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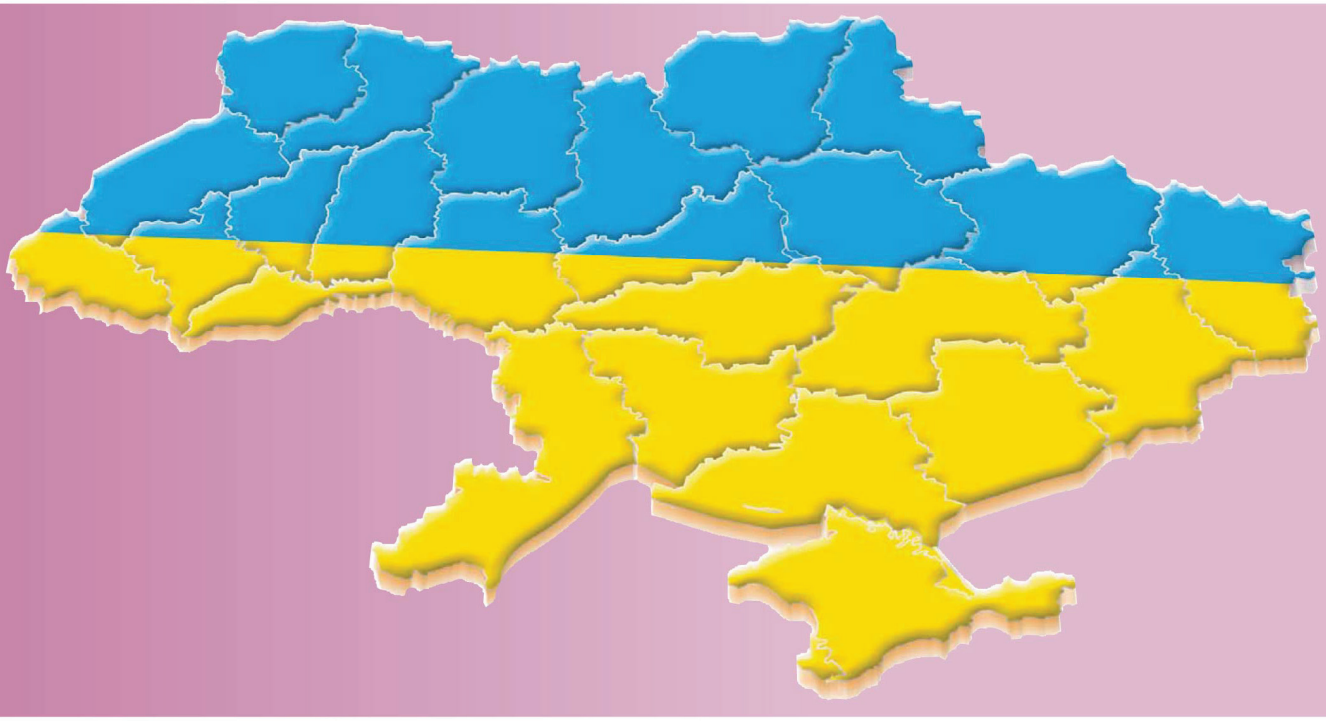

HIV Epidemic Among Key Populations in Ukraine: Review of Secondary Data

Kyiv – 2013

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This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents of this publication do not necessarily reflect the views of USAID or the United States Government.

Kyiv – 2013

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CBO	Community based organization
CDC	Centers for Disease Control and Prevention
CIC	Centers of Integrated Care
CSO	Civil society organization
FSW	Female sex worker
GBV	Gender based violence
GoU	Government of Ukraine
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HCT	HIV counseling and testing
IEC	Information, Education and Communication
IDU	Injecting drug user
LGBT	Lesbian, gay, bisexual and transgender persons
MARP	Most-at-risk populations
MAT	Medication-assisted treatment
MOH	Ministry of Health
MOFYS	Ministry of Family and Youth Services
MOJ	Ministry of Justice
MSM	Men who have sex with men
NAP	National AIDS Programme
NGO	Non-governmental organization
NSP	Needle and syringe program
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWA	People living with AIDS
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PWID	People who inject drugs
STI	Sexually transmitted infection
SPSU	State Penitentiary Service of Ukraine
TB	Tuberculosis
UNAIDS	Joint United Nation's Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Executive Summary

The USAID RESPOND Project (Improving HIV/AIDS Services Among Most-at-Risk Populations in Ukraine) undertook a secondary data review of the HIV epidemic among key populations in Ukraine in order to form a detailed analysis of the situation, identify gaps and review program interventions.

This report summarizes findings of national assessments, bio-behavioral surveillance, and program reports by key populations: people who inject drugs (PWID), female sex workers (FSW), men who have sex with men (MSM), prisoners, most-at-risk adolescents (MARA) and people living with HIV (PLHIV). For each key population, four main topics were reviewed and available data were summarized: epidemiological data, behavioural and contextual information, legal and policy frameworks, and intervention and service coverage.

