultural and economic conditions of their work, including de-criminalization of the sex industry over the long run.

#### **5.4 Services for SubPopulations of PWIDs and their Partners**

In 2011, HIV prevention services for subpopulations of PWID’s covered a total of 28,224 Sex Workers (40% of the estimated total), 19,130 MSM (20% of the estimated total), as well

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<sup>101</sup> Artuh, O., et al, Ibid., p13.

<sup>102</sup> Artuh, O., et al, Ibid., p15.

<sup>103</sup> Artuh, O., et al, Ibid., p21-22.

as 25,497 prisoners (18% of the estimated total). This is a significant achievement in addition to the HIV prevention services delivered to PWID as outlined in Section 4, above<sup>104</sup>.

#### **5.4.1 Female Sex Workers (FSW)**

A total of 46 local NGO partners work with Alliance Ukraine on HIV and STI prevention among female sex workers (FSW) with the IBBS of 2011 estimating there to be between 54,800 and 84,800 women involved in sex work and a national consensus established at 80,000 women involved in the industry<sup>105 106</sup>. As of 31 December 2012, a total of 29,043 FSW had received HIV and STI prevention interventions from Alliance Ukraine through its local NGO partners throughout the country. This equates to a coverage of 36% which is lower than in recent years but better than during the period between 2004 and 2007.

The basic package of services delivered to FSW's include the following:

- Distribution of male and female condoms;
- Distribution of essential medicines and personal hygiene products, if needed;
- Counseling on HIV and safer sex;
- Distribution of IEC materials on behaviour change;
- Self-support groups;
- Training for FSWs;
- Voluntary counseling and testing for HIV with rapid test; and,
- STI diagnosis and treatment, including the use of rapid tests for syphilis, gonorrhea and Chlamydia.

Additional services, as outlined below, may also be provided dependent on the individual needs of the FSW and the time available as well as the location of the interaction between the NGO staff member and the individual FSW or group of FSW's:

- Hepatitis B and C rapid test;
- Access to a community centre;
- Services on sexual and reproductive health;
- Development and publishing of IEC materials for FSW;
- Peer Driven Intervention (PDI) for FSWs using structured interventions;
- Referral to relevant medical institutions, if needed;
- Mobilization of leaders to undertake skills development so as to become FSW representatives;
- Developing strategies to prevent, avoid, or deal with, violence;
- Individual case-management; and,
- Online outreach.

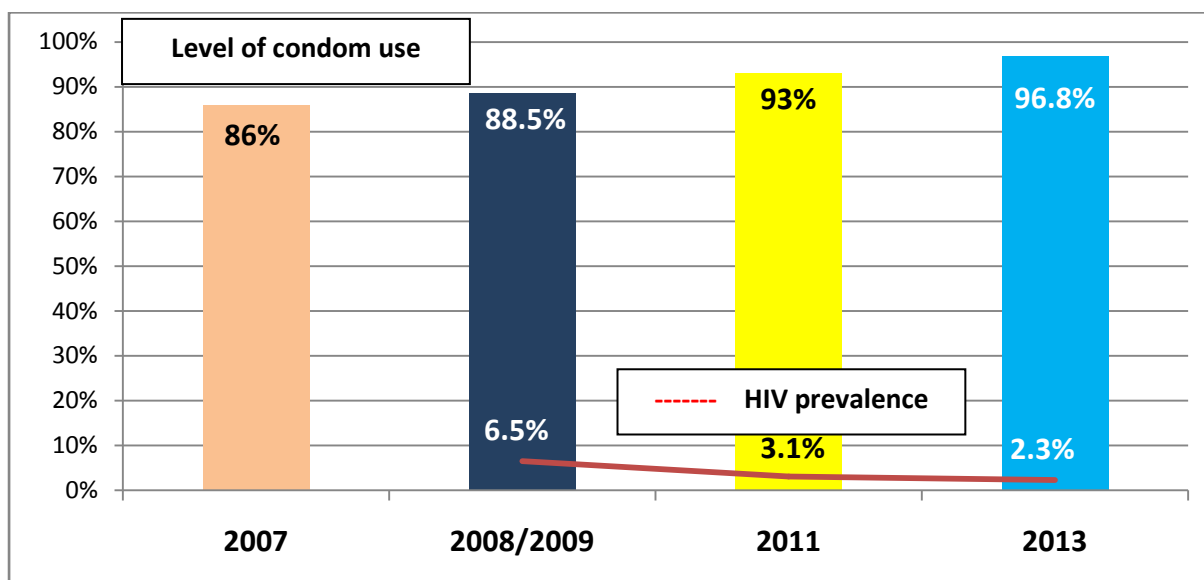
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<sup>104</sup> International HIV/AIDS Alliance in Ukraine, Annual Report, Op. cit., p6.

<sup>105</sup> SYREX programme data. Op. cit., 2013.

<sup>106</sup> Berleva, G., Dumchev, K.V., Kobyshcha, Y.V., Paniotto, V.I., Petrenko, T.V., Saliuk, T.O., Shvab, I.A. Analytical report based on sociological study results: Estimation of the size of populations most at-risk for HIV infection in Ukraine in 2009. Kiev, ICF International HIV/AIDS Alliance, 2010, in, UCSF/CDC, Op. cit., p58.

HIV prevalence among FSWs below the age of 25 years is decreasing and the percentage of such FSWs who use a condom every time they have sex is increasing, as can be seen in Fig. 31, below.



**Fig. 31: HIV prevalence and level of condom use among FSWs aged under 25 years in Ukraine, 2007 to 2013**

Source: Based on IBBS data from FSW in Ukraine in 2007, 2008, 2009, 2011 and adjusted with data of IBBS 2013.

#### 5.4.2 Men who have Sex with Men (MSM)

Alliance Ukraine estimate that there are in the region of 176,000 Men who have Sex with Men (MSM) in Ukraine, although the use of other methodologies put the number higher at 222,775 (range from 200,200 to 245,350) and that more than 1% of MSM are PWID although it appears that few MSM sell sexual services. HIV prevalence among MSM was estimated in 2011 to be 6% but with some cities of Ukraine reporting such HIV prevalence among MSM to be as high as 20%<sup>107</sup>. MSM overall appear to be younger and more educated than other key populations in Ukraine and, consequently, the HIV prevention approach is targeted towards such key factors.

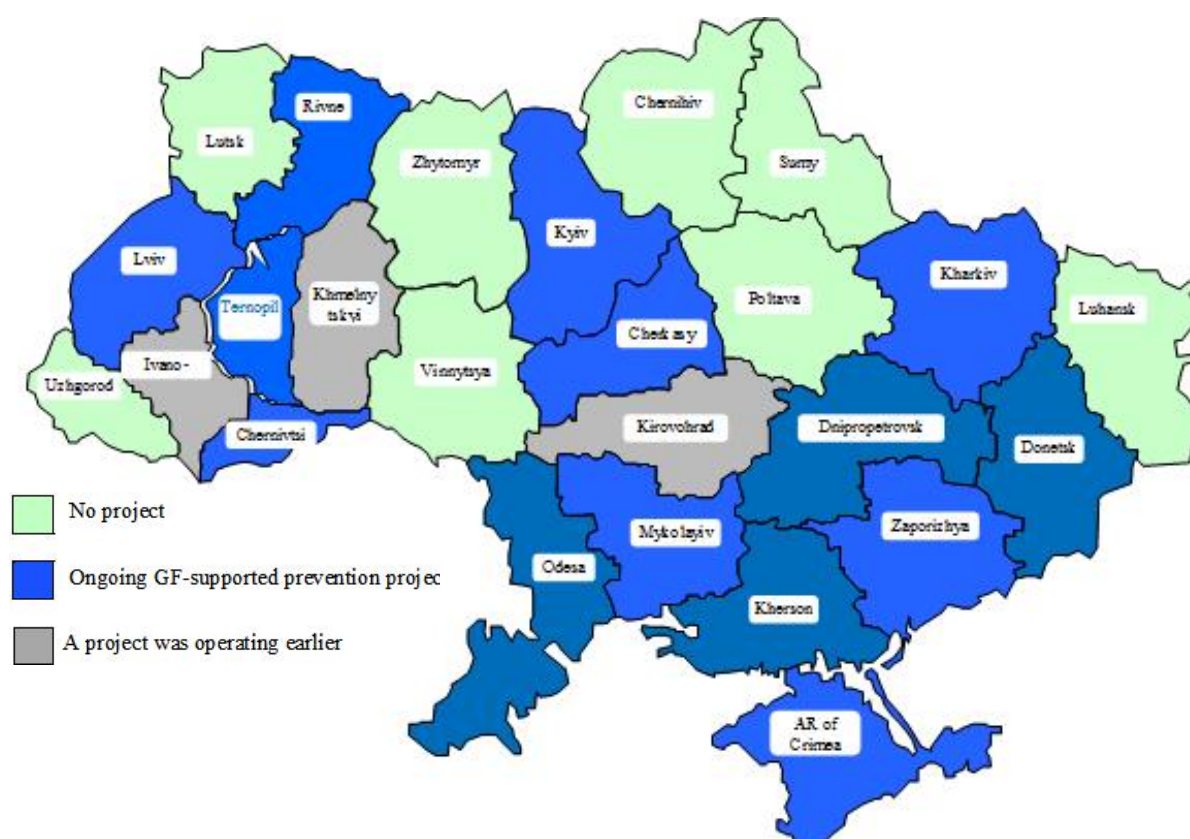
During 2013, Alliance Ukraine through its partners targeted 20,724 MSM (or 12% coverage using the Alliance Ukraine population size estimate, or 9% using the IBBS 2011 population size estimate) with HIV prevention interventions in those areas indicated in Map 3, below. The package of services provided to MSM by Alliance Ukraine partners includes the following:

- Distribution of male/female condoms and lubricants
- Information materials on how to prevent HIV transmission
- Counselling by a specialist, such as a social worker, doctor (proctologist, urologist), psychologist, and lawyer, as needed

<sup>107</sup> Berleva, G., et al, op. cit., p58; [http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm\\_en\\_2011.pdf](http://www.aidsalliance.org.ua/ru/library/our/2012/me/msm_en_2011.pdf), accessed 30 June 2013.



- Voluntary HIV testing and counselling
- STI diagnostics and treatment
- Diagnostics of Hepatitis B and C, vaccination against Hepatitis B
- Group work
- Client involvement in training activities
- Organization of prevention-oriented leisure activities for clients
- Peer-driven counselling
- Basic household services
- Mentor support programme
- Counselling on safe sexual practices
- Online counselling (through social networks)



**Map 3: HIV prevention projects for MSM in Ukraine**

Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, July 2013.

However, to-date, there is no widespread agreement in Ukraine as to what should constitute the minimum package of services for MSM although the minimum package of services for MSM within programmes supported by the Global Fund consists of condoms, informational material and counselling. Furthermore, Alliance Ukraine developed, ‘Standards for providing social services to prevent HIV infection among persons at high risk of HIV infection through sexual intercourse’, in which a package of services for MSM is described, and for which the Government of Ukraine has given its approval for use by all implementing agencies in the country<sup>108</sup>.

<sup>108</sup> <http://zakon4.rada.gov.ua/laws/show/z0904-10>, accessed 30 June 2013.

### 5.4.3 HIV prevention services to Most at Risk Adolescents (including Street Children)

The United Nations defines children as aged 0 to 18 years, with the WHO view that adolescents are aged from 10 to 19 but UNICEF considering adolescents as those aged 10 to 18 years, as included in the Convention on the Rights of the Child, and for young people to be those aged 10 to 24 years with ‘youth’ being aged 15 to 24 years. The term most at-risk adolescents (MARA) is used by UNICEF to include adolescent<sup>109</sup>:

- male and female injecting drug users (IDUs) who use non sterile injecting equipment;
- males who have unprotected anal sex with males;
- females and males who sell unprotected sex, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex; and,
- males who have unprotected sex with female sex workers (part of sexual initiation in many countries where female virginity at marriage is highly valued).

However, Alliance Ukraine and its partners use a slightly broader definition of MARA than that of UNICEF which was developed following research undertaken in 5 towns of Ukraine and an analysis of subgroups of at-risk children and MARA, respectively. Consequently, Alliance Ukraine includes in its definition of at-risk children and MARA,

‘Children and young people who are most at risk of HIV infection as a result of their risky behaviour, namely: injecting and non-injecting drug and alcohol users; adolescents who practice unprotected sex; male adolescents who have sex with males; adolescents who practice sex for profit and those who are deprived of care, and are homeless and live on the streets.’

Support is also given to children and adolescents who are in conflict with the law as well as those that have been institutionalised or who have ‘graduated’ from an institutional upbringing. Such scenarios put children and adolescents at much higher risk of HIV through their resultant behaviours<sup>110</sup>.

Alliance Ukraine works with its 17 local partner NGOs and the Government in support of HIV prevention, and associated services, for most at-risk street children and adolescents throughout the country. Such children and teenagers are located at social rehabilitation schools, boarding schools for orphans and support is also given to children who are disabled or deprived of parental care and those who fall within the jurisdiction of Social Services for Children.

UNICEF in Ukraine estimate there to be approximately 85,000 most at-risk children and adolescents throughout the country, of which around 65% are male and 35% female.

Interventions for such children and teenagers are spread between services that fall under the mandate of the Ministry of Family, Youth and Sports of Ukraine – which was incorporated

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<sup>109</sup> Homans, H. UNICEF Manual on Programming to prevent HIV in most at-risk adolescents, Final Draft. Geneva, UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), 2008, p1.

<sup>110</sup> SYREX programme data. Op. cit., 2013.

into the Ministry of Social Policy during 2011 – including, for example, socio-psychological rehabilitation of children, and those of the Ministry of Education and Science of Ukraine – which became the Ministry of Education and Science, Youth and Sports of Ukraine during 2011 – such as general and social rehabilitation as well as vocational training. Alliance Ukraine provides NGO partners with skills training in areas such as HIV prevention techniques and formation of healthy lifestyle skills with the homeless and for uncared-for children, as well as HIV prevention training and awareness-raising for children at relevant institutions run by the Ministry of Family, Youth and Sports of Ukraine, even though there are many concerns relating to the conditions in which children and adolescents live in such institutions and the possible abuse that they face.

During 2011, a total of 13,788 most at-risk children and adolescents received support, of which 4,085 (30%) were located at 115 institutions under the jurisdiction of the Ministry of Social Policy. 2,025 individuals (15%) were supported at 75 educational institutions for ‘socially unsecured categories of children’ that are under the jurisdiction of the Ministry of Education and Science, Youth and Sports<sup>111</sup>. It is also estimated that 9% of all most at-risk populations (MARPS) included in Alliance Ukraine interventions are adolescents<sup>112</sup>.

The Alliance Ukraine model, originally piloted with funding from USAID, helps local NGOs to develop the skills to ensure that street children and most at-risk adolescents (MARA) have access to existing health care and social infrastructure.

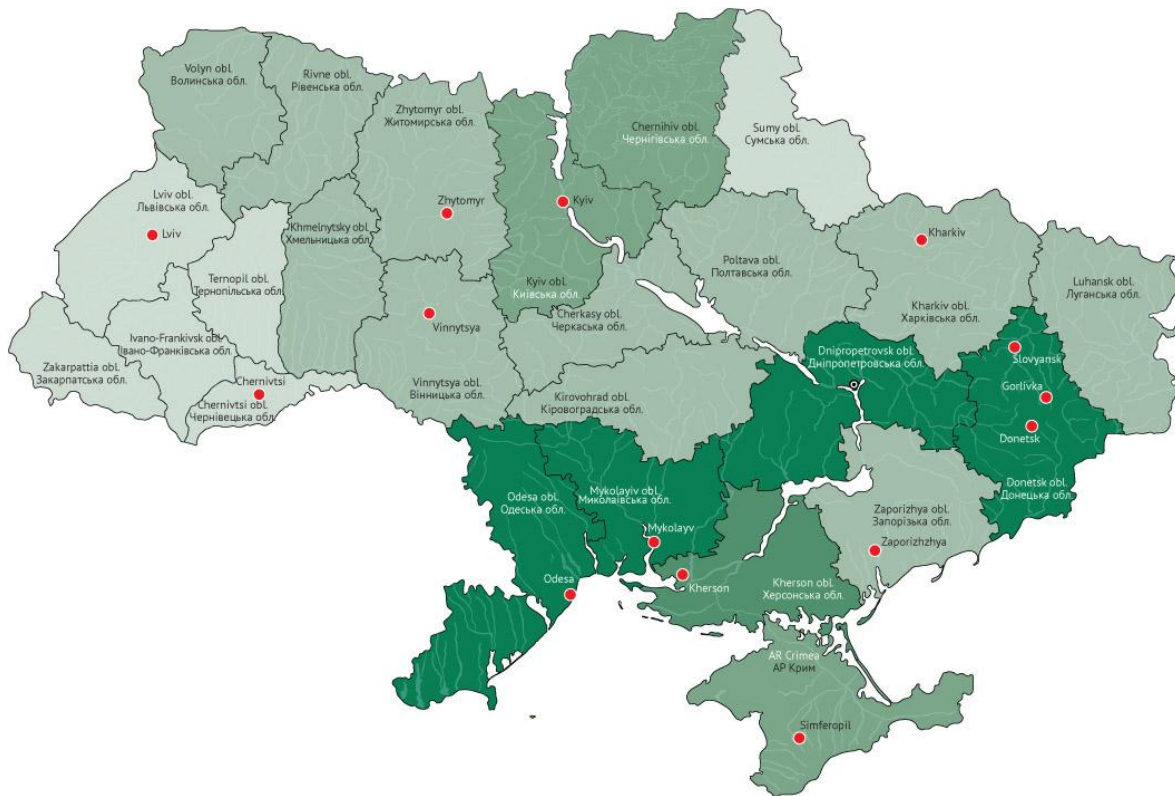
In addition, support is given to the development of local NGOs to run ‘social patrols’ by NGO staff, each comprising a social worker, a psychologist and a nurse, who deliver basic pre-medical and social services at locations where uncared-for children congregate. Services include the training of children and adolescents in the basic techniques of HIV/STI prevention, counselling of children and adolescents as well as access to a child psychologist, rapid testing for HIV, Hepatitis B and C, and STIs – with all testing starting from 14 years of age – as well as assistance in dealing with the criminal police and social services together with cross-referral to/from other assistance projects. During 2012, a total of 8,602 children (63% boys and 36% girls) received such support<sup>113</sup>. The locations of HIV prevention projects for MARA in Ukraine can be seen on Map 4, below.