The reviewed sources show that a strong foundation has been established for the next phase of national response, but numerous policy, research and service changes are required to achieve impact in HIV prevention, care and treatment among key populations.

Key recommendations identified include:

- The development and expanded coverage of standardized packages of services tailored to key populations based on evidence of need and demonstrated effectiveness. Additionally, evidence-based interventions targeting the sexual partners of key populations and MSM are urgently needed.
- Scale-up of MAT services and the continued review of the evidence for effective delivery of MAT services in the Ukrainian context.
- Improved demand creation for HIV testing and the expanded coverage of rapid testing.
- In addition to expanding treatment access to key populations living with HIV, greater focus on the loss in the treatment cascade is urgently needed.
- Services tailored to the needs of younger key populations.
- Greater government involvement and coordination with civil society systems for key populations, particularly as it relates to the continuum of care.
- Gender issues and stigma and discrimination to be addressed within all programs and services as well as at the larger national policy level. These critical issues affect service access and quality for all key populations.

1. Introduction

The HIV epidemic in Ukraine is concentrated among key populations and their sexual partners: people who inject drugs (PWID), female sex workers (FSW), men who have sex with men (MSM), prisoners and most-at-risk adolescents (MARA). People living with HIV (PLHIV) are also highly vulnerable. HIV prevalence among the general population is 0.8% and consistently exceeds 5% among key populations. In 2011, HIV prevalence among key populations detected through bio-behavioral surveillance ranged from 6.4% in MSM to 21.5% in PWID. There was uneven geographic distribution; 77.1% of HIV cases were in urban areas [1].

Trend data between 2005 and 2012 show a shift toward sexual transmission of HIV [2], and an increasing proportion of cases in women [3]. Between 2005 and 2011, men represented 57.5% of reported HIV cases in adolescents and adults and women made up 42.5% of cases [4]. In men, most infections were attributed to injecting drug use. In women, heterosexual transmission was reported as the main mode of transmission [5].

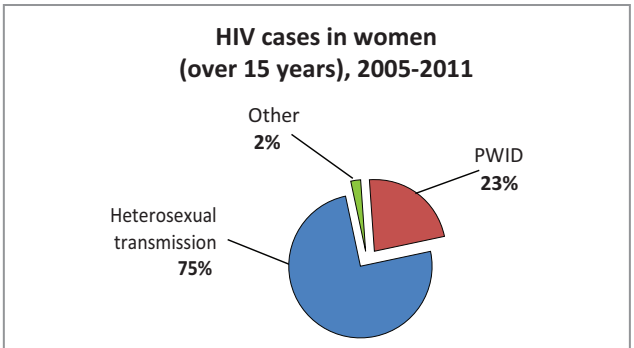

Figure 1. Mode of transmission attributed to HIV cases in women, 2005-2011

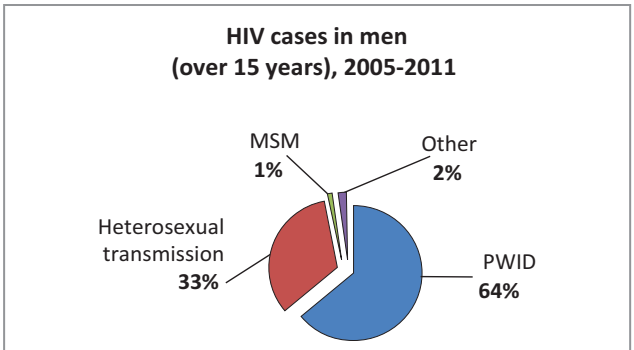

Figure 2. Mode of transmission attributed to HIV cases in men, 2005-2011

The number of people living with HIV continues to increase. In 2011, 21,177 new HIV cases were officially registered, the highest annual number since 1999 [6], although the number of cases registered during 2012 decreased to 20,777 cases. At the same time, evidence suggests a stabilization of the epidemic in some groups: pregnant women, PWID and youth, likely due to prevention interventions. Prevention of mother-to-child transmission of HIV (PMTCT) has been scaled up nationwide, reaching over 90% of pregnant women. Mother-to-child transmission reduced significantly from over 23% in 2001 to 4.2% in 2009 [7]. Greater access to harm reduction programs, the largest coverage in the region (over 157,000 PWID or 54% of the estimated number) [8] between 2004 and 2010 dramatically reduced HIV prevalence among young PWID from 29.9% in 2004 to 5.5% in 2011.

1 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

2 Information on officially registered cases of HIV, AIDS and AIDS-related deaths as of December 2012, "Український центр контролю за соцхворобами МОЗ України" (Ukrainian Center for Control of Socially Dangerous Diseases of the Ministry of Health of Ukraine). http://ucdc.gov.ua/uk/statystyka/epidemiologiya

3 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

4 Abdul-Quader, A. Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

5 Ibid

6 Ibid

7 UNAIDS Country Office in Ukraine, Summary Report of the National Consultation on Building Sustainability and Strategic Investments into the National HIV Response in Ukraine, Kyiv, Ukraine, December 3-4, 2012.

8 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012; International HIV/AIDS Alliance, Annual Report, 2010.

While injecting drug use remains the primary driver of the HIV epidemic and the majority of HIV cases are among PWID, a shift to sexual transmission of HIV has occurred. There is increasing concern about HIV risk for sexual partners of key populations. Subsets of groups with combined or overlapping risk characteristics are at the highest risk of HIV infection [9].

Access to prevention services has expanded. For example, opioid substitution therapy (OST) has increased almost three-fold since 2009. Yet the coverage by key populations remains below levels to have public health impact [10]. Between 2005 and 2011, basic services reached 160,000 PWID, including 6,600 people receiving substitution treatment, 30,000 FSW, 20,000 MSM and 25,000 prisoners [11], approximately half of those in need.

Anti-retroviral treatment (ART) has been made available in all 27 regions of Ukraine with currently over 32,000 people living with HIV receiving treatment, a tremendous increase since 2004 when there were 1,300 people receiving treatment. However, only 25% of the estimated needs are currently met, constituting the group of countries with one of the the lowest coverages in the world [12]. About half of the 230,000 PLHIV in the country are aware of their HIV status. Of those tested during bio-behavioral surveillance, 62.7% receive treatment. Among people on treatment, 82.3 % adhere to their treatment.

Evidence suggests that there are also epidemics of co-infections of TB and HIV; TB is diagnosed in 62.5% of AIDS cases. There is also evidence of an epidemic of Hepatitis C and HIV, primarily associated with injecting drug use, although official data are not available.

Ukraine has demonstrated considerable political commitment to address the HIV epidemic in a comprehensive manner. The increasingly supportive policy framework has allowed an evolving national response to HIV that is tailored to meet the needs of key populations. Programs and services are guided by the Government of Ukraine's National Programme to Ensure HIV Prevention, Treatment, Care, and Support to HIV-positive People and Patients with AIDS (hereafter, the National AIDS Programme (NAP) for 2009-2013) and the Law on HIV/AIDS. Priority directions include strengthening prevention, provision of treatment, and upholding the rights of PLHIV. The Government concentrates on HIV counseling and testing (HCT), ART and PMTCT through a network of AIDS Centers and Trust Cabinets, while civil society has created strong systems for prevention, care and support for key populations.

Barriers and gaps remain. The scope, quality and coverage of some core services are limited, and are not integrated. Additionally, pervasive societal and provider stigma and discrimination toward key populations, and gender dynamics contribute to risk and vulnerability, including low use of services. In Ukraine, legislation provides a supportive framework for gender equality. However, gender expectations have a differential impact on the risk and vulnerability of both men and women, particularly regarding drug use and sexual behaviours, violence, and access to HIV prevention and treatment services.

In Ukraine, a substantial amount of evidence has been generated and knowledge gained of the factors contributing to the response to HIV. This report collected published and unpublished assessments, reviews, and evaluations to analyze and synthesize epidemiological data, behavioral and structural information, and program experiences by key population: PWID, FSW, MSM, prisoners and MARA.

9 Ibid

10 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

11 Strategic Investments for Impact: Global Fund Results Report, 2012. www.theglobalfund.org

12 UNAIDS Country Office in Ukraine, Summary Report of the National Consultation on Building Sustainability and Strategic Investments into the National HIV Response in Ukraine, Kyiv, Ukraine December 3-4, 2012.

2. HIV Prevention Context, Behaviors and Needs of Key Populations

In this part of the review, epidemiological, behavioral and contextual data, service coverage, and documented gaps have been compiled from available research and analysis for each key population.

2.1. People Who Inject Drugs (PWID)

Epidemiological Situation

Most HIV infections in Ukraine were attributed to contaminated injecting equipment until 2008 when the number of HIV cases due to heterosexual transmission surpassed those attributed to drug use. In 2008, sexual transmission accounted for 51% of reported infections among people over 15 years while drug use accounted for 46%. Between 2005 to 2011, there was a stabilization of the epidemic among PWID with a decrease in both the proportion of PWID among all HIV cases and the number of new HIV cases registered among PWID [13]. In 2011, PWID represented 31% of new HIV infections [14].

Nevertheless, drug use remains the driving force behind the HIV epidemic in Ukraine, and PWID the most affected key population [15]. The new wave of HIV infection is due to sexual transmission linked to risky sexual behavior of PWID and their sexual partners [16], with a concurrent shift to more HIV infections among women. By 2010 women comprised 48% of all new cases among adults [17].