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<sup>111</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Op. cit., p56.

<sup>112</sup> SYREX programme data. Op. cit., 2013.

<sup>113</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2012, Op. cit.



**Map 4: HIV prevention projects for MARA in Ukraine**

Red dots are projects; Green zones are areas that are most affected by the HIV epidemic in a region. Source: SYREX programme data. Kiev, International HIV/AIDS Alliance, July 2013.

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### Case Study – Odessa

The city and region of Odessa is located in southern Ukraine, close to the Black Sea. There are about 20 NGOs working in the Odessa region and each has a particular niche role to play in the delivery of a continuum of prevention to care and treatment for HIV/AIDS. The local NGO, ‘Way Home’, has a wide range of programmes available for the more than 12,000 adults, children and adolescents most at-risk of HIV/AIDS, including prisoners, in the Odessa region.

‘Way Home’ provides a comprehensive package of HIV/AIDS interventions, as well as screening, diagnostics and treatment for other communicable diseases including STIs, TB and viral Hepatitis. The services are broadly split into those for most at-risk children and adolescents, of which there are about 300, with around 25% of them being female, and for adults, of which there are more than 9,500 PWID, of whom about one-third are female.

NSP and HTC, together with rapid testing for STIs and viral hepatitis, and screening for TB, are available through several entry points including mobile outreach on foot and a small bus that acts as a mobile drop-in centre, as well as at a community centre in Odessa city; half a dozen pharmacies also provide NSP and are trained to make referrals to other health services. In the near future, the outreach workers of ‘Way Home’ will undertake case management for

people in particular need of more hands-on assistance to access a range of health and psychosocial services.

Outreach workers – many of whom are from one of the key populations most at-risk – select routes in the city where they live as their familiarity with such areas makes them more efficient at locating new clients. Once first contact has been made with a new client, basic information is collected by the outreach worker and a unique identifier code (UIC) issued on a small plastic card that is standard for all of the Alliance Ukraine partners working on HIV prevention nationwide. New clients are given the opportunity to visit a community centre where they can get food, have a wash and clean their clothes. A community centre in Odessa city operates for all key population groups and is run by 4 staff that provide a range of services, as well as teaching computer skills and holding discussions on a range of health, social and legal subjects. Six pharmacies in the city work in collaboration with ‘Way Home’ to provide packs of sterile needles/syringes with alcohol swabs and IEC materials, plus condoms.

Other options for new clients to receive assistance include a mobile drop-in centre and from an outreach worker on foot. There is also the opportunity for them to access basic health services and engage in discussion groups on the problems that they face in their daily lives. A total of 5 outreach workers patrol 7 routes in Odessa city on a regular basis.

Between 3pm and 6pm each afternoon doctors and nurses of the city AIDS Centre join a mobile bus to provide rapid HIV tests to young people as well as adults, and to assist with referral, if needed, to access ART. There are approximately 32,000 PLHA in Odessa. Access to ART is not easy for PWID in Odessa, as is the case all over Ukraine, due to the cumbersome registration rules required by AIDS Centres who dispense ART through doctors. In Odessa, the head of the main AIDS Centre in the city is adamant that the support given by the ‘Way Home’ staff is vital in helping the vulnerable groups, especially PWID, to access ART. Alliance Ukraine have delivered a range of trainings to staff of the Odessa AIDS Centre on issues related to PWID in particular. However, only about 2% of HIV-positive PWID have so far been able to access ART in the Odessa region, a rate of coverage that both the head of the AIDS Centre and the ‘Way Home’ team plan to rapidly increase in partnership with each other in the coming months.

To-date, OST and ART are not yet available at the same location in Odessa but both the local Government and the NGO are trying to remedy this situation together with two combined OST/ART sites planned to be operational by the end of 2013. Officially, ART is available to prisoners in the Odessa region unlike in most other regions of Ukraine. OST is also supposed to be available to prisoners but the reality is that it is not.

‘Way Home’ currently facilitates OST access for 157 people, for both methadone and for buprenorphine, of which the vast majority are male. The OST clinic has one coordinator, 2 social workers, one part-time TB specialist, 1 person that deals with communicable diseases, one psychologist, one general doctor and one neuro-pathologist. Other specialists are brought into the clinic as needed. At present the maximum dose of methadone dispensed is 200mg’s whilst the average dose is around 120mg’s. 1-2 patients/clients relapse each month on average, equating to a drop-out rate of approximately 8-15% per year. The Government receives the OST medications from Alliance Ukraine, paid for by Global Fund.

There are 8 sites in Odessa where Hepatitis B vaccinations are available; outreach workers help PWID to access such locations as needed. From 3-5% of PWID have Hepatitis B and 20% have Hepatitis C in the Odessa region, far lower than in many other regions of Ukraine. Outreach workers maintain a journal of patient/client health conditions and follow-up – usually by phone – when further treatment action is due. Referral of FSWs between NGOs in Odessa to access specific services is working well. For example, CARITAS is able to provide free x-rays for TB diagnosis, a service not available at ‘Way Home’.

‘Social Patrols’ take place in areas of Odessa city where most at-risk children and adolescents are known to congregate. Staff of ‘Way Home’ build a trusting rapport with the children and adolescents over time through play, art and discussion groups. Many sports activities are also available as a temporary alternative to living and working on the street for children and adolescents. Overnight stay is also available for those most at-risk. Unfortunately, only ‘Way Home’ has such a service for MARA as other organizations only provide day-care services at a centre. Many of the children and adolescents are internal migrants from less affluent areas of Ukraine and move to the Odessa region when it is popular with tourists from Ukraine and other countries. The standard comprehensive harm reduction package is made available to such at-risk children and youth with the exception of NSP if they are below the age of 14 years<sup>114</sup>. In addition, if a young person is below the age of 14 years and is HIV-positive, the AIDS Centre requires a legal parent or guardian to sign approval for the dispensing of ART to that young person; this, however, is not always possible. Therefore, a pragmatic approach is taken by the AIDS Centre if it is clear that the young person has a reliable mentor who can act in the best interests of the young person, in which circumstance ART will be provided.

‘Way Home’ is also heavily engaged in the production of several regional and national newspapers for specific key populations most at-risk of HIV/AIDS. They also produce a periodic children’s magazine, “Kot” (The Cat), with safe behaviour and health messages interwoven with fun stories and pictures.

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<sup>114</sup> Balakireva OM, Bondar TV, Tsviliy OV, Sudakova AV, Sakovych OT. Review of the National Legislation and Current Practices on the Guidelines of HIV counselling and testing of Adolescents, including Most-at-Risk Adolescents. Kiev, Ukrainian Institute for Social Research after Olexander Yaremenko, UNICEF, 2013; [http://www.unicef.org/ukraine/Analysis\\_VCT\\_for\\_MARA\\_Eng\\_ed.pdf](http://www.unicef.org/ukraine/Analysis_VCT_for_MARA_Eng_ed.pdf), accessed 30 June 2013.

From January 2012, Phase 1 of Global Fund Round 10 has supported 17 NGOs through Alliance Ukraine to fill existing gaps in HIV prevention services through focused outreach to locations where most at-risk children and adolescents stay and to further consolidate a model of health care and social management for such children and MARA<sup>115</sup>. Starting in 2013, Peer-Driven Interventions (PDI) are being used by 4 NGOs to reach out to those aged 10 to 18 years with small rewards made for those who enrol peers aged 10 to 14 years and living on the street.

Alliance Ukraine and UNICEF are working together to try to change the existing system so that institutionalising children and adolescents is undertaken as a last resort rather than as a first option for agencies of local government. They are also working together to establish minimum standards of service for health and social services for at-risk children and MARA and to establish youth-friendly clinics in some regions of Ukraine, funded by UNICEF initially.

#### **5.4.4 Prisoners & People on Probation**

Prisoners are considered by WHO, UNODC and UNAIDS as part of the key populations most at-risk of HIV/AIDS<sup>116</sup>. Furthermore, all prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community<sup>117</sup>.

##### **5.4.4.1 HIV prevention services for Prisoners**

The provision of HIV prevention, treatment and care services to people in prison is the responsibility of the All-Ukrainian Network of PLHA as part of the overall division of labour between ‘the Network’ and Alliance Ukraine vis-a-vis Phase 1 of the Round 10 grant from the Global Fund. It is understood that the focus of the work of ‘the Network’ is not HIV prevention for prisoners, but rather access to OI/ART. However, although Alliance Ukraine has little direct work being undertaken inside of prisons in Ukraine, they are actively working on an innovative approach to HIV prevention, treatment and care for people on remand from prison who are required to register with local police on a regular basis.

The National Penitentiary Service comprises people being temporarily detained pending trial as well as correctional facilities – or prisons – for those found guilty in a court of law. As of 1 August 2013, there were 134,957 prisoners incarcerated in 182 prisons throughout Ukraine with 13 prisons for females only and a further 8 prisons for children/adolescents aged 14 years and older<sup>118</sup>.

With grants from Global Fund Rounds 1 and 6, Alliance Ukraine and its local NGO partners implemented a peer-to-peer strategy for HIV prevention in prisons which is now being implemented by ‘the Network’. There are, on average, between 500 and 1,500 inmates in

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<sup>115</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Op. cit., p58.

<sup>116</sup> WHO, UNODC, UNAIDS Technical Guide, Op. cit.

<sup>117</sup> WHO/UNODC/UNAIDS. Evidence for action Technical Paper: Effectiveness of interventions to address HIV in Prisons. Geneva, WHO, 2007; see, [www.who.int/hiv/idu/en/index.html](http://www.who.int/hiv/idu/en/index.html), accessed 31 July 2013; UNODC/WHO/UNAIDS. HIV/AIDS prevention, care, treatment and support in prison settings: A framework for an effective national response. Vienna, 2006; see, [www.unodc.org/pdf/HIV-AIDS\\_prisons\\_July06.pdf](http://www.unodc.org/pdf/HIV-AIDS_prisons_July06.pdf), accessed 31 July 2013.

<sup>118</sup> SYREX programme data. Op. cit., 2013; see also, <http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/628075>, accessed 31 July 2013.

each prison; each prison comprises 7 to 8 'units', or departments. Volunteers from each unit are then trained in HIV prevention techniques, such as condom and lubricant use, distribution of IEC materials, etc., which are then distributed by the volunteers to others in their unit; this is in addition to the basic health services provided by the Prison Department inside of each prison.

In a 2003 study involving 43,000 prisoners who were tested, the HIV prevalence was reported as 8%. Research in 2004 demonstrated that the level of HIV infection in prisons ranged from 13% to 33%<sup>119</sup>. The IBBS of 2009 found the infection rate to be 15% among prisoners<sup>120</sup>. Prisoners can get access to ART but there is no community involvement which could result in a lack of awareness regarding safer behaviours inside prison for the prevention of HIV and other communicable diseases<sup>121</sup>. During 2011, the coverage of prisoners with HIV prevention services was 17.6% (25,497 persons) out of an estimated 145,000 prisoners nationwide, through work undertaken by 19 local NGOs in 54 prisons located in a total of 15 regions of Ukraine<sup>122</sup>.

However, due to cutbacks in the Phase 1 grant of Round 10 of the Global Fund, and the new role of 'the Network', the prevention interventions have been reduced in size. The emphasis now is on motivating prisons to be tested for HIV using rapid test kits and the distribution of a small amount of IEC materials. This approach has no role for the active participation of prisoners and, it appears, there has been a movement away from quality interventions to increasing the number of interventions received in prison. Approximately one-third of prisoners have now been tested for HIV.

Although OST services are provided for in prison regulations, the reality is that no such services are actually being implemented in most prisons of Ukraine. It is also too expensive to transport opiate-dependent prisoners to OST sites located in the community each day and, therefore, no OST provision is yet available. It is noted, however, that 1-2 prisons have OST available on an informal basis through assistance provided by local NGOs.

The situation may improve based on the lessons learned from a UNODC supported pilot OST programme in collaboration with the Government in 3 regions that will involve one prison for males, one prison for females and one site holding people at the pre-trial stage of court proceedings. UNODC in Ukraine is planning to support a total of 15 interventions as part of the pilot programme, including OST<sup>123</sup>.

As of the first-half of 2013, there are no NSP services available in any prisons of Ukraine.

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<sup>119</sup> Bobrovskyy O., Bochkova L., Eshchenko O., Hayovych Y., Kobyshecha Y., Kruhlov Y., Kuzin I., et al. Ukraine Harmonized AIDS Response Progress Report, January 2010-December 2011. Kiev, International HIV/AIDS Alliance, 2012.

<sup>120</sup> Demchenko I, Kostyuchok M, Byelonosova N. Analytical Report on Results of the Linked Research. Monitoring of awareness, behavior and HIV prevalence among prisoners as part of second generation HIV surveillance. Kiev, International HIV/AIDS Alliance / The Global Fund, 2010, p45; [http://www.aidsalliance.org.ua/ru/library/our/monitoring/pdf/zvit\\_zakl.indd\\_eng.pdf](http://www.aidsalliance.org.ua/ru/library/our/monitoring/pdf/zvit_zakl.indd_eng.pdf), accessed 31 July 2013.

<sup>121</sup> SYREX programme data. Op. cit., 2013.

<sup>122</sup> International HIV/AIDS Alliance in Ukraine, Annual Report, Op. cit., p54.

<sup>123</sup> Briefing from Sultanov, M., UNODC, Kiev, 5 July 2013.



#### 5.4.4.2 HIV prevention services for people on Probation

A more recent development has been the introduction of a programme of HIV prevention targeting people on probation, meaning that they have a suspended prison sentence and must regularly register with police at a specific location. Such registration is run by the 'Criminal Inspection' unit of the Government which, it is believed, will soon be renamed the 'Probation Service' and for which there are 287 units throughout Ukraine. On average, people on probation must report to the police 1-2 times every week. It is estimated that up to 70% of all people on probation are drug users, many of which are PWID, and have been in conflict with the law due to the possession of illicit drugs<sup>124</sup>.

Initially, Alliance Ukraine and 13 local NGO partners are focusing on implementing the programme with 85 Criminal Inspection units in 9 regions of Ukraine; for a region to be selected, it must have 5 or more Criminal Inspection units with 100 or more people on probation with each unit. The target is to have 7,000 people in the HIV prevention programme by the end of 2013, which is most likely as 2,500 people are already part of the programme within the first 3 months of implementation since January 2013; of the 2,500 clients enrolled by 31 March 2013, 1,700 of them (68%) reported as having never received any form of HIV prevention intervention before<sup>125</sup>.

The minimum package provided to people on probation includes sterile needles/syringes with alcohol swabs, together with condoms, lubricant, IEC materials and counselling; HIV, TB and Hepatitis B and C rapid testing are also available as part of the basic package.

### 5.5 Innovation

Alliance Ukraine has developed innovative techniques of working with the populations that are most vulnerable to HIV through interventions concerning HIV, STI, viral hepatitis and TB prevention that were developed or adapted to meet the local operational conditions in recent years. Such innovations are directly helping to increase the availability and accessibility of harm reduction services for key populations in Ukraine.

Of note is the documentation that Alliance Ukraine has undertaken of its innovation for use by people managing programmes for PWUD, PWID, FSW, MSM, children and adolescents who practice risky behaviours, as well as for professionals who directly provide services to such key populations at-risk of HIV/AIDS. Much of the innovation comes from operational research and the adaptation of different models, frameworks and approaches.

Specific innovations include:

- Involvement of nurses in the work on outreach routes for the provision of pre-doctor medical care to PWID;
- Peer-driven prevention of HIV for PWID;
- Brief intervention for non-injecting drug users;
- Controlled secondary syringe exchange;
- Online outreach work for FSW and PWID;

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<sup>124</sup> SYREX programme data. Op. cit., 2013.

<sup>125</sup> SYREX programme data. Op. cit., 2013.

- Peer-driven prevention of HIV for FSW;
- Peer-driven prevention among adolescents engaging in HIV/STI risk behaviours;
- “Social Patrol” for street children and adolescents;
- Mentor support programme;
- Web-based information portal for MSM health;
- Peer-driven prevention of HIV for MSM;
- Prevention of HIV for MSM through social networks;
- Community initiated treatment interventions (CITI), also known as the provision of social support – case management – services to ensure access by vulnerable populations to ART;
- Creation of Gender-sensitive Services;
- Early Detection of Pulmonary Tuberculosis in IDU, IDU partners, MSM, FSW and adolescents who practice risky behaviours;
- Supervision of the HIV-service NGO Psychologists;
- The Editorial Board of the Alliance-Ukraine Serves to Increase the Quality of Reading Materials Published by the HIV-service organizations;
- The Inter-Regional Knowledge Hubs (IRKH) on HIV/AIDS; and,
- Online Harm Reduction Lessons.

A summary of the innovative approaches piloted and adopted by the Alliance Ukraine partners to address specific issues and challenges over recent years can be found at Annex 3.

## 6. KEY CHALLENGES AND HOW THEY ARE BEING OVERCOME

### 6.1 Legislation and Policies

A range of legislation, policies and orders inhibit the effective delivery of a comprehensive package of harm reduction, and associated interventions, for all key populations, and their respective partners, throughout Ukraine. Some of the key challenges in this regard, and the results to-date, include – but are not limited to – the following<sup>126</sup>:

- Issue: Homophobic legislation proposed by some members of Parliament since 2012.  
Status: Strong advocacy is taking place with a range of people of influence in Parliament and the Government to have this approach dropped. The Government has drafted an anti-discrimination law, but this has been rejected by many Members of Parliament. This issue is still outstanding and, if such legislation is passed, will severely hamper HIV prevention, treatment and care services for MSM in particular.
- Issue: In 2010, Ministry of Health Order No. 634 (which amends Order No. 188 of 2000) brought into force amendments that significantly reduce the legal threshold for ‘small’, ‘large’, and ‘extra large’ quantities of certain types of illegal drugs, including those most commonly used by PWID in Ukraine, with criminal liability for possession of acetylated opium – the most widely used injectable drug in Ukraine – reduced by a factor of 20; this has resulted in a dramatic reduction in the return of used needles/syringes by PWID as well as a reduction in the number of PWID willing to enrol in OST programmes throughout the country.  
Status: Advocacy and technical assistance is being given to relevant stakeholders, including the Ministry of Health, the Ministry of Interior, and the State Service on Drug Control. The issue has also been raised at the 106<sup>th</sup> Session of the UN Human Rights Committee, Geneva,
- Issue: Administrative responsibility for individual prostitution and related repressive police activities. Sex work was decriminalised in 2006 and such work is now an administrative violation rather than a criminal act. However, police activities and discriminatory attitudes toward sex works are having negative consequences on HIV prevention work among sex workers.  
Status: Alliance Ukraine and its partners are advocating for regional governments and police authorities to change their approach and to thereby facilitate the provision of health services, including HIV prevention, treatment and care, to sex workers.
- Issue: Establishment of a common authority to coordinate activities for the implementation of the HIV/AIDS policy.  
Status: The National Coordination Council was established in May 2005 that includes 17 representatives of state bodies, international organizations and NGOs.
- Issue: Protection of the rights of people living with HIV/AIDS (PLHA).  
Status: An Advocacy Committee was formed by the Government for the protection of the rights of PLHA and vulnerable groups that has become a generator of ideas to

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<sup>126</sup> SYREX programme data. Op. cit., 2013.

change policy to overcome stigma and discrimination, to make changes to the drug control policy and address regulatory problems faced by PLHA and vulnerable people on a daily basis.

- Issue: Draft law of 2005 sought to allow medical staff to disclose the HIV-positive status of a person to their relatives, partners and others who reside with the person without the prior consent of the individual. This is contrary to the key principles of the right to protection of the individual and patient confidentiality.  
Status: As a result of considerable advocacy work, the draft law was excluded from further consideration in September 2005.
- Issue: Slow implementation of OST services.  
Status: A range of advocacy activities and events took place resulting in the President of Ukraine to issue a Decree in December 2007, 'On additional urgent measures to respond to the HIV/AIDS epidemic in Ukraine', that included specific activities to remove obstacles to the scaling-up of OST programmes and for Government agencies to establish cooperation with NGOs.
- Issue: Lack of state funding for HIV/AIDS prevention and treatment programmes.  
Status: A powerful information and advocacy campaign was undertaken targeting senior government officials, members of parliament and the Cabinet of Ministers, including the involvement of the mass media. This resulted in an increase of the state budget for such services from 21m UAH in 2006 to 98m UAH in 2007, an almost five-fold increase.
- Issue: Absence of appropriate Government regulations and models of prevention service provision for PWID, FSW, and MSM, that make it virtually impossible for Alliance Ukraine, or others, to hand over funding of such services to Government institutions, such as AIDS Centres and the Ministry of Social Services, etc.  
Status: Alliance Ukraine and its partners are advocating for the development of such regulations and are piloting models of prevention service provision.
- Issue: Concerning Ministry of Health Order No. 188 of 21 January 2010 on the strict regulation of the circulation of legal narcotic drugs within medical facilities that is creating a lack of some medications, such as take-away doses for OST patients/clients.  
Status: Alliance Ukraine and its partners are advocating with the Ministry of Health to change such restrictive practices.
- Issue: Concerning Ministry of Health Order No. 200 of 27 March 2010 on OST regulations for health care facilities, there are numerous restrictions for OST patients such as a ban on driving a car, etc.  
Status: Once again, Alliance Ukraine and its partners are advocating with the Ministry of Health to make further amendments to those already included in the 27 March 2012 revision.
- Issue: Absence of OST, or the continuation of OST, for those patients/clients arrested and/or imprisoned.

Status: Advocacy is being undertaken to fully operationalise Order No. 821/937/1549/156 of 22 October 2012 of the Ministries of Health, Interior, Justice and the State Service on Drug Control concerning the provision of OST to such people so all such people can consistently receive OST at all prisons and other closed settings throughout Ukraine.

- Issue: Systematic violations of the rights of PWID, including OST patients/clients, through repressive police behaviours, such as requests to service providers to give confidential patient information, unlawful arrest, fingerprinting, and searches, especially around OST sites.

Status: Alliance Ukraine is raising these issues at both regional and national levels to seek a change in approach by law enforcement agencies, especially in areas around OST sites.

## 6.2 Practices

For all members of key populations, and especially for PWID, one of the biggest challenges to overcome in being able to access health and social services is the lack of having a ‘passport’, or means of official identification. This results in the individual being ineligible, for example, to register for ART. In order to obtain an official identification, the individual must have an address; for many PWID, they are either unable, or unwilling, to provide such details for fear of police action against them due to the official view that PWID are breaking the law of Ukraine through their drug using activities.



This specific obstacle is now being overcome through assistance provided by NGO case managers who can assist, on a voluntary basis, the individual PWID, MSM or FSW to apply for, and receive, a national identification document. This thereby enables the individual person to access many more health and social services than would otherwise be the case.

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### Case Study – Poltava

The city of Poltava, and the region of the same name, is located in northeast Ukraine and is the home to the local NGO, ‘Svitlo Nadiyi’, or ‘Light of Hope’. This city is a very good example of how Government and NGO partnership can work effectively in helping key populations most at-risk of HIV/AIDS through the development of integrated care centres that act as one-stop shops for people who inject drugs (PWID), for example, to access the key health services recommended by WHO, UNODC and UNAIDS for the prevention, treatment and care of HIV/AIDS. Such services include the provision of sterile needles/syringes, the availability of rapid tests for HIV, STIs and viral Hepatitis, and assisted referral to nearby TB and HIV confirmatory laboratory tests.

The main site in Poltava town, open daily from 8am to 2pm, dispenses opiate substitution therapy (OST) by Government physicians to over 200 opiate-dependent people every day, both buprenorphine and the tablet form of methadone, as well as support from social workers

and case managers from the local NGO. Drug dependent people with co-occurring diseases are able to get all of their treatment needs catered for at the one site, saving them considerable time. As one person who use to inject opiates noted at the clinic,

“I was ill for more than a year with tuberculosis and before the existence of the integrated centre, I had to go to different places for treatment and waste a lot of time. But now I don’t have to go anywhere else...when I felt ill, the social worker phoned me to urge me to come and get my methadone dose.”

As a result, the drop-out rate from the OST programme is an average of only one person per month out of a total of 210 patients/clients, or just 5.7% per year, well within the global average rate for drop-out of around 30%. Partnership between the local NGO and the local Government means that if an OST patient is arrested and has his/her OST ID card in their possession, the local police will contact the clinic.

The integrated care centre also has facilities to treat emergency cases, such as people who are in distress from excessive alcohol abuse, and in-patient facilities for up to 25 people. The NGO also assists self-help groups, such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) to hold their regular meetings at the centre, and also provides therapy sessions, including sand, body and art therapy.

In a separate building adjacent to that which delivers health interventions, a social dormitory provides a place to stay for up to 38 homeless people and those who have been recently released from prison and have nowhere else to go; plans are under development to add a further 20-30 beds due to demand. Rooms are locked between 8am and 8pm daily in order to motivate clients to undertake productive activities outside. Special assistance is also available for women in complex situations, including support to pregnant women and newborn babies with their mothers. Everyone who is given a place to stay on a temporary basis also has access to 3 meals every day, clothes and washing facilities. It is the local Government administration that funds the running of the facility as well as paying for 85% of the costs of ART and all costs for the purchase of methadone and buprenorphine. The local Government also provides opportunities for people at the social dormitory to undertake community work for which they are paid, such as painting, gardening, etc. The NGO also provides assistance in finding employment and are in the process of refurbishing a run-down building at another location in Poltava city in which vocational training will be delivered.

Of particular importance is the role that the local NGO plays in helping PWID and female sex workers (FSW) to get the necessary identification and other related Government documents in order to register for, and gain access to, ART for those who are HIV-positive.

Staff of the ‘Light of Hope’ receive technical, administrative, financial and human resource training from Alliance Ukraine. Alliance staff make periodic visits to Poltava to provide such trainings as well as to assist in the strategic development of the programme and the strengthening of the organization as a whole. Currently, Light of Hope receives funding from several donors, including as a subrecipient of Alliance Ukraine from Global Fund Round 10. Of note is that the Light of Hope programme, and the related GFATM funding, have been integrated into the annual work plan of the local Government of Poltava city.

With regards to the collegiate approach of the local health, social and administrative authorities in Poltava, the deputy head of the health care department stated, “we understand

the problems and we solve them together”. A coordination council comprising all key stakeholders in the city’s response to HIV/AIDS and other communicable diseases, meets regularly and also invites the local media to cover such meetings so as to inform the public and to be open and accountable. A formal memorandum of understanding was signed in 2011 between the Light of Hope local NGO, the regional administration and the coordination council on collaboration to help key populations most at-risk of HIV/AIDS.

The deputy head of the Poltava region’s OST programme notes that there have been no new cases of HIV among OST patients/clients since the service became operational in collaboration with the Light of Hope NGO several years ago. In addition, 40% of OST patients/clients have secured employment and the health care leadership now want to establish a training facility in Poltava where they can train health personnel from other regions to work using a similar approach to that demonstrated to be successful in Poltava.

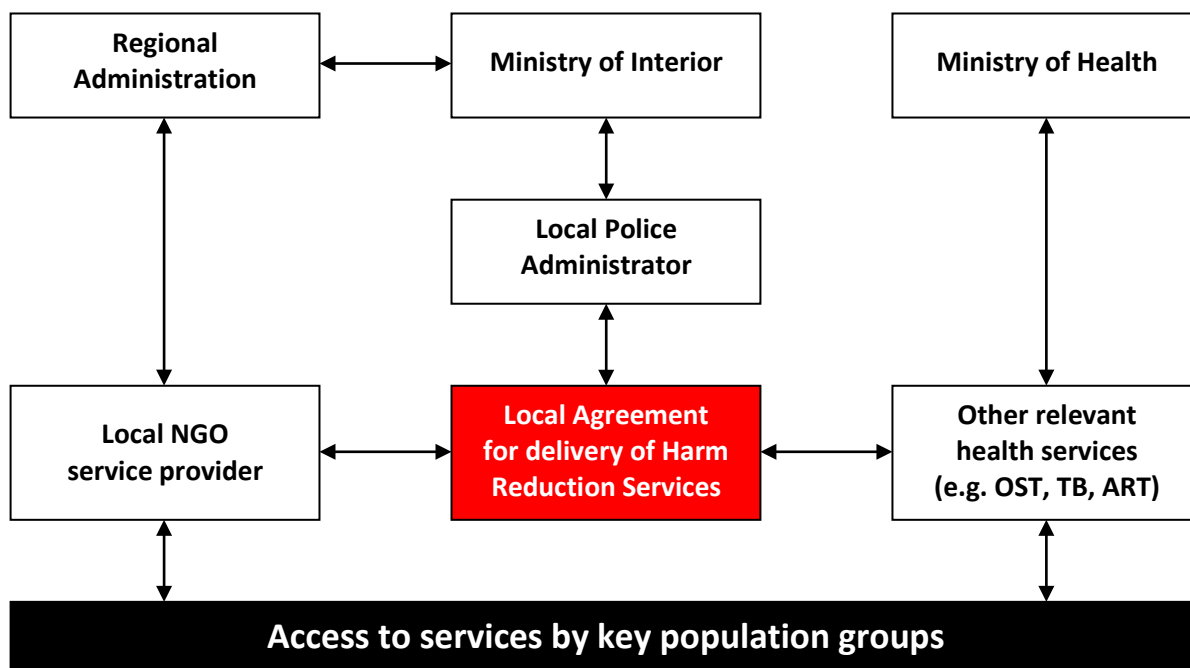
The Light of Hope also provides community outreach, including visits to the homes of PWID to dispense sterile needles/syringes and to undertake rapid testing for HIV, STIs and viral Hepatitis. Training of outreach staff from the Government has resulted in a change of attitude toward PWID, resulting in a great improvement in client satisfaction and acceptance of the harm reduction interventions.

The head of the Light of Hope NGO has been active in trying to negotiate a reduced cost with manufacturers for the provision of treatment for Hepatitis C. However, further discussions are needed and support from WHO, in particular, to facilitate such negotiations with the pharmaceutical companies would be of great assistance. In addition, a Hepatitis C stand-alone treatment protocol is also very much needed so that when the treatment becomes economically viable then implementation of a treatment regime can immediately commence.

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A further major obstacle to implementing services has often been the lack of knowledge and understanding of local government administration and, in particular, law enforcement agencies at the grassroots level of services targeting PWID. This situation has led to confusion and delay in the provision of services for key populations, especially outreach interventions into the community.

The approach taken to overcome this obstacle to service delivery was the development of a local agreement signed by the harm reduction NGO service provider and the local police and other government administration units, as needed; see Fig. 32. The written agreement outlines the activities to be undertaken, the locations involved, and the respective roles and responsibilities of all the signatory parties in order for the interventions to be unimpeded by local government agencies.



**Fig. 32: Schematic of the key partners and relationships in facilitating access by key populations to harm reduction interventions at the local level in Ukraine.**

If OST is part of the package of support services for key populations, then the head of the drug treatment facility will also be a party to the agreement, usually a relevant senior officer from the local hospital. If ART-related care and support are provided to key populations in an area, then the local head of the AIDS Centre will also be a party to the agreement. The duration of such an agreement is usually stipulated as one calendar year, but in reality the agreements continue in effect until such time as any party to the agreement wishes to change any aspects of the agreement, at which time the signatories meet and discuss revisions to the agreement; once revisions have been agreed, a new local agreement is signed by all relevant parties. Although a standard outline template exists for such local agreements, they are usually modified to meet the needs of a specific geographic area<sup>127</sup>.

Considerable challenges are also faced in delivering a comprehensive package of services to MSM in Ukraine including the following issues:

- Homophobic legislation that is being prepared by some parts of the Government;
- Increasing coverage through new HIV prevention programmes;
- Expansion of services to other regions of Ukraine not yet covered;
- Retention of loyal clients in the programme;
- The lack of sustainability of some new projects for the future; and,
- Use of the internet as a HIV prevention tool.

<sup>127</sup> SYREX programme data. Op. cit., 2013.



Some of these challenges have been overcome, to-date, through innovation developed by local NGOs in partnership with Alliance Ukraine, including:

- Peer-driven interventions (PDI);
- A MSM health information portal on the internet (<http://www.msma.org/>); and,
- Use of social networks (online and in the community) to promote HIV prevention among MSM<sup>128</sup>.

For all the key population groups – PWID, FSW and MSM, respectively – the introduction of peer-driven interventions (PDI) as well as case management is helping to overcome a considerable number of challenges faced to implement the HIV prevention programme throughout Ukraine. Specifically, PDI is helping to make contact with new clients in the community that would not otherwise be reached through the existing outreach mechanisms. Case management is helping individuals to gain access to services that they would otherwise not receive.

### **6.3 Other Structural Barriers**

The relatively low salaries of Government staff is a barrier to the provision of efficient services for key populations in Ukraine and appears to provide many opportunities for corrupt practices to take place in order to access health and other services in a timely manner. For example, the average monthly salary of a nurse in Ukraine is in the region of €100 which is insufficient to cover the average cost of living in the country.

In addition, nurses are often used by doctors and health care facilities to undertake the processing of paperwork rather than to undertake medical-related service delivery with patients for whom nurses have received training to deliver. This results in service delivery being slow, relatively costly and inefficient.

Alliance Ukraine and its local partners have increasingly overcome such structural barriers through making agreements with health care facilities to have nurses undertake an increasing number of medical-related activities with key populations for which they are already qualified, and certified, to perform.

Often, nurses working in government-run health care facilities work for the government health system for part of the day and for the NGO-supported services for the remainder of the day; alternatively, they work several days of the week for the Government and the remaining days of the week for the NGO.

This public-private partnership appears to be working well in most geographic areas as the additional, and/or refresher, training received by such nurses from Alliance Ukraine and its local partners can also be used by the nurses in their Government-related work, wherever possible.

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<sup>128</sup> SYREX programme data. Op. cit., 2013.

## **7. HUMAN RESOURCE CAPACITY AND TECHNICAL SUPPORT TO PROGRAMME DEVELOPMENT**

A crucial part of the delivery of cost-effective and efficient services for key populations, and especially for PWID, is the regular support given by Alliance Ukraine to its many NGO partners throughout the country.

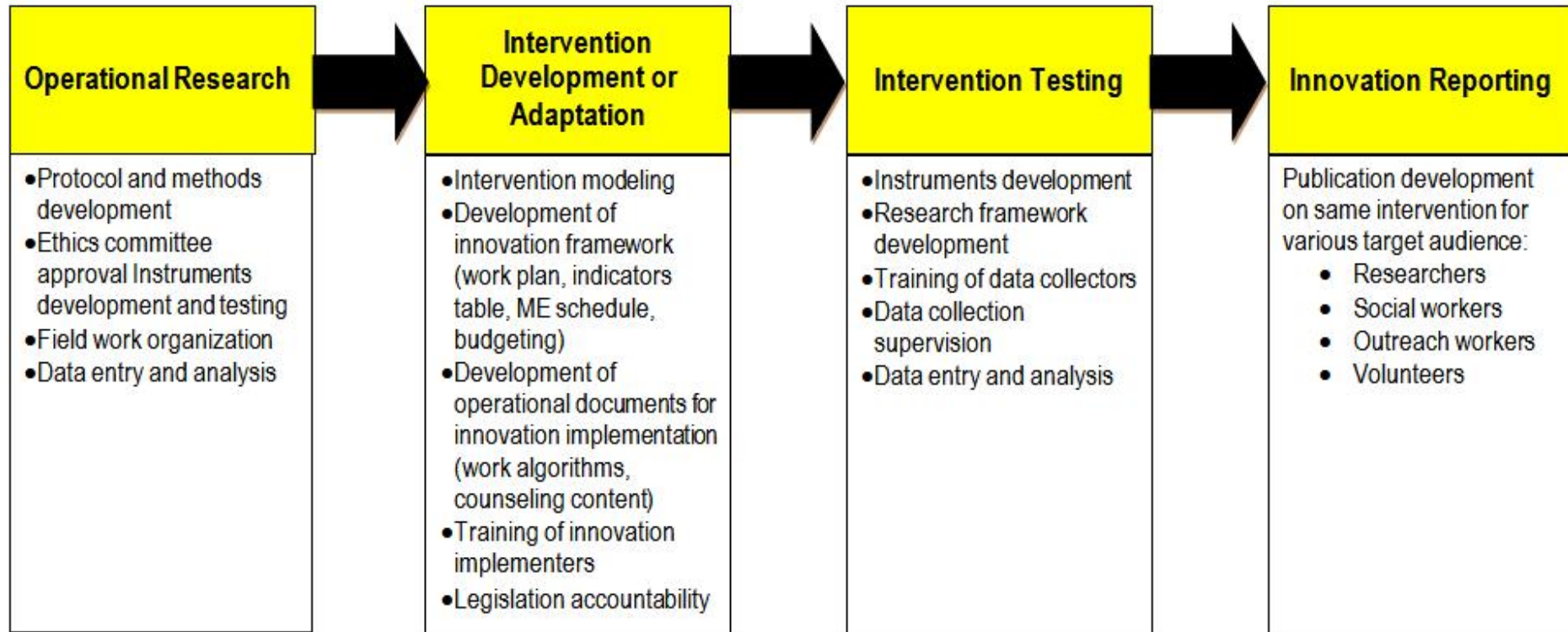
Alliance Ukraine implements a rating system that is given following assessments of each local NGO partner that is undertaken on a semi-annual basis. Failure of a local NGO to reach the minimum standards required in their agreements with Alliance Ukraine will result in specific actions being taken to assist the NGO to immediately address the issues of concern.

Local NGOs are also required to provide Alliance Ukraine with quarterly programme, administrative and financial reports that give Alliance Ukraine the opportunity to keep abreast of developments, or challenges being faced by the local NGO partners, on a regular basis between the assessment site visits undertaken every six months.

Such an approach provides not only close and detailed monitoring of service delivery to PWID, but also gives the opportunity for both the local NGO and Alliance Ukraine to consider human resource capacity requirements to address obstacles to the efficient delivery of services to PWID.

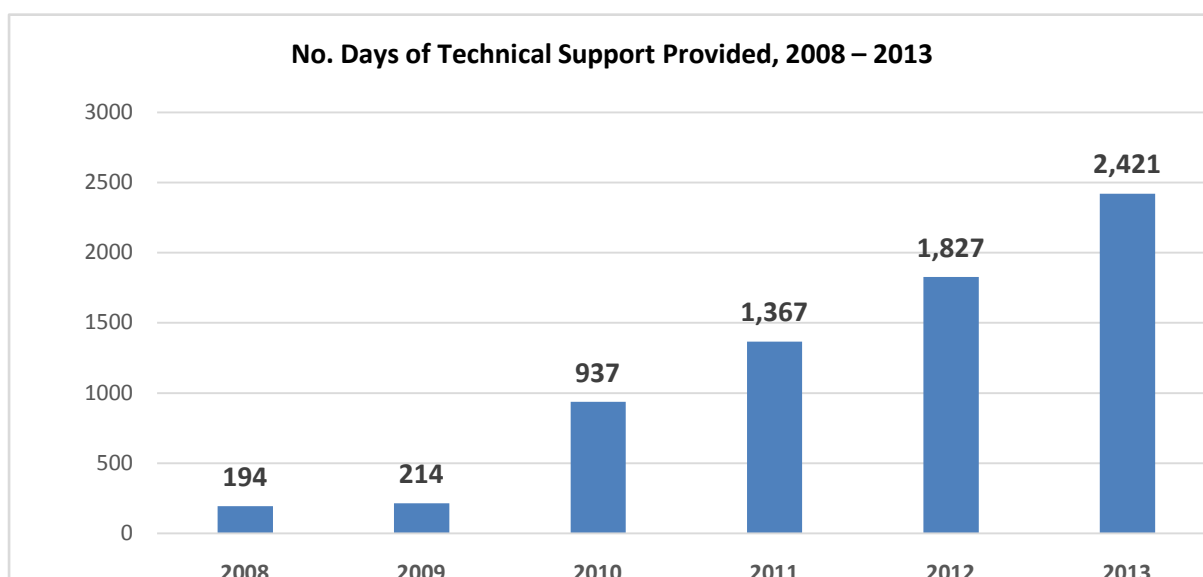
The technical support unit of Alliance Ukraine has a systematic intervention development cycle to support programme development approaches as outlined in Fig. 33. Much of the information and insights on the needs of key populations, including most at-risk adolescents, comes from the operational research that is a high priority for the organization. A list of recently completed and ongoing operational research activities can be found at Annex 1.

## Intervention Development Cycle



**Fig. 33: Components of the Alliance Ukraine Intervention Development Cycle to support programme development.**

A regional technical support hub for eastern Europe and central Asia was established by Alliance Ukraine in 2008 to improve access of civil society organizations to high-quality technical support services in order to expand activities aimed at responding to HIV/AIDS throughout the region.

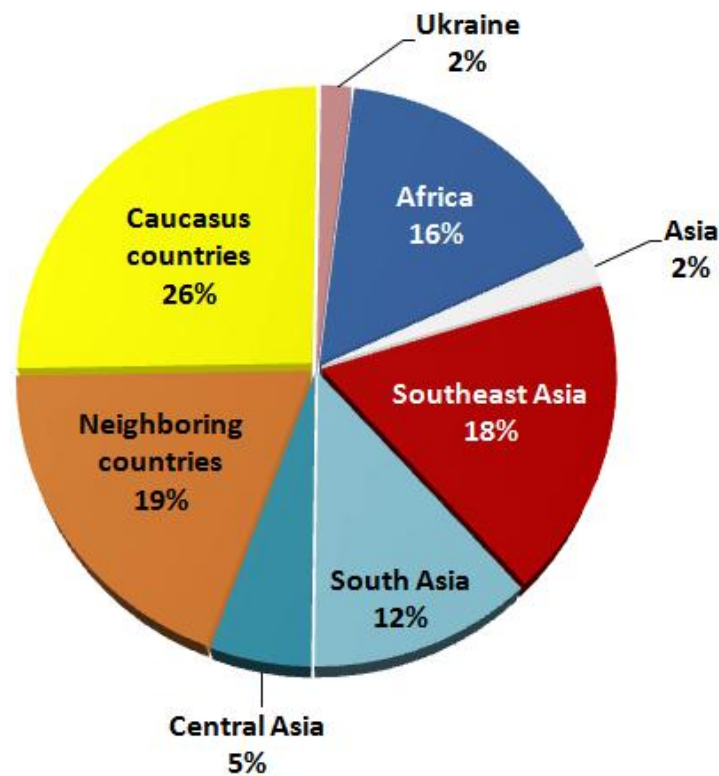


**Fig. 34: Growth of technical support to the region from Alliance Ukraine, 2008-2013**

Source: International HIV/AIDS Alliance in Ukraine, Annual Report 2013, Kiev, 2014.

The Regional Technical Assistance Center ('the Hub') in 2013 has become increasingly competitive in the provision of technical harm reduction services in the region. As in previous years, 2013 is characterized by the increase of not only consultancy days but also by geographical mapping of technical support provision, as can be vividly seen from Fig. 35, demonstrating a steady trend in the increase of technical support to countries of Africa, the Caucasus and neighbouring countries of eastern Europe. In the course of 6 years, **over 80** projects have been implemented in **28 countries** through the technical assistance of the Hub, with a total of **6,959** consultancy days delivered<sup>129</sup>.

<sup>129</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2013, Kiev, 2014.



**Fig. 35: Geographic distribution of technical assistance projects by Alliance Ukraine to different regions, 2013.**

Source: International HIV/AIDS Alliance in Ukraine, Regional Technical Support Hub, Kiev, 2014; <http://www.tshub.org.ua/en/news.htm>, accessed 4 April 2014.

Structured training for female harm reduction staff is an important component in the overall sensitization to, and integration of, gender into service by, and for, key populations. The training comprises of weekly and monthly sessions with a wide range of harm reduction staff. Weekly sessions are conducted at the same time on the same day of the week and include socialising, education, and reporting on peer outreach conducted during the previous week. At the end of each session, those women who work on a voluntary basis are paid a reward for conducting and reporting on the peer outreach work that they have delivered. In addition to the standard harm reduction subjects that are normally delivered in such trainings to harm reduction service delivery staff, the following additional issues are covered:

- Safer sex;
- Condom use and related negotiation skills;
- Reproductive health of female drug users;
- Nutrition for drug users and making a healthy menu with a low budget;
- Understanding, identifying and avoiding dangerous sexual and drug-related situations;
- Drugs, health and beauty: how to care for your health and personal appearance while using drugs; and,
- Parenting skills: how to avoid losing the custody of your child and how to talk to your child about drugs<sup>130</sup>.

<sup>130</sup> Shulga, L., Tokar, A., Smirnov, A., Dvinskykh, N. Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users. Kiev, International HIV/AIDS Alliance, 2011, p11.

## **8. MODELS OF GOOD PRACTICE APPROACHES, SYSTEMS AND TOOLS FOR REPLICATION AND/OR SCALE-UP**

Models of good practice approaches, systems and tools for possible replication and/or scale-up should consider how services will be made available to each of the key populations, i.e. to try to make available a wide range of entry points for key populations to health, social and other services. A model must also integrate gender sensitivity into such delivery mechanisms and service delivery. Mechanisms for collaboration between service providers and local government agencies, especially police and local administrations, are also crucial in order to facilitate access to services at the community level, resulting in an enabling environment in which key populations feel safe, secure and confident that their basic rights will be consistently secure.

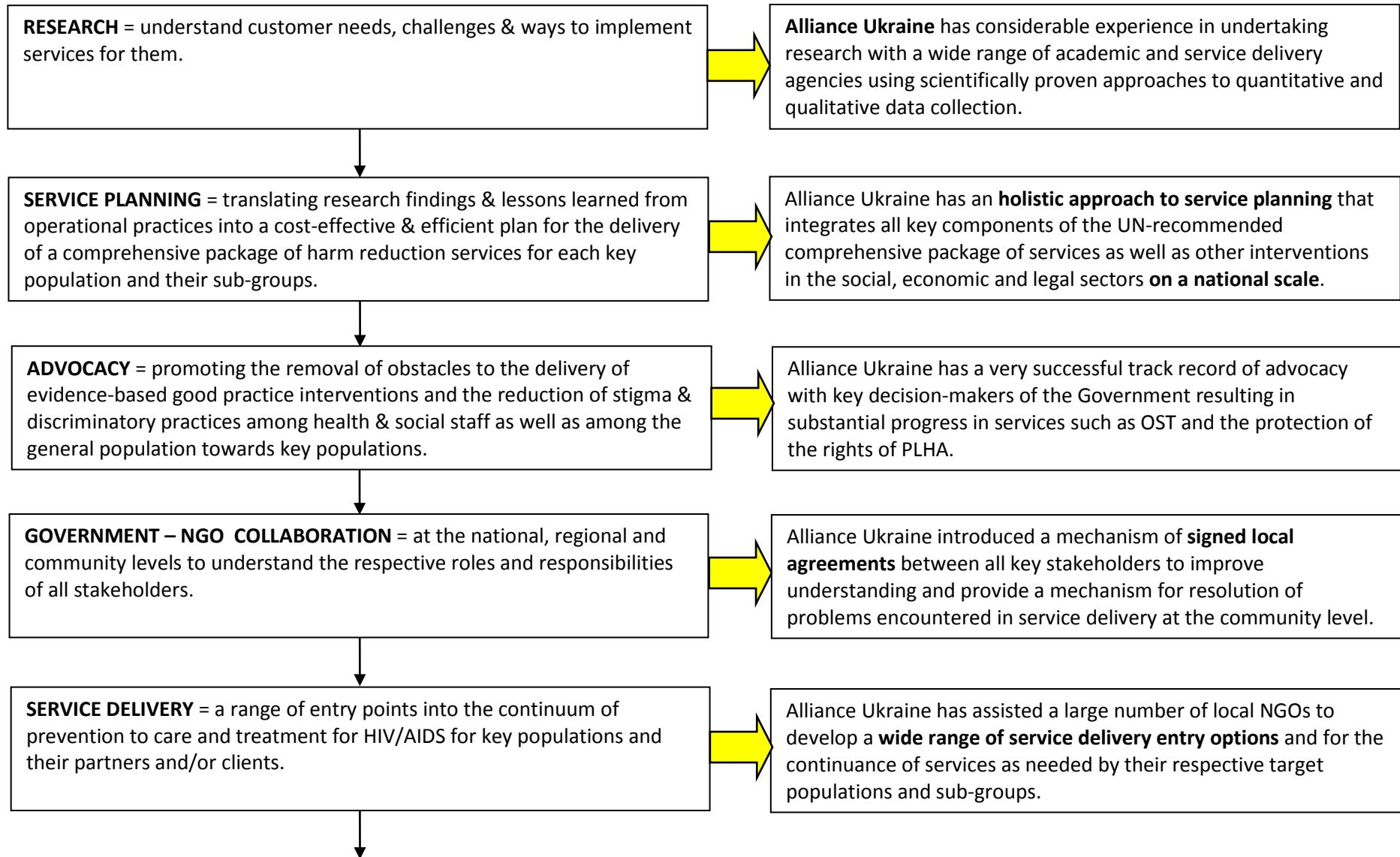
The integration of services at one location is highly recommended wherever possible in order to reduce cost for both service providers as well as for patients/clients in relation to travel time and travel costs. An integrated care centre also lessens the chance of loss to follow-up by people not arriving at the referral point to receive services.

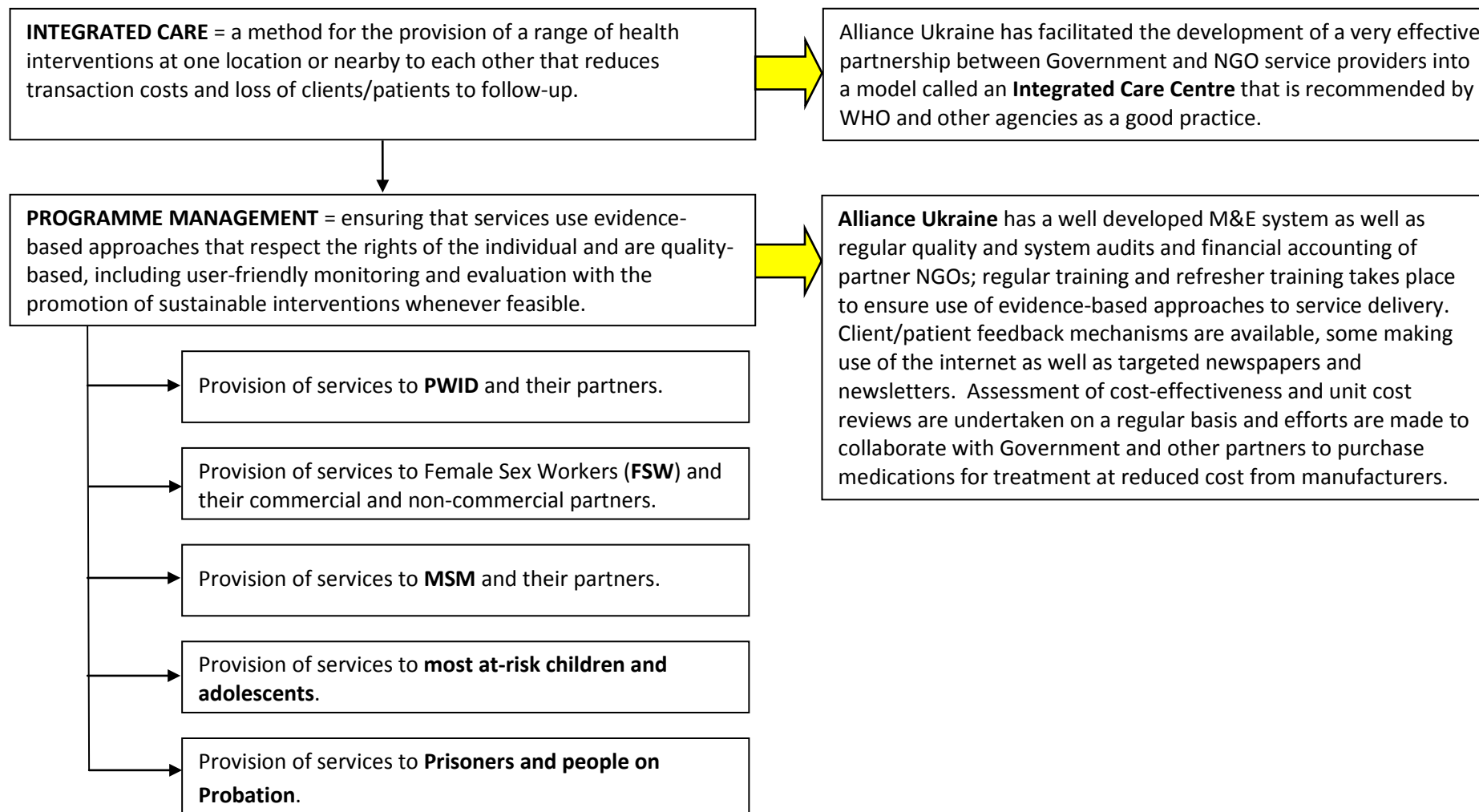
Assisted referral and case management are also key models of good practice to assist the most vulnerable of the key populations at-risk of HIV/AIDS and other communicable diseases by providing guidance through the sometimes complex regulations and associated paperwork and, again, reducing the chances of drop-out from services as well as improved adherence to treatment programmes such as OST and ART, for example.

Whilst generalised approaches are good in terms of outlining the structure and needs of the system for key populations, it is also a requirement that specific approaches are used for specific groups, including PWID, MSM, FSW and most at-risk children and adolescents. Gearing service delivery to the particular needs of such groups, and of subgroups within each key population, will make the services more attractive and thereby reach a level of coverage of each key population that will eventually have an impact on the HIV epidemic in that group an more broadly.

A robust, yet user-friendly, monitoring and evaluation mechanism is also required in order to ensure quality and coverage of technically sound interventions. Continuous quality assurance (CQA) and continuous quality improvement (CQI) should be integral parts of the overall service delivery and management approach at the community level.

An overview of the main components to an holistic harm reduction national programme is at Fig. 36 that uses the experiences of Alliance Ukraine as a case model.





**Fig. 36: Overview of the approach to harm reduction programme modelling using the experiences of Alliance Ukraine.**



## 8.1 Service Planning

Service planning is the translation of research findings and lessons learned from operational practices into a cost-effective and efficient plan for the delivery of a comprehensive package of harm reduction services for each key population and their subgroups.

In order to plan a service, it is necessary to understand the needs of the people who are being targeted. Therefore, it is essential that research be undertaken to ascertain a comprehensive understanding of the needs and challenges facing a group of people. Often it is found that a group, such as PWID, are not an homogenous entity but have subgroups with sometimes very different needs. An investment in research, and undertaking ongoing operational research whilst services are being implemented, will help to build knowledge and understanding of the services needed and how to implement them in a manner suitable to specific groups and subgroups of key populations most at-risk of HIV/AIDS. It is crucial that members of the group and subgroups affected should have a meaningful role throughout the research, from its initial concept through to the activities and reporting in order to not only get better quality results from the research but to also provide opportunities for a more rapid response to be implemented during, or soon after, the research itself.

A service plan should map out the specific health and other interventions that are needed by the target population and their partners and locations for the provision of those services located as close as possible together or, preferably, on the same site. Services must include rapid testing for HIV, TB, Hepatitis B and C, the assessment for, and dispensing of, OST, overdose prevention and treatment, and the dispensing of ART and treatments for opportunistic infections (OI). Associated counselling and mental health services should also be made available at no cost.

Key populations, including PWID, should have as many opportunities and entry points as possible to the comprehensive package of HIV prevention, treatment and care package regardless as to their geographic location or personal socioeconomic circumstance. In addition, every person should have the opportunity to move to different geographic locations without losing access to any component of the comprehensive package.

An individual from a key population can access the comprehensive package of harm reduction services that are available through any of the following entry points that exist in most main urban centres throughout Ukraine:

- NGO outreach on foot
- NGO mobile drop-in centre
- NGO fixed site drop-in centre
- NGO staff collaborating with Government staff at a health care facility
- Pharmacy
- TB screening service
- TB diagnostics service
- TB treatment service
- Hepatitis B diagnostic service
- Hepatitis B vaccination service
- Hepatitis B treatment service

- Hepatitis C diagnostic service
- A service providing opioid substitution therapy (OST)
- Evidence-based drug detoxification service
- Evidence-based drug treatment service
- ART service at an AIDS Centre
- Probation services

It is vital that service planning integrates the needs of female clients into its approach in order to attract females to such services and to retain them in the medium to long term. Alliance Ukraine has developed 10 indicators to measure the extent to which a service provider has gender sensitive approaches and services outlined as follows<sup>131</sup>:

1. Is the service provided to women in a separate space (a women-only space)?
2. Is the service provided to women at a separate time (a women-only time)?
3. Did the staff receive specific training in this service?
4. Does the service minimize the risk of HIV-infection among female IDUs (e.g. selling sex for money/drugs/other, being unable to inject on one's own, having no control over the situation while using drugs, domestic violence)?
5. Is the service delivered in a context or environment that is physically safe for women?
6. Is the service delivered in a context or environment that is emotionally safe for women?
7. Does the service take into account women's roles, socialization, and/or relative status within the larger culture and/or within the IDU culture?
8. Do the service providers treat female IDU participants as intelligent and capable persons?
9. What evidence indicated the need for this service? (scientific literature, local epidemiology, client reports, focus groups, etc.)
10. Is this service easy for women to access?

## **8.2 Governmental-NGO Collaboration**

Many harm reduction services at the grassroots level around the world experience difficulties through disturbance to implementation of services caused by law enforcement agencies and other agencies of local government administration due to their respective lack of awareness and understanding of harm reduction and the reasons why such services are being provided to individuals and groups that some parts of the national legislation consider to be criminals, such as drug users and sex workers.

A key finding from Ukraine is the utilization of local agreements between local police, local government administration, and NGOs undertaking service delivery for key populations.

The approach taken to overcome this obstacle to service delivery is the development of a local agreement signed by the harm reduction NGO service provider and the local police and other government administration units. The written agreement outlines the activities to be undertaken, the locations involved, and the respective roles and responsibilities of all the signatory parties in order for the interventions to be unimpeded by local government agencies.

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<sup>131</sup> Shulga, L., et al, Ibid., p33.

At the national and regional levels, it is also important to develop good relations with key Government officials who can influence relevant regulations and/or their interpretation vis-a-vis implementation. Alliance Ukraine has an effective approach in working at the national level and supporting its NGO partners to work at the regional level in advocating for the removal of obstacles to service provision for key populations. A key strategy is to assist Government agencies for health, social and law enforcement mandates to link together in an holistic manner for operational purposes at the national and regional levels. By helping to facilitate such linkages, the NGO can become a vital advisor to all those Government agencies and thereby influence the decision-making on key issues affecting the population groups being targeted.

### **8.3 Service Delivery**

A good model of service delivery for key populations most at-risk of HIV/AIDS and other communicable diseases involves using a multitude of approaches, each of which fits with the lifestyle and availability of specific groups or subgroups. Often a combination of service delivery approaches provides for the greatest coverage of a target population.

Periodic reviews of the cost-effectiveness and efficiency of each service delivery method is needed to ensure each is fit for purpose. In addition, the individual service provider organization should review and, if needed, revise policies and procedures to help make service delivery staff aware of gender roles and to understand the reasons that changes take place in their organization with respect to the service delivery and their particular role in those changes. Greater awareness by staff promotes the rejection of negative gender roles and stereotypes among women and men and increases women's understanding that they are worth special attention<sup>132</sup>.

However, a problem that has been noted by Alliance Ukraine is how to support the greater involvement of women with specific experiences, such as injecting drug use or sex work, as programme staff members of local NGOs. In four of the five NGOs involved in an Alliance Ukraine evaluation, 75% or more of the staff were women but there were only a handful of female IDUs in paid staff positions, and none in leadership positions<sup>133</sup>. It appears that both male and female PWID have very little involvement in the delivery of services unless they are in positions that, in effect, provide no regular income at a level that can be used to sustain the individual. If the meaningful involvement of members of key populations is to be realized in terms of NGO management as well as service delivery, then real opportunities must be provided to allow such members of the community to take such key roles in local NGOs as well as in the local, regional and national Government agencies in the longer term and to be paid a professional salary for their expertise and service.

#### **8.3.1 Mobile Clinics**

An effective way of reaching key populations, especially PWID, FSW and most at-risk children and adolescents is through outreach services, including mobile clinics. In Ukraine, Alliance has supported its local NGO partners in many urban areas of the country with the purchase of small buses within which a range of rapid tests can be undertaken as well as

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<sup>132</sup> Shulga, L., et al, Ibid., p14.

<sup>133</sup> Shulga, L., et al, Ibid., p28.

counselling and sexual and reproductive health interventions. Being mobile means that more than one location where such key populations congregate can be covered each day and, consequently, such an approach can be very cost effective vis-a-vis the number of people serviced versus the number of staff needed and the operational costs of a small bus or van. A good model of such service provision has the mobile clinic call at specific locations at specific times on specific days that are known to the community in that location.

Targeted outreach by, and/or for, females is an important approach to encourage more females to access the basic services provided by local NGOs and to assist them in referral, as needed, to drop-in centres and government-run health care facilities in which the NGO provides assistance as part of a public-private partnership. As a result of the advocacy work undertaken by Alliance Ukraine, training to outreach workers and the approach such NGO staff take in the field has become more gender-focused with respect to sex and gender aspects of drug dependence, such as the types of dependence developed among women, and the interdependence of drug use and sex, for example. In addition, the approach includes male clients who are asked about their female partners as well as relatives or acquaintances that use drugs, that serves the dual purpose of recruiting more women into the harm reduction programme and to provide male IDUs with more information on the needs of female IDUs so that the programme can become more popular among clients of both sexes<sup>134</sup>.

A further vital aspect of an outreach model for harm reduction interventions is the creation of an emotionally and physically safe environment for females, as well as for most at-risk children and adolescents.

Due to the feeling of being threatened, and being uncomfortable in discussing sensitive issues, some of the harm reduction NGO service providers have a designated time when female IDUs can access the HIV prevention services without the presence of male IDUs. Equally, those NGOs who also work with most at-risk children and adolescents will designate particular times for particular age groups, and for boys and girls, to access services. This approach is based on the concept that emotional and physical safety will increase the service utilization rate by such children, adolescents and adults, respectively.

Regular group meetings between social workers and female IDUs, especially those involved in peer education and secondary syringe exchange, occur in order to strengthen relationships between NGO staff and clients and to allow for regular feedback concerning service delivery and new developments in the community, enabling a better response by the NGO to the needs of female IDUs. This approach also fosters a more sympathetic attitude toward female IDUs among NGO service staff.

Regular meetings also take place between specialists in most need by female IDUs, such as gynaecologists, and lawyers, which helps to improve communication and thereby increase the service utilization and enhancement of referral. The establishment of personal contacts helps female IDUs overcome their fear of being counselled by specialists and gives specialists a better understanding of the needs of female IDU clients<sup>135</sup>.

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<sup>134</sup> Shulga, L., et al, Ibid., p10.

<sup>135</sup> Shulga, L., et al, Ibid., p14.

Secondary Syringe Exchange (SSE) enlists peers to exchange used needles/syringes and to disseminate information, harm reduction skills, and other supplies within their social networks. SSE has helped to improve service access for female IDUs who are unable to visit harm reduction sites due to various reasons including, for example, distance to travel, lack of time or childcare, opposition from a partner, discomfort at the harm reduction site, or fear of being exposed as a drug user. Consequently, a visit by a female friend bringing sterile needles/syringes and information is a convenient, discreet, and comfortable alternative for many female IDUs<sup>136</sup>. The experience of Alliance Ukraine is one in which follow-up of the SSE activities is periodically undertaken to check that more hard-to-reach female IDUs really are receiving sterile needles/syringes.

### **8.3.2 Integration of HIV, STI and other relevant services**

HIV rapid tests and STI screening and diagnostics are a basic requirement for any harm reduction health intervention for all key populations. From the experiences in Ukraine, an integrated approach is easier for the clients as well as being more cost-effective for the Government and NGOs, respectively. An excellent model of integrated care has been developed under the auspices of Alliance Ukraine with its local Government and NGO partners.

As detailed in Section 4.5, Efficiency of Services, the ‘Integrated Care Centre’ (ICC) model represents a ‘one-stop-shop’ approach for key populations.

The ICC model is run as a public-private partnership between the regional component of the Ministry of Health and the local NGO partner of Alliance Ukraine and integrates both medical and psychosocial services and related support/follow-up either at one site or in several sites that are located very close together, usually within easy walking distance of each other. In reality, this realizes the engagement in programme activities of the respective specialists of key government agencies – such as doctors who dispense OST and diagnosis and treatment of communicable diseases, and NGOs who provide a range of counseling, social support, follow-up and referral services undertaken by nurses, social workers, and psychologists.

Such a model provides a range of approaches to organizing health and social services into health care facilities in order to improve the accessibility of such services for key populations. Integrated care programmes are based on the concept of equal access to a complete range of services that should be free of stigma and discrimination towards the individual as well as being flexible and responsive to the needs and issues of the patient/client, including the family and friends of each person. This integrated care model in Ukraine led to the development of a guideline published in 2012 by WHO that details the steps needed to establish and operate such integrated services<sup>137</sup>.

### **8.3.3 Other Facilities**

The provision of short-term childcare is a motivating factor for many female IDU with babies and/or children who are unable to access health and social services due to their childcare

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<sup>136</sup> Shulga, L., et al, Ibid., p13.

<sup>137</sup> WHO, Alliance Ukraine, USAID, Clinton Health Access Initiative, Op. cit.; see also, [http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/167315/e96608-update.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/167315/e96608-update.pdf), accessed 31 July 2013.

responsibilities. Consequently, to entice such women to attend drop-in and community centres and the related health and social services and harm reduction trainings, local NGOs are encouraged by Alliance Ukraine to provide short-term childcare facilities at the NGO site. Children can remain on-site only as long as their mother is also there, thus avoiding potential problems with children being left for excessively long periods without parental oversight<sup>138</sup>.

#### **8.4 Referral and Case Management**

A major problem with the referral of patients/clients to other services is the number of people who ‘drop-out’, i.e. they either never arrive at the place to which they have been referred, or they arrive and receive a test but never return for the result. Even those who return for the result may then not go back for the required treatment. One method to overcome this problem is through the provision of active case management.

Case management can be a very effective method of assisting individuals and groups from key populations to access a range of health, social, economic and legal services and opportunities through assistance given usually by an outreach or social worker who is familiar with the regulations and procedures for access to a particular service, such as to ART. Alliance Ukraine developed case management support in the first quarter of 2013 in response to the low number of PWID being able to enrol onto ART and associated services at AIDS Centres. Although beyond the scope of the official division of labour between Alliance Ukraine – responsible for HIV prevention – and the All-Ukrainian Network of PLHA – responsible for HIV treatment and care – the lack of PWID access to ART, believed to be in the region of 50,000 people, became so serious that support had to be provided by Alliance Ukraine and its partners as a matter of urgency<sup>139</sup>.

It is recognized as good practice to try to help PWID to remain in a continuum of prevention to care and treatment for HIV/AIDS. In reality, this can mean that outreach workers who make the initial contact with a PWID, and develop a trusting relationship with an individual drug user, is best placed to assist the same person through the often complex registration process to access ART if such medications are required. This support to PWID often includes paperwork to apply for new identification papers from the Government administration before registration at an AIDS Centre can take place.

This approach by Alliance Ukraine has been termed ‘Community-Initiated Treatment Interventions’ (CITI). Existing outreach workers now have a new task to facilitate access to ART for those key populations who require such treatment. Each outreach worker will, as a consequence, have a caseload of approximately 30-40 people with follow-up assistance being given for up to 6 months.

However, adherence to ART could drop if such support is not continued for some patients/clients beyond 6 months. Therefore, consideration is made by Alliance Ukraine and its NGO partners as to the introduction of Community-Based Adherence that could help to support individuals with ART as well as other treatment regimes, especially OST, for example.

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<sup>138</sup> Shulga, L., et al, Op. cit., p13.

<sup>139</sup> Briefing from Smyrnov, P., Deputy Executive Director: Programmes, International HIV/AIDS Alliance, Kiev, July 2013.

Experience from various countries and service providers has shown that access by female IDUs to assistance, adherence to treatment regimens, and their overall general well-being can be greatly improved through the provision of case management. Consequently, Alliance Ukraine supports local NGO partners to develop such personalized assistance to female IDUs so as to help them to navigate their way through a variety of medical and social services and thereby improve coverage of each service as well as retention in treatment<sup>140</sup>.

## **8.5 Programme Management**

Effective models of programme management include service planning, service delivery, as well as referral and case management, as outlined above. In addition, robust – yet user-friendly – monitoring and evaluation systems need to be established and maintained. Good practice models for programme management in the harm reduction sector also focus on modifying general approaches to meet the needs of specific target groups. Alliance Ukraine has assisted its governmental and NGO partners to develop programme management approaches that are specific for FSW, MSM, most at-risk children and adolescents, and for people on probation from prison.

In addition, a unique identifier code (UIC) is used for all HIV prevention interventions in Ukraine based on the lessons learned from a pilot project run by PSI in central Asia. The code, developed with the participation of all HIV service partner organizations, is based on the unique personal data of a client and includes 8 symbols: the first letter of the client's full name; the first letter of the full name of the client's mother; the first letter of the full name of the client's father; 2 digits from the client's date of birth; the last 2 digits from the client's year of birth, and the final symbol is the client's gender. As a result, an individual client who receives services from several different organizations is counted as one person in the overall programme and thereby the risk of duplication is reduced and data accuracy is increased<sup>141</sup>. The reliability of reporting data has been confirmed by independent auditors through a formal data quality audit (DQA) initiated by USAID and in late 2011, Global Fund reviewed the accuracy of the Alliance Ukraine approach and awarded an 'A' rating for all the indicators verified: the main at-risk population coverage, HTC and the indicator of visits to mobile clinics<sup>142</sup>.

### **8.5.1 Provision of services to Female Sex Workers (FSW) and their commercial and non-commercial partners**

Based on the experiences of, and lessons learned from, Alliance Ukraine and its Governmental and NGO partners, a model of good practice for delivering HIV prevention and associated services to female sex workers (FSW) needs to understand – through research – the many and varied environments in which FSW undertake their trade and the related risks and opportunities related to that environment and the persons, groups or agencies that have a form of control of the individual FSW. Research is also needed to understand the peer system(s) that exist among and between FSW and the support that such systems provide to the individual. By understanding such dynamics of life as a FSW, it is possible to identify opportunities by which a basic package of HIV prevention services can be made available to the individual FSW and, through them, possibly to a wider group of FSW involving a form of

<sup>140</sup> Shulga, L., et al, Op. cit., p13.

<sup>141</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Op. cit., p75.

<sup>142</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Op. cit., p77.

peer-driven intervention (PDI). And through the FSW, it may also be possible to make such interventions available to the commercial and/or non-commercial partners of the FSW.

Of note is the need to integrate interventions concerning the reduction, and avoidance, of violence which is a common aspect of life as a FSW. HIV prevention interventions are meaningless without putting them into the context of violence and the skills that FSW need to develop to better deal with a wide range of scenarios in which they are faced with direct, or indirect, violence of many kinds.

As already developed through Alliance Ukraine support, FSW in countries where HIV prevention interventions are planned should be encouraged, and given the opportunity, to actively participate in a meaningful way in undertaking research activities and periodic assessments thereafter, as well as in the development of programme interventions and a mechanism for continuous feedback to programme managers.

The basic package of services required by FSWs, and some of which can also be made available to the commercial and/or non-commercial partners of FSW, include the following:

- Distribution of male and female condoms;
- Distribution of essential medicines and personal hygiene products, if needed;
- Counseling on HIV and safer sex;
- Distribution of IEC materials on behaviour change;
- Self-support groups;
- Training for FSWs;
- Voluntary counseling and testing for HIV with rapid test; and,
- STI diagnosis and treatment, including the use of rapid tests for syphilis, gonorrhoea and chlamydia.

Additional services, as outlined below, may also be provided dependent on the individual needs of the FSW and the time available, as well as the location of the interaction between the NGO staff member and the individual FSW or group of FSW's:

- Hepatitis B and C rapid test;
- Access to a community centre;
- Services on sexual and reproductive health;
- Development and publishing of IEC materials for FSW;
- Peer Driven Intervention (PDI) for FSWs using structured interventions;
- Referral to relevant medical institutions, if needed;
- Mobilization of leaders to undertake skills development so as to become FSW representatives;
- Developing strategies to prevent, avoid, or deal with, violence;
- Individual case-management; and,
- Online outreach.

The use of local agreements between key stakeholders at the grassroots level is a vitally important mechanism so as to reduce misunderstanding between police, in particular, and NGO outreach staff who are often working at night in somewhat dangerous environments. Such local agreements also provide the opportunity to strengthen linkages for referral to more



specialist health, social and legal services of use to the FSW and their commercial and/or non-commercial partners.

### **8.5.2 Provision of services to MSM**

A model of good practice approaches for MSM needs to understand the environment in which MSM live and work. Through research, subpopulations of MSM can be identified and the specific needs of each group can be understood within the context of the environment in which MSM interact with each other and with Governmental and NGO health, social, legal and economic services. It is recommended that Transgender people (TG) are not integrated into MSM service delivery approaches unless there is overwhelming evidence from a wide range of TG peoples that they prefer to receive health interventions as part of a MSM approach. In Ukraine, for example, the limited number of TG who have been approached to discuss this issue have indicated that they currently prefer to receive health services from NGOs within the context of female sex work (FSW) interventions rather than those targeting MSM. Age distributions, as well as socioeconomic dynamics, are vitally important components of an overall understanding of the MSM community in a particular location. An investment in high quality research at the beginning, as well as periodic updated assessments thereafter, will pay dividends in terms of having effective and attractive approaches to enrolling and maintaining MSM in health sector interventions, such as those for HIV prevention, treatment and care.

The package of services provided to MSM by Alliance Ukraine partners includes the following:

- Distribution of male/female condoms and lubricants;
- Information materials on how to prevent HIV transmission;
- Counselling by a specialist, such as a social worker, doctor (proctologist, urologist), psychologist, and lawyer, as needed;
- Voluntary HIV testing and counselling;
- STI diagnostics and treatment;
- Diagnostics of Hepatitis B and C, vaccination against Hepatitis B;
- Group work;
- Client involvement in training activities;
- Organization of prevention-oriented leisure activities for clients;
- Peer-driven counselling;
- Basic household services;
- Mentor support programme;
- Counselling on safe sexual practices; and,
- Online counselling (through social networks).

Once again, as with other key populations, the experiences from the work of Alliance Ukraine and its Governmental and NGO partners, strongly recommends the use of local agreements between key stakeholders at the grassroots level. A local, signed agreement is a vitally important mechanism so as to reduce misunderstanding between police, in particular, and NGO outreach staff. Such local agreements also provide the opportunity to strengthen linkages for referral to more specialist health, social and legal services of use to MSM.

The experiences from Ukraine suggest that online approaches to supporting MSM is an effective way of engaging with individuals and the larger MSM community owing to the relative high education of many MSM that become known through the initial research undertaken by Alliance Ukraine and its NGO partners across the country.

### **8.5.3 Provision of services to most at-risk adolescents and street children**

The models to be used in a country to assist most at-risk children and adolescents is largely dependent on the infrastructure available to the Government and its partners to officially care for such children and adolescents. In the case of Ukraine, there are several Ministries who have a mandate that includes some types of children and adolescents who are not part of a functioning family. Consequently, the development of an approach for such children and adolescents depends, as with other key populations, on robust research and assessments as to the range of people in need and their socioeconomic environment.

The options available to provide HIV prevention, treatment and care support to children and adolescents fall into two categories: support through institutions, such as orphanages and rehabilitation centres; and, support through outreach to areas where uncared-for children and adolescents congregate. In Ukraine, such outreach into the community is referred to as ‘social patrols’ undertaken by NGO staff who deliver basic health and social services.

In general, interventions for most at-risk children and adolescents include HIV prevention, counselling and access to a child psychologist if needed, rapid testing for HIV, Hepatitis B and C, and STIs, as well as assistance in dealing with the criminal police and social services together with cross-referral to/from other assistance projects.

The use of local agreements between key stakeholders at the grassroots level, as with other key population groups, is highly recommended. A local, signed agreement is a vitally important mechanism so as to reduce misunderstanding between police, in particular, and NGO outreach staff dealing with children and adolescents. Such local agreements also provide the opportunity to strengthen linkages for referral to more specialist health, social and legal services, as well as to bring key institutions into the broader mechanism for child protection.

### **8.5.4 Provision of services to people on Probation from Prison**

Providing HIV prevention and associated services to people on probation following release from prison has proven to be an innovative approach by Alliance Ukraine and its local NGO partners to getting many more people into the continuum of prevention, treatment and care for HIV and other communicable diseases than would otherwise be the case.

This model takes as its premise the requirement of both men and women on probation to register 1 to 2 times per week with a police office. Consequently, this provides an opportunity for the NGO to meet with such people on probation on a very regular basis, making follow-up an easier activity than is the case with some other key population groups.

Furthermore, the Governmental structures for people on probation exist in all regions of Ukraine and, therefore, no additional infrastructure is required for the initial contact with the individual.

In addition, the HIV and other interventions provided by NGOs within prisons is a conduit through which awareness can be raised of the probation-related health services, especially for prisoners approaching the date of their release from the prison, or those who are released on probation pending further judicial activities related to their case.

The model uses the same minimum package as that received by PWID in the community, including sterile needles/syringes, alcohol swabs, condoms, lubricant, IEC materials, counselling, and rapid testing of HIV, TB and Hepatitis B and C, respectively. Self-referral or assisted referral can then be undertaken for follow-up service delivery at a drop-in centre or health care facility, as required. For those on probation in particular need of support, case managers can provide assistance to help the individual to navigate their way through the range of standard HIV and other tests and, if required, registration for access to ART, OST and TB treatment.

## 9. NATIONAL IMPACT OF THE RESPONSE

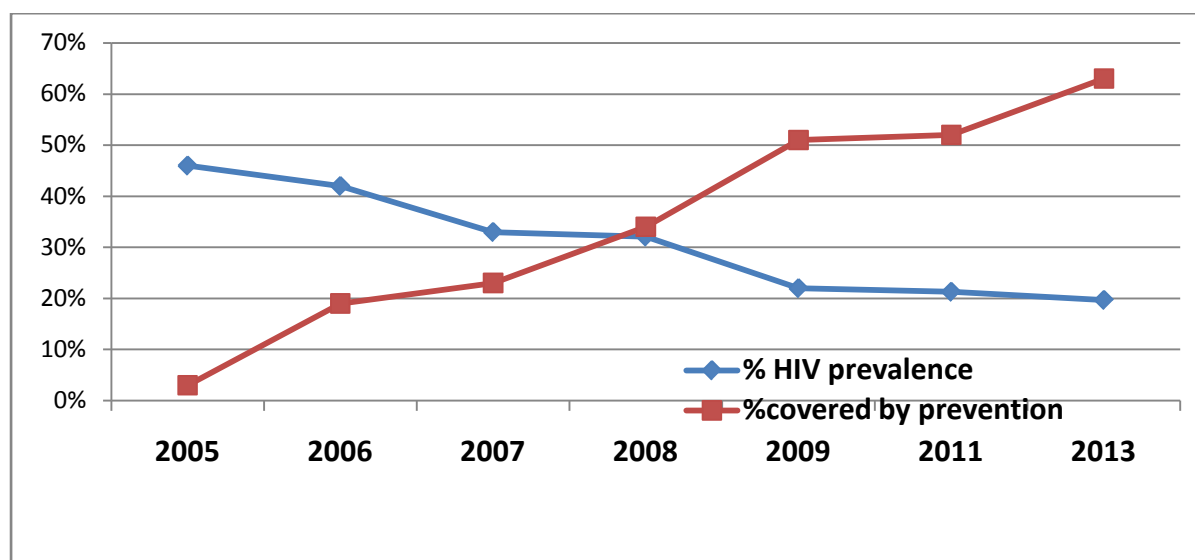
The official data of the Ukrainian AIDS Centre of the Ministry of Health shows that the rate of new HIV cases has fallen by almost a factor of four since Alliance Ukraine commenced implementation of Global Fund grants as well as through the support provided by the US Agency for International Development (USAID) and others.

As noted by Michel Kazatchkine, the then Executive Director of the Global Fund, during his visit to Kiev in February 2012,

“The Partnership of the Global Fund with Alliance has had a significant impact on the situation with response to the HIV/AIDS epidemic in eastern Europe. The incidence rate among injecting drug users has stabilized, and the HIV prevalence among this population has decreased. Harm reduction programmes for most vulnerable groups have become a pledge of such performance. Although much remains to be done, the experience of prevention programmes for most vulnerable populations in Ukraine gains in global spread as best practices. In severe circumstances, a significant progress has been achieved which results can be proud of”<sup>143</sup>.

### 9.1 Expansion of HIV prevention service coverage among PWID

The rapid increase in the coverage of PWID with HIV prevention services, including the provision of sterile needles/syringes, since 2005 has played a major role in the reduction of HIV prevalence among PWID over the same period as can be seen in Fig. 37.



**Fig. 37: Coverage of PWID by HIV prevention programmes and their HIV prevalence rate in compared cities, 2005-2013**

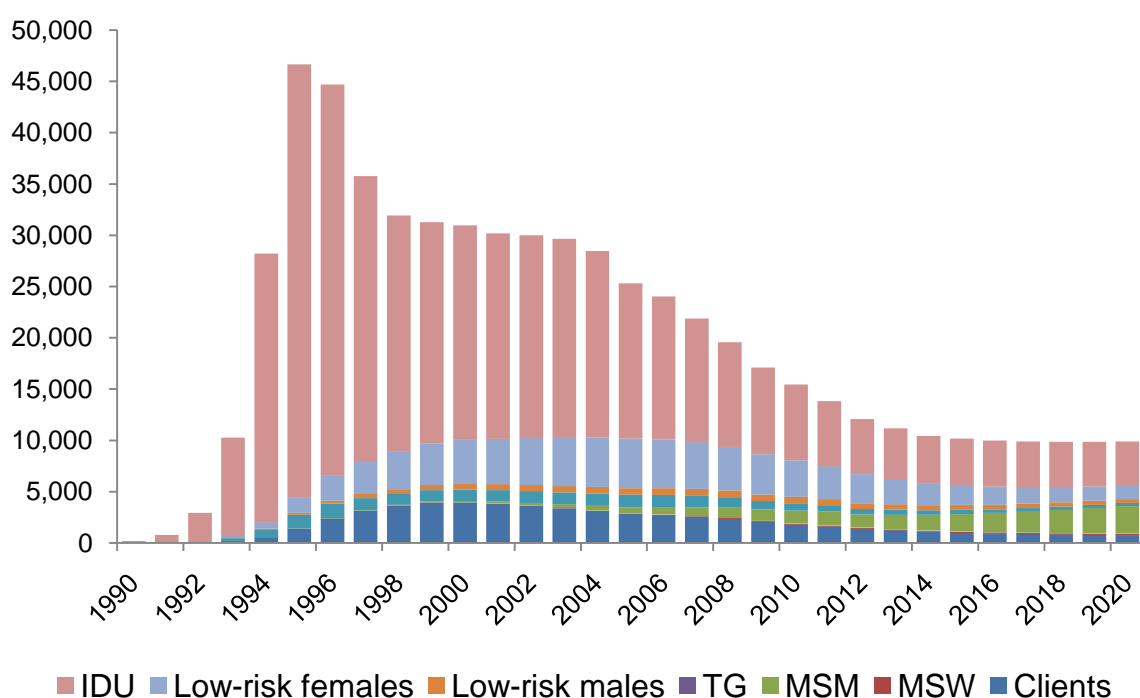
Source: Based on sentinel surveys among PWID (2005 and 2006) and IBBS among PWID (2007, 2008 and 2009, 2011, 2013); the data of coverage of HIV prevention programmes is from SYREX programme data, April 2014.

<sup>143</sup> International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Op. cit., p5.

This is a clear demonstration that a comprehensive package of harm reduction interventions does stop and reduce HIV prevalence amongst PWID if undertaken at a large enough scale, as is the case in Ukraine.

However, further efforts are required to ensure that the benefits achieved now will continue into the future rather than there being a resurgence of HIV/AIDS among PWID as a result of complacency.

Based on the available data and its analysis, as shown in Fig. 38, the projected number of new HIV cases among PWID is likely to slowly decrease until 2025. However, projections for MSM show a marked increase in HIV incidence in the coming years, indicating that a greater focus on HIV prevention among MSM is required.



**Fig. 38: Annual new HIV infections projected to 2020**

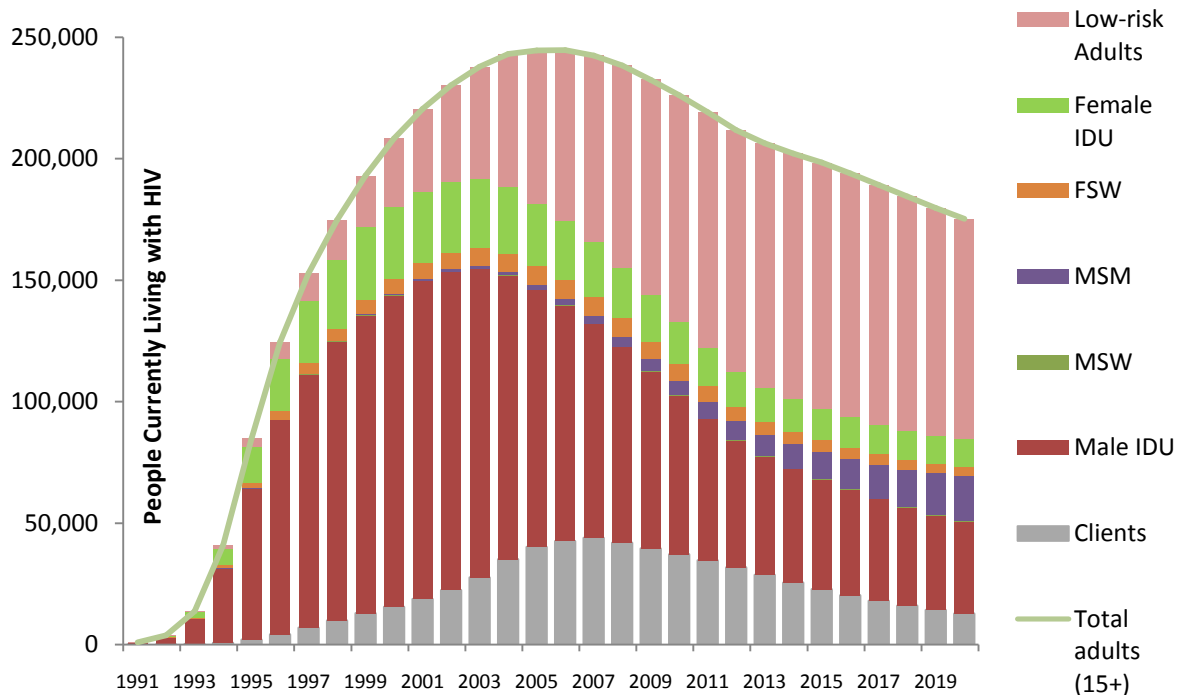
Source: Saliuk, T. AIDS Epidemic Modelling (AEM) Country projection exercise. Kiev, International HIV/AIDS Alliance in Ukraine, Powerpoint Presentation, National M&E Conference, 2013.

## 9.2 Improved outcomes of key interventions related to HIV prevention among PWID

Data produced by the same updated AEM modelling exercise in 2013 shows that one of the main outcomes of the key interventions related to HIV prevention among PWID is the reduction in HIV incidence, i.e. a steady reduction in the number of new cases of HIV as a result of injecting illegal drugs in Ukraine; see Fig. 39.

With the rapid expansion in the provision of OST that is currently underway throughout Ukraine, and with plans of the Government and its partners to substantially increase the number of people who can access ART paid for in the future by the government's budget, it is likely that the reduction in HIV incidence among PWID will continue.

In 2013, there were 3,906 AIDS-related deaths in Ukraine, of which approximately 60% are believed to be related to PWID<sup>144</sup>; continued and improved harm reduction service delivery should, in time, reduce this figure significantly.



**Fig. 39: People Living with HIV projected to 2020**

Source: Saliuk, T. AIDS Epidemic Modelling (AEM) Country projection exercise. Kiev, International HIV/AIDS Alliance in Ukraine, Powerpoint Presentation, National M&E Conference, 2013.

<sup>144</sup> Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC). HIV Infection in Ukraine. Bulletin No. 41, Op. cit.

## 10. CONCLUSIONS AND RECOMMENDATIONS

In light of the information and analysis presented, the following is a review of the work of Alliance Ukraine within the context of the 'good practice' criteria set out in Section 2.

### **Criteria 1: All 9 UN recommended interventions are being implemented**

All 9 interventions recommended by WHO, UNODC and UNAIDS are being implemented by local NGO and Governmental partners of Alliance Ukraine. In addition, Alliance Ukraine is clear in regarding the importance of the 9 interventions and also considers NSP and OST as the priority interventions for HIV prevention, as does the UN.

### **Criteria 2: At least 50% of the targeted populations are covered by each intervention**

It is difficult to estimate the coverage of each of the recommended interventions due to often large disparities in the denominator used for such calculations. Alliance Ukraine uses the relatively robust data from IBBS 2011 as its denominator. However, the Government of Ukraine uses its own data, the sources of which are unclear and the scientific validity of its resultant denominators is questionable.

**NSP:** Coverage is 'medium' at approximately 56%; it is important to note that the Alliance Ukraine NSP does not attempt to cover a very high proportion of PWID because research has shown that many PWID acquire sterile needles/syringes and related injecting commodities from other sources not directly related to the Alliance Ukraine programme. Therefore, it is likely that NSP coverage in Ukraine beyond just that provided by the Alliance Ukraine programme is 'high'.

**OST:** Coverage appears to be low at 7.4%; however, considerable efforts are already underway to rapidly expand coverage in collaboration with the Government. If the Government's denominator is used, then coverage can be considered as 'medium', at 35.9%, although it is recommended that the IBBS 2011 data be used for OST indicators and targets.

It must be stressed that the work towards implementation, expansion and improving the quality of OST services by Alliance Ukraine has been undertaken within a very rigid health care system and in the context of a lack of state ownership of the OST programme until very recently. In addition, drug treatment doctors have been very reluctant to accept OST as a treatment option for opiate-dependent people. Therefore, the way in which these obstacles have been overcome by Alliance Ukraine and its partners could be considered as a 'good practice' for NGO implementation of OST at a national level.

**HTC:** Coverage is 'medium' as, according to IBBS 2011, only 35.7% of PWID undertook testing for HIV over the previous 12 months and more recent data shows only marginal improvement.

**ART:** 117,000 people are estimated to be in need of ART in Ukraine but only 44,525 (38%) people were receiving ART as of May 1, 2013. One-in-five PWID (21.6%) are HIV-positive. As of May 1, 2013, there were 4,689 PWID receiving ART out

of 5,935 registered HIV cases (79%) among PWID. However, most PWID have been unable to register for ART and, therefore, the actual number of PWID in need of ART is far higher than those currently being reported in such data.

**Condoms:** Although the coverage of the number of PWID with access to condom services is in the ‘mid-to-high’ category at 67%, the number of condoms distributed per PWID, per year, in 2011 and 2012 was ‘low’ based on the recommendations of WHO, UNODC and UNAIDS, respectively, but was ‘high’ in 2013. However, consistent condom use by PWID remain a concern.

**IEC:** Coverage is ‘high’ at 77%. It remains unclear, however, the extent to which such targeted IEC materials result in actual behaviour change by PWID, as, for example, the lack of consistent condom use by PWID indicates that targeted IEC materials have been insufficient to make any change in such high HIV risk behaviour.

**Hepatitis:** Coverage is ‘low’ at 4.3% for vaccinations and revaccinations against viral Hepatitis B in key populations groups, including PWID.

**TB:** Stand alone TB services for key populations were only introduced by Alliance Ukraine through its partner NGOs in April 2013 and, consequently, it is too early to assess coverage of such services among PWID and other key populations in Ukraine.

**Criteria 3: Referral, assisted referral, case management systems exist to link clients between services with patient/client drop-out rates consistently falling as a result**

Alliance Ukraine has made considerable progress in addressing the issues of drop-out from self-referral to other health services by PWID and other key population groups. The development of case management is an innovative response to this challenge and effectively addresses the needs of PWID who require both assisted referral to other health care facilities as well as help in negotiating their way through a myriad of paperwork and regulations that are sometimes required to assess particular treatment regimens, such as ART.

**Criteria 4: Psychosocial support and linkage to vocational training and income earning opportunities are available to clients**

For people on OST, access to psychosocial support is more readily available than it appears to be for PWID who access, for example, NSP services through outreach workers, mobile clinics, drop-in centres or pharmacies. There are some excellent examples of local NGOs implementing an holistic approach to the health, social, legal and economic needs of the individual, whether they be a PWID, FSW, MSM or a child or adolescent most at-risk in the community. Using lessons learned and ‘good practices’ from such local NGOs – The Way Home in Odessa and Light of Hope in Poltava, for example – wider availability of a comprehensive range of services is possible, although there will likely always be difficulties in the funding of such comprehensive approaches that cut across a range of sectors.

**Criteria 5: Different services are integrated at one location, i.e. one-stop shop, or located nearby to each other**



The Integrated Care Centre (ICC) approach is an excellent way of providing a range of health services to PWID and other key populations. Even where such ICCs are not currently available, the care taken to link different health services located near to each other is an effective approach to be highly commended for replication in other countries. Such linked services include NSP, OST, HTC, STI, TB, Hepatitis and distribution of condoms and IEC materials.

**Criteria 6: There are specific services for females, children, and adolescents available**

There is a very strong gender component to all of the services implemented by local NGOs throughout Ukraine based on the technical support given to them by Alliance Ukraine. There are also several examples of comprehensive harm reduction programming being implemented for most at-risk children and adolescents that could be replicated elsewhere. Further efforts are needed to give opportunities to female PWID to develop into more senior level management positions in local harm reduction NGOs.

**Criteria 7: All client/patient data is kept confidential at all times by service providers**

The Alliance Ukraine approach, including the use of a unique identifier code (UIC), is an excellent example of how data is kept confidential in all aspects of programme and service delivery for the individual patient/client.

**Criteria 8: Coordination and collaboration takes place with other sectors, agencies and services, including local administration and law enforcement**

Both Alliance Ukraine and its local NGO partners are active throughout Ukraine in actively participating in cooperative and collaborative mechanisms, be it for service delivery or for coordination of interventions between organizations, both Governmental and NGO. Alliance Ukraine focuses on national level coordination and collaboration, with local NGOs focusing their efforts at the regional and/or local level. Such mechanisms include health sector only, but some groups and committees involve health as well as social and law enforcement sectors. It appears that a considerable amount of staff time is spent in the meaningful involvement of Alliance Ukraine, and by its local NGO partners, in the range of mechanisms to cooperate and collaborate with others. The result of such hard work and investment of time is a high level of mutual respect between key officials of the Government at national and regional levels and, thereby, the ability and opportunity to at least discuss substantive challenges to programme implementation when they are encountered.

**Criteria 9: Continuous Quality Assessment (CQA) of services and staff exists and is being implemented**

Although not always termed as continuous quality assessment (CQA) by Alliance Ukraine, in effect the organization does undertake CQA as demonstrated by its on-site visits to partner agencies every six months and the quarterly reporting it receives from every partner NGO; the ranking of its partners is a further indicator that CQA is an integral part of the Alliance Ukraine approach to service delivery and programme management.

**Criteria 10: A mechanism for Continuous Quality Improvement (CQI) exists and is being implemented**

Alliance Ukraine is very active in reviewing and revising service delivery techniques and developing the capacity of its own staff as well as those of the considerable number of partner NGOs throughout the country. CQI is an integral part of the Alliance Ukraine approach and the introduction of such approaches as case management and peer-driven interventions (PDI) are just some of the examples of how CQI is being taken seriously and implemented throughout the components of the organization.

**Criteria 11: Innovation to address challenges is an integral part of the programme, together with operational research activities**

The development of innovative responses to programmatic challenges is a very strong component of the work of Alliance Ukraine, as is the enthusiasm to undertake a wide range of research activities to learn more from key populations as well as to better target existing interventions. There is a systematic approach to problem solving within Alliance Ukraine that enables a thorough review of all issues involved. The use of pilot interventions helps to produce lessons learned for further development of an innovation into a full component of a project or programme, such as peer-driven interventions (PDI) and community-initiated treatment interventions (CITI), more commonly known as active case management.

Alliance Ukraine and their governmental and NGO partners have a substantial number of ongoing research activities and frequently publish the findings of such research online, as well as periodically in hard-copy, so that as many people as possible can access the wealth of information produced. The detailed analysis of the IBBS 2011 data as it relates to PWID, FSW and MSM are of particular note over recent years.

**Criteria 12: Sustainability of Services: Increasing role of Government staff in service delivery**

For the provision of OST, there appears to be a very well developed public-private partnership existing between Ministry of Health and NGO staff that results in an holistic service for the individual patient/client, including the dosing of methadone or buprenorphine, the provision of diagnostics for HIV, TB, STIs and viral Hepatitis, as well as counselling and follow-up support, including active case management. There is no reason to believe that such operational arrangements between the Government and NGOs will not continue regardless as to the source of funding for such service delivery in the future. The same applies to the screening, diagnosis and treatment of HIV/AIDS, TB, STIs and Hepatitis B, and the diagnosis of Hepatitis C. In some regions – but not all – there is a steady increase in the role of Government staff in the provision of HIV prevention services for key populations in collaboration with local NGOs supported by Alliance Ukraine. If funding levels were to drop as a result of the discontinuance of Global Fund support in the medium to long term, and a lack of Government financial support, then it is most likely that the NGO component of such operational partnerships will find great difficulty in continuing to perform their important role in support of service delivery for key populations.

**Criteria 13: Sustainability of Services: Increasing proportion of local and/or central Government funding to services, including the no-cost provision of government buildings for service delivery**

It is likely that each individual component of HIV prevention for PWID could be financed by local and/or national Government in Ukraine. However, the combined cost of all nine interventions, and related activities, appears to be too high at present for the Government to undertake. However, the Government is showing its willingness – more than in many other countries – to fund some key components of the comprehensive package of harm reduction interventions for PWID, including some of the costs to purchase ARVs. They also plan to fund the purchase of methadone and buprenorphine for OST in the future together with a planned exponential increase in the number of people on OST nationwide. Some diagnostic supplies are also funded by the Government.

In addition, the Government provides infrastructure, such as buildings and/or offices, at no or little cost to NGO partners to deliver services for key populations. This usually depends on the nature and duration of the relationship between the two entities, as well as the availability of infrastructure for the Government to provide to the NGO.

**Criteria 14: The financial cost of each intervention is at a level that central and/or local Government funding can sustain in the future**

The unit cost, per year, for HIV prevention services for key populations is at a level that is lower than many other countries but possibly higher than can be funded by the Government of Ukraine under the current economic constraints facing most countries of the world. The price component for medications is a key issue in which entry into the European Union (EU) may, or may not, provide the opportunity for price reductions when purchased in bulk; further assessment of such opportunities, and risks, should be undertaken in order to provide guidance to key Government officials.

**Criteria 15: Ongoing advocacy takes place to remove legislative, administrative, financial and societal obstacles to the rapid scaling-up of quality harm reduction services for key populations through the active and meaningful involvement in the development, implementation, monitoring and evaluation of each service by relevant key populations**

Substantial challenges and obstacles have faced the development of HIV prevention, treatment and care services for key populations in Ukraine, especially for PWID. It should not be underestimated the amount of time expended by Alliance Ukraine and its partners in addressing each obstacle and in advocating for change; this work continues and will likely need to continue for quite some time at the national, regional and community level. A significant number of positive changes have come about in the legislative, administrative and financial spheres due to the advocacy undertaken by Alliance Ukraine, sometimes as part of a coalition of organizations within Ukraine and sometimes with the support of organizations in the region and beyond. However, most of the changes have come about due to the delicate work undertaken by the staff of Alliance Ukraine itself, in close consultation with their local NGO partners.

The rapid scaling-up of quality harm reduction services for key populations is the goal but this might not happen due to the lengthy process of achieving real, practical change in Ukraine from the Government and its key agencies, in particular the Ministry of Health and the Ministry of Interior, including the police.

Alliance Ukraine has undertaken substantial efforts to promote the active and meaningful involvement in, and participation of, each key population – including females within each group – at national, regional and community level, albeit with varying levels of success due to the deeply held stigma and discrimination of the general public that is reflected all too often in the actions and attitudes of Government staff at all levels, including health service providers.

**Criteria 16: Sharing of lessons learned, technical skills, etc., through publications and online materials**

Alliance Ukraine may well be one of the leaders in Europe and further afield in the number of quality publications it has developed and made available either online or in-print, or both. The organization has a very good practice of documenting its work and sharing lessons learned as well as technical skills for a wide range of environments and services. A look at their website (<http://www.aidsalliance.org.ua>) will testify to this wealth of information available, although most is, naturally, in the Ukrainian and/or Russian languages.

**Criteria 17: A mechanism in place for clients/patients to give feedback on effectiveness of each service**

Considerable efforts have been made by Alliance Ukraine to support the development of national, regional and community organizations to represent key population groups, and to assist specific people from each community to become representatives to advocate for what their community needs. As a result of this approach, each main key population group in Ukraine now has its own organization to represent its members and community. This includes for example, the ‘Legal Life’ organization of sex workers (<http://legallife.com.ua/>), the national LGBT internet portal for Ukraine ([www.lgbt.org.ua](http://www.lgbt.org.ua)), and FULCRUM, amongst others. Such organizations publish their own newspapers, newsletters, and support their own websites and internet portals so that their members and community can access information through a range of means and have the opportunity to raise issues and to provide feedback on the many challenges that affect them.

**Criteria 18: A strong monitoring and evaluation system is functioning and provides timely and useful reports for all levels of the programme**

Alliance Ukraine uses SyrEx2, a database management system. The programme is used for monitoring and recording components of the HIV prevention programme for key populations. The key functions of SyrEx2 include client registration using a unique identifier code (UIC), the recording of commodities and services provided; and, the recording of trainings and other group events. SyrEx2 can generate many types of report and can transmit and aggregate data from multiple sources<sup>145</sup>.

Reports from local NGO partners are submitted to Alliance Ukraine on a quarterly basis and are integrated into the database for consolidation so that timely reporting can be made on a range of variables for central and regional Government, NGO partner organizations, and for donors. Relevant staff of Alliance Ukraine must transfer data from their SyrEx2 database to the reporting format for Global Fund on a semi-annual basis.

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<sup>145</sup> See, <http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/library/syrex/index.htm>, accessed 31 July 2013.

**Criteria 19: Specific technical training is provided to staff and refresher training is available and undertaken on a periodic basis**

Over 100 technical and training activities are undertaken every year by staff of Alliance Ukraine who travel throughout the country to delivery such trainings to their local NGO partners. Periodic refresher trainings on key issues are also provided. Alliance Ukraine utilizes master trainers to undertake training-of-trainers in many of the issue areas for which technical training is sought by local NGO partners. Periodic assessments of local NGO technical capacity are undertaken by Alliance Ukraine and follow-up trainings delivered in a timely manner if needed.

**Criteria 20: Training in administration, finance, human resource, fundraising and general management issues is provided to relevant staff and refresher training is available and undertaken on a periodic basis**

Particular attention is given by Alliance Ukraine as to the organizational capacity of their local NGO partners. When first becoming a partner with Alliance Ukraine, an assessment is undertaken of the administrative, financial and general management capacity of the organization and trainings are then provided based on the needs of the local partner. Alliance Ukraine is always available to provide particular support or guidance when issues arise in a local NGO for which they are unable to address on their own. Such support was noted by many local NGOs met in Ukraine as being vital to the ongoing capacity of the organization to deliver harm reduction services in a manner that is compliant with international donor standards.

The **recommendations** arising out of this review of the Alliance Ukraine HIV prevention programme are as follows:

**10.1 Revision of Order No. 188 concerning the quantity of drugs for personal use**

Since 2010, Order No. 188 has provided heavy sanctions against PWID who are in possession of extremely minute quantities of illicit drugs, such as the residue remaining in a used needle or syringe. This has resulted in many PWID refusing to exchange their used needles/syringes due to fear of police action against them for being in possession of quantities of drug above those provided for in Order No. 188. Therefore, assistance should be provided by WHO, UNODC and UNAIDS as one consolidated UN group – and in collaboration with other concerned stakeholders such as Alliance Ukraine – to the Ministry of Health, the Ministry of Interior, the Cabinet of the Council of Ministers and, in particular, to the head of the State Service of Ukraine on Drug Control for the immediate revision of this Order so that it has quantities of drugs that are commensurate with WHO guidance and the norms as used in other countries of the region and beyond.

**10.2 Rapid scale-up of access and adherence to OI/ART for PWID through GFATM funding through Alliance Ukraine**

For all relevant partners – with the technical assistance of WHO Ukraine – to negotiate with the Global Fund for Round 10, Phase 2, funding for HIV/AIDS care and support for key populations to be implemented by Alliance Ukraine through its partners in order for a rapid increase in the number of PWID to access ART using the

established outreach worker and case management support structures nationwide. The suggested redistribution of roles and responsibilities in the HIV/AIDS sector in Ukraine is outlined in Table 4.

| <b>HIV/AIDS Sector</b>   |                                   |   |
|--|-----------------------------------|---|
| <b>Key Populations</b>   | <b>General Population</b>         | <b>Key + General Populations</b>                      |
| Alliance Ukraine   | The All-Ukrainian Network of PLHA | Ministry of Health                                    |
| Prevention, Care & Support   | Prevention, Care & Support        | OI/ART Treatment                                      |
| Outreach, Drop-In Centres, Health care Facilities, NSP sites, pharmacies, drug treatment sites, AIDS Centres | AIDS Centres                      | AIDS Centres  |
| UIC = anonymity  |                                   |   |
| Rapid Test, Registration Support   | Registration Support              | Confirmation Test                                     |
| -  | -                                 | Dispensing of ART                                     |
| Adherence support through case managers  | Adherence support                 | Dispensing of treatments for Opportunistic Infections |
| TB/HIV co-infection support through case managers  | TB/HIV co-infection support       | TB treatment followed by ART                          |
| OST + ART support  | -                                 | Dispensing of OST + ART                               |
| Viral Hepatitis support  | Viral Hepatitis support           | Dispensing of Hepatitis C treatment                   |

**Table 4: Recommended revisions to the distribution of roles and responsibilities in the response to HIV/AIDS in Ukraine**

### **10.3 ART Adherence**

Support the further development of Community-Based Adherence to ART for PWID nationwide.

### **10.4 ART access for all HIV-positive OST patients/clients**

Increase access to ART for OST patients/clients who are HIV-positive with a CD4 count of 500 cells/mm<sup>3</sup> and in need of such medical support in accordance with WHO global recommendations.

**10.5 Improved awareness raising of key Government officials**

Make greater efforts to make key senior Government officials aware of the achievements of the programme and the Alliance and its partners, including the provision of written programme updates in the Ukrainian and Russian languages.

**10.6 Increased role of WHO in facilitating access to Hepatitis C treatment**

Greater involvement of WHO in supporting the scaling-up of treatment of Hepatitis C through dissemination of WHO recommendations and technical assistance to the Government and its civil society partners.

**10.7 One Unique Identifier Code used by all components of the HIV/AIDS sector**

One Unique Identifier Code (UIC) should be used for the complete continuum of care of key populations, from the point at which first contact is made by an individual with a HIV-prevention, or other, service, through to the receipt of – and adherence to – ART and associated services including, for example, OST.

**10.8 Increased meaningful involvement of PWID in NSP developments**

National guidelines and programmes related to NSP need to include the meaningful involvement of PWID, including female drug injectors, to make them more relevant and effective.

**10.9 Operational research on HIV-risks related to use of pre-filled syringes**

Operational research is urgently required to assess the risk of communicable disease transmission to, and between, PWID through the use of pre-filled syringes and opportunities to reduce communicable disease risks, including HIV and Hepatitis C.

**10.10 Improved awareness by PWID of injection-related HIV risks**

PWID awareness should be urgently raised as to the risks involved in the injection of any substance(s) when they did not see how a sterile syringe was filled with drugs and/or filled from other already used syringes, and/or shared flasks for the distribution of drugs, and/or shared utensils for the preparation of drugs.

**10.11 Rapid increase in HTC for PWID**

With only around one-third of PWID undertaking a HTC in the past year, a range of awareness and advocacy approaches are needed to encourage many more PWID to undergo such testing and counselling than is currently the case and for those needing treatment to be provided with a robust linkage to ART.

**10.12 Research on PWID sourcing of sterile needles/syringe outside of HIV programme interventions**

Research needs to be urgently undertaken to ascertain the extent to which PWID acquire sterile needles/syringes from sources other than Government and NGO health

service providers. Such information will help guide programme managers in the extent to which existing services need to be expanded or the extent to which free-market mechanisms can play a greater role in the future for a more sustainable NSP throughout Ukraine.

**10.13 Research to better understand reasons for low condom use by PWID**

Research should be undertaken to ascertain (a) the extent to which PWID who have no contact with NGO services are purchasing condoms from pharmacies and/or elsewhere; and, (b) to better understand the motivations, or lack thereof, of PWID to use a condom every time they have sex.

**10.14 Research to assess HIV risks associated with non-injecting stimulant users**

Research should be conducted to assess the level and extent of HIV risk associated with the non-injecting use of stimulants, especially by younger people, and the resultant increased HIV risks as a result of behaviours whilst under the influence of such stimulant drugs, or combination of drugs, including alcohol.

**10.15 Independent Certification for Alliance Ukraine Master Trainers**

Currently, no system exists for the independent evaluation of master trainers of Alliance Ukraine with regards to HIV prevention skills that are passed to trainers of local NGOs throughout Ukraine. It is recommended that an external, independent agency periodically evaluate the quality of each training curriculum and its delivery by Master Trainers of Alliance Ukraine to ensure that the most up-to-date and relevant techniques and information is made available to local NGO and Government partners and that the current high quality standards are consistently maintained by Master Trainers of Alliance Ukraine.

**10.16 All key partners to reach consensus on the minimum package of interventions for MSM through WHO facilitation**

Currently, there is no consensus between key partners as to what should constitute the minimum package of services for HIV prevention, care and treatment for MSM. Therefore, it is recommended that WHO facilitate the reaching of a consensus between all relevant stakeholders on the components of such a basic package and support the monitoring of the delivery of the agreed package and its outcomes.

**10.17 Reconciling differences in OST population size estimates and OST services in prisons and other closed settings**

It is with some urgency that technical assistance should be provided to the relevant agencies of the Government of Ukraine to reconcile the difference between their estimate of the number of opiate users in Ukraine and the estimate generated by IBBS 2011 in order to reach consensus between all stakeholders as to the denominator to be used when calculating coverage of OST services and, crucially, the targets to be set for rapid scale-up of such services throughout the country with the subsequent burden of cost falling upon the Governmental budget. Consideration of OST provision in prisons and other closed settings should also be undertaken as a matter of great urgency by the Government with the support of the UN and its NGO partners nationwide.



**10.18 Efforts needed to motivate more females to enter OST**

Further efforts should be undertaken in motivating female opiate dependent injectors to enter into OST and for both male and female OST patients/clients to be given socioeconomic support by all current and future OST sites in addition to just the medical intervention of OST itself. Consideration could also be given to introducing different ‘streams’ of OST clients, such as one stream for stable patients and another for those less stable, in order to make it easier to maintain the progress achieved. Advocacy for female drug users to access crisis centres, including centres specifically for victims of violence, will help to promote greater access by females who use opiates to OST and other drug dependence services. Linkages could also be made between harm reduction, crisis centre and ‘mother and child’ programmes as a way of accessing contraceptives through government funding.

**10.19 Assess the risks and benefits of Ukraine entry to the EU in relation to cost of medications for the delivery of the comprehensive package of harm reduction services for key populations**

The price component of medications is a key issue in the overall costing of each harm reduction intervention, especially for OST and ART, respectively. It is recommended that an assessment be undertaken as to the risks and opportunities of Ukraine entry into the European Union (EU) vis-a-vis potential cost savings or increases especially when such medications are bought in bulk. Similar reviews have been undertaken in other countries around the world when faced with the changing dynamics of international trade and economic development.

**10.20 Longer-term sustainability is needed through greater Government funding and diversification of external donor development partner support**

The current funding from the Global Fund will not continue indefinitely and there are currently no major alternatives in the provision of external donor development partner support for Ukraine. Therefore, it is essential that Alliance Ukraine, in partnership with all other stakeholders in the HIV/AIDS response, including UN agencies, to continue its work to advocate in the strongest possible terms for an ever increasing level of Government funding to all aspects of the continuum of care for HIV/AIDS prevention, treatment and care for all communities in Ukraine, especially for PWID, FSW, MSM, most at-risk children and adolescents, prisoners and people on probation.

## ANNEX 1

### Operational Research Activities

Evaluation of the gender sensitive approaches to HIV prevention and Harm Reduction interventions among IDUs, 2009

[http://www.aidsalliance.org.ua/ru/library/research/pdf/GenderResearch\\_Eng.pdf](http://www.aidsalliance.org.ua/ru/library/research/pdf/GenderResearch_Eng.pdf)

Brief Summary of Results of Operational Research: Possibilities to Improve Access of FSW to STI Treatment Programmes, 2009

[http://www.aidsalliance.org.ua/ru/library/research/pdf/Summary\\_report\\_web\\_EN.pdf](http://www.aidsalliance.org.ua/ru/library/research/pdf/Summary_report_web_EN.pdf)

Brief Summary of Results of Operational Research: Assessment of Efficiency of HIV Prevention Programmes at Penitentiary Facilities, 2009

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## ANNEX 2

### Components of Service Packages for Key Populations through Alliance Ukraine and its local NGO partners

| Description of Service                                   | PWID | FSW | MSM |
|--|------|-----|-----|
| Distribution of female/male condoms and lubricants       | PWID | FSW | MSM |
| Specialist counselling by a social and/or medical worker | PWID | FSW | MSM |
| Voluntary testing and counselling (HTC) for HIV          | PWID | FSW | MSM |
| Diagnostics and treatment of STIs                        | PWID | FSW | MSM |
| Diagnostics of hepatitis B and C                         | PWID | FSW | MSM |
| A system of referrals to relevant specialists            | PWID | FSW | MSM |
| Group work   | PWID | FSW | MSM |
| Legal advice   | PWID | FSW | MSM |
| Involving clients in training activities                 | PWID | FSW | MSM |
| Distribution of medications for general use              | PWID | FSW | MSM |
| Organizing the leisure time of clients                   | PWID | FSW | MSM |
| Services of mobile clinics                               | PWID | FSW | MSM |
| Peer-driven counselling                                  | PWID | FSW | MSM |
| Basic household services                                 | PWID | FSW | MSM |

| Description of Service  | PWID | FSW | MSM |
|---|------|-----|-----|
| Sterile needle/syringe distribution and exchange  | PWID |     |     |
| Distribution of alcohol wipes   | PWID |     |     |
| Overdose prevention   | PWID |     |     |
| Intervention-based prevention of HIV among PWID using stimulants through individual behaviour change interventions at the group level | PWID |     |     |
| Brief individual intervention   | PWID |     |     |
| Sterile needle/syringe exchange projects targeted at women  | PWID |     |     |
| Pharmacy-based sterile needle/syringe distribution and exchange   | PWID |     |     |
| Structured secondary sterile needle/syringe distribution and exchange   | PWID |     |     |
| Peer-driven intervention  | PWID | FSW |     |
| Peer-driven intervention through the social network of PWID   | PWID |     |     |
| Counselling of sexual partners of PWID  | PWID |     |     |
| Distribution of antiseptics   | PWID | FSW |     |
| Physiologist counselling  | PWID | FSW |     |
| Skills training and help in finding employment  | PWID | FSW |     |
| Day care centres for children of PWID   | PWID | FSW |     |

| <b>Description of Service</b>   | <b>PWID</b> | <b>FSW</b> | <b>MSM</b> |
|---|-------------|------------|------------|
| Cosmetologist and hairdresser services for female IDUs  | PWID        | FSW        |            |
| Sewing and needlework courses   | PWID        | FSW        |            |
| Online counselling  |             | FSW        | MSM        |
| Social and psychological counselling  |             | FSW        |            |
| Response to violence  |             | FSW        |            |
| Training programmes on the use of female condoms  |             | FSW        | MSM        |
| Distribution of pregnancy tests   |             | FSW        |            |
| Mentor support programme  |             |            | MSM        |
| Counselling on safe sex practices   |             |            | MSM        |
| Group and individual counselling with a psychologist  |             |            | MSM        |
| Awareness-raising and preventive leisure, including parties aimed at developing safe sexual behaviour |             |            | MSM        |

Source: International HIV/AIDS Alliance in Ukraine, Annual Report 2011, Kiev, 2012, p37-38.

## ANNEX 3

### INNOVATIONS

The following is a summary of the innovative approaches piloted and adopted by the Alliance Ukraine partners to address specific issues and challenges over recent years.

- 1. Involvement of nurses in the work on outreach routes for the provision of pre-doctor medical care to PWID** through the integration of pre-doctor medical care into the harm reduction project and delivery of services such as wound bandaging and treatment, calling for a district doctor, and inpatient admission. The services are provided on the outreach routes, in mobile clinics, at clients' homes, and at the permanent syringe exchange points resulting in an individual approach that ensures the improvement of the clients' attitude towards their own health.
- 2. Peer-driven prevention of HIV for PWID** based on the snowball technique under which each client recruits and trains further clients on his/her own. Then, each recruited client is trained one-on-one by a social worker for 1.5-2 hours. This model enables outreach to hard-to-access subpopulations of PWID, such as young users and women who use specific types of drugs, even within a 'closed' drug scene in which NGO/CBO staff cannot gain access. Changes are tracked using an awareness test and a questionnaire on practiced behaviours. A linked survey option is also possible, i.e. it can be combined with testing for HIV, for example.
- 3. Brief intervention for non-injecting drug users** in which a social worker provides the client with a rapid screening of HIV risk behaviours (1-5 minutes) and counsels him/her on the major risks identified; the counselling session is of between 10-30 minutes depending on the degree of the client's readiness for dialogue. This approach is particularly useful for the counselling of clients who cannot be assisted in a more systematic way.
- 4. Controlled Secondary Syringe Exchange** using the existing social networks of PWID to arrange the secondary syringe exchange and establish contact with the clients who don't attend the harm reduction project activities. The intervention is recommended for the localities with a closed drug scene and hard-to-access segments of the IDU population, including female IDU. Until recently the secondary syringe exchange was perceived as an uncontrolled service for syringe distribution only. The Ukrainian model made it possible not only to get it under control of the social workers, but also to use this intervention for the involvement of new clients.
- 5. Online Outreach Work for FSW and PWID** that is a localization of the Social Intervention Tool. The original version was designed for sex workers. The Ukrainian localization includes a separate component for PWID who don't attend the harm reduction project activities. The creation of a regional website is based on the existing information platform. The website's function is endorsed by its promotion of strategies among the web users through special forums uniting the PWID. Website visitors can get counselled online and can make an appointment with a social worker. This is a use of information technologies for the purpose of reaching the client subpopulations who don't attend the harm reduction project activities and oftentimes represent a different culture of psychoactive substance users. The social workers are employed full-time under the project and work in line with the given strategies and algorithms. The operating time of the staff who work online is accounted for automatically.

Individual record keeping on clients is possible and the intervention's efficiency is evaluated through polling of the clients (online and by phone) who received online services.

6. **Peer-driven prevention of HIV with FSW** is a model of the 'link-by-link chain' work in prevention using already existing social networks of female sex workers (FSW). FSW take an active part in training each other and then each client is trained one-on-one by the social worker that takes 1.5 to 2 hours. This model enables outreach to hard-to-access subpopulations of FSW even when the subpopulation has a closed nature and allows for a controlled involvement of the client of a specific type, such as those of a specific age or behaviour. The changes are tracked using a questionnaire containing an awareness test. A linked survey option is also possible that can be combined with HIV testing and counselling.
7. **Peer-driven prevention among adolescents engaging in HIV/STI risk behaviours** based on the snowball technique under which each enrolled adolescent client recruits and trains further adolescents on his/her own. Each adolescent is then given one-on-one training by a social worker for 1.5 to 2 hours. As a result, adolescents with risk behaviours play an active role in training other adolescents and develop effective communication skills as well as having the opportunity to get tested for HIV, STI, and viral Hepatitis. This approach helps to reach hard-to-access subpopulations of children and adolescents. Behaviour changes are tracked by using a questionnaire. A linked survey option is also possible that can be combined with HIV testing and counselling.
8. **'Social Patrol' for street children and adolescents** comprises a team of three professionals, usually a social worker, a nurse, and a psychologist, who go to remote areas to provide children and adolescents with the following services: counselling on HIV/STI prevention; distribution of information materials; testing for HIV/STIs; pre-doctor medical care; counselling sessions with a psychologist; and referral to other prevention services.
9. **Mentor support programme** in which the work between the client and mentor (or tutor) lasts 4-5 months during which time the client and mentor meet once every two weeks with each meeting lasting 2-3 hours. The mentor works in line with an assigned module that comprises 10 topical blocks. The work targets attaining achievable objectives and increasing the level of social responsibility. The programme promotes development of the volunteer movement through the service providing organization. The client's behaviour is monitored in 4 phases during the course of the work with the client and 6 months after completion of the programme. The monitoring is centred around such indicators as behaviour, knowledge, and attitude to health.
10. **The website information portal for MSM health** has been created as an information resource for MSM who spend a lot of time on the internet. It seeks to satisfy their social needs with the website regularly updated with information. It also allows for online counselling sessions by professionals, including social workers, physicians, psychologists and legal specialists. A portion of the prevention information is presented in an easy and entertaining form and the web-resource is designed both for the HIV-service organization professionals and for MSM who are clients. All the information is updated on an ongoing basis and is available round-the-clock at <http://www.msmua.org/>
11. **Peer-driven prevention of HIV within MSM** based on the snowball technique under which each client recruits and trains further clients on his own. Each recruited client is then trained



one-on-one by a social worker for 1.5 to 2 hours. This model enables reaching the hard-to-access subpopulations of MSM even when the population has a closed nature. The model allows for the involvement of clients of a specific type, such as those of a specific age or behaviour.

12. **Prevention of HIV in MSM through social networks** through the use of existing social networks of MSM for HIV prevention. The work targets the MSM subpopulations who do not visit the HIV-service organizations but do spend a lot of time on the internet. As a result, each MSM gets the opportunity to participate independently in HIV/STI prevention within their community. Each MSM passes an online knowledge test and participates in interactive training in the format of a video quest and has the opportunity to receive consumables (brochures, condoms, lubricants) by mail if they wish. There is also the opportunity to be counselled online by a social worker with a follow-up one-on-one meeting if and when needed. MSM are tracked using a questionnaire and it is envisioned that individual registration will allow for an assessment of the coverage of this innovation.
13. **Community Initiated Treatment Interventions (CITI)**, also known as the provision of social support (or Case Management) services to ensure access of the vulnerable populations to antiretroviral therapy (AT). The approach delivers individual care to a client for the purpose of registering them on the outpatient medical records at the regional AIDS Centre and getting ART prescribed as well as a comprehensive set of related medical and social services. Routine data is collected on the number of people who have been put on the outpatient medical records and receive ART to assess the effectiveness of this approach.
14. **Creation of gender-sensitive services** including several components that are focused on the personnel engaged in work with clients as well as on the clients themselves. This model emphasizes the shifted to the organization of services for women, including remedial education for staff in order to ensure a better understanding of the process of establishing gender-sensitive services that are reached, on average, within 12 months. The intervention can't be built up and established in a stand-alone project and bears an impact on all the components of the organization's activities.
15. **Early detection of Pulmonary Tuberculosis in PWID and their partners, MSM, FSW and adolescents who practice risky behaviours** by taking a sample from clients who are found to have symptoms of TB subsequent to a screening. Taking of phlegm is performed by a nurse in the course of outreach work. The clients who have disease symptoms are referred to follow-up examination and treatment. Such pulmonary TB detection services are integrated into the harm reduction programme. The result has been an increase in the number of clients who have successfully been treated for TB and the service delivery time has been reduced to 10 minutes for the screening and 10 minutes for the taking of phlegm by the nurse.
16. **Supervision of a team of specialist psychologists** to assist the key populations most vulnerable to HIV/AIDS through the provision of professional support. They are supervised once every two months on an ongoing basis resulting in an improvement in the techniques of their work. The optimal number of participants in one supervised group is 12-15 psychologists.
17. **The Editorial Board of Alliance Ukraine serves to increase the quality of reading materials published by the HIV-service organizations** by controlling the accuracy of provided materials, quality of product design, and compliance with copyrights and disclaimer

policies. The editorial board is comprised of professionals in development and publishing of information and educational materials on HIV-services. The editorial board supports more than 150 HIV-service organizations.

- 18. The Inter-Regional Knowledge Hubs (IRKH) on HIV/AIDS** are guidance centres that provide support to HIV-service organizations. Such hubs deliver technical support, organizational training as well as the provision of consultancy, logistical and informational assistance to organizations, projects, task forces, NGOs, sector-specific government entities and associations of the NGO-service organizations at the regional level of Ukraine in accordance with regional needs. One inter-regional knowledge hub (IRKH) can cover 4-5 regions. On average, one IRKH holds 8-10 training sessions per year and trains more than 200 people. The work of the IRKH largely reduces the costs of on-the-ground technical support.
- 19. Online harm reduction lessons** through the use of web-technologies for training social workers given the high turnover of personnel and the lack of a state-run system for training professionals in harm reduction and HIV prevention. The web-based training course contains materials that serve as the basis for modern social work in the field of HIV/AIDS and also reflect the major medical aspects of HIV/AIDS and drug dependence. The first level training course comprises 20 sessions on the social and medical component of the harm reduction project services. The second level training course is comprised of 10 sessions that offer information on the key aspects of social work with families and people facing difficult life circumstances. Upon completion of the training course, the trainees' knowledge is tested using 40 random questions and they receive a personal certificate if they pass. The training course is available in three languages: Ukrainian, Russian and English. The number of participants is not limited.

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