Size Estimates: According to the most recent size estimates for key populations at risk of HIV, published by the AIDS Center in the end of 2012, the total number of PWID in Ukraine is 310,000 with more than 40% located in Kyiv City, Odeska, Donetska and Dnipropetrovska oblasts [18].

Figure 3. Size estimates for PWID population by region, 2012

The 2011 bio-behavioral survey sample of PWID was primarily males between 15 to 49 years of age, with an average age of 33 years. The sample was older than previous surveys, with longer injecting

13 Abdul-Quader A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

14 UNAIDS Ukraine, Assessment of the Implementation of the National AIDS Programme Ukraine: Synthesis Report, Kyiv, 2012.

15 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

16 Ibid

17 Pinkham, S., and Anna Shapoval, Making Harm Reduction Work for Women: The Ukrainian Experience, Open Society Institute, New York, 2010.

18 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project. Draft Final Report, September 13, 2012.

histories suggesting an aging of this population; in 2008, 42% of PWID had injected for 11 years or longer while in 2011 53% injected 11 years or longer [19].

HIV Prevalence: The 2011 bio-behavioral survey [20] found an HIV prevalence of 21.5% (range: 20.6 – 22.8%) among PWID. Older age and duration of injecting drug use, gender, risky injecting practices, and time in prison were risk factors associated with HIV infection. HIV prevalence was higher in PWID older than 25 years (24.4%) than those younger than 25 years (7.1%), and among those who had injected over six years.

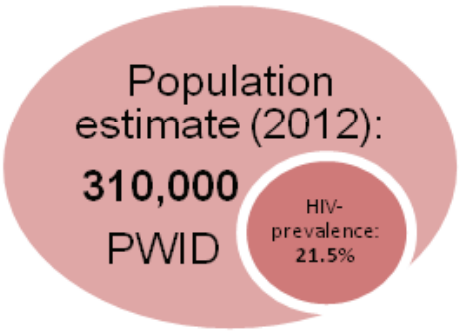

Figure 4. PWID size estimates and HIV prevalence

There was a general trend to lower sero-prevalence over time. In 2009, HIV prevalence was 22.9% (range: 21.9 –23.9%) [21] showing a decrease in prevalence over the past few years. The decrease was also observed among young people under 25 years of age between 2005 and 2011, along with a corresponding 62% fewer HIV cases among young people [22]. The decrease in prevalence was associated with greater program coverage in 2009 and 2007.

Prevalence and trends also varied by geographic region. Mykolayiv, Dnipropetrovsk and Chernigiv had high HIV prevalence while Chernivtsy, Sumy and Uzhhorod had the lowest. In nine cities HIV prevalence among PWID increased, while in 14 other cities it decreased.

Sexually Transmitted Infections (STIs): There are no data on STIs among PWID.

TB:TB, including multidrug-resistant TB, disproportionately affects PWID living with HIV and complicates medical care for a range of conditions [23]. In 2011, there was a total of 30,695 new cases of TB (prevalence 67.2 per 100,000 population) and 11,217 cases of HIV and TB. HIV co-infection has been detected in 15.1% of all TB active cases [24].

Hepatitis C Virus (HCV): A study among PWID in central Ukraine in 2009 found 73% prevalence of HCV [25]. HCV infection was significantly associated with back and front-loading from another syringe. More PWID living with HIV have HCV; 83.7% of HIV-infected PWID compared to 43.1% of HIV negative PWID [26].

Behaviors and Needs of PWID

Risky Injecting Behaviors

The ICF International HIV/AIDS Alliance's bio-behavioral surveys in Ukraine documented that 82% of PWID in 2009 and 80% of PWID in 2011 reported injecting opioid extract or heroin, and

19 Balakiryeva, O.M. T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

20 Ibid

21 Ibid

22 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

23 Curtis, M., Building Integrated Care Services for Injection Drug Users in Ukraine, WHO Regional Office for Europe, World Health Organization, 2010.

24 Regional Workshop on HIV and Drug Use Report, HIV Prevention, Care and Treatment for People Who Inject Drugs: A review of evidence-based findings and best practices, AIDSTAR-TWO, Kyiv, 2011.

25 Dumchev, K.V. et al., HIV and hepatitis C virus infections among hanka injection drug users in central Ukraine: a cross-sectional survey, Harm Reduction Journal, 2009, 6:23.

26 Sergeeva, T., How many people with hepatitis C are living in Ukraine? (presentation). Presented at the round table on Hepatitis C, September 5, 2009.

40% and 35%, respectively, used stimulants [27]. In 2011, 21% of PWID both injected opioids and used stimulants [28]. Stimulants such as "vint" (methamphetamine), "jeff" (methcathinone), and "boltushka" (cathinone) were used by younger PWID [29,30]; 41% of adolescent PWID and 35% of PWID 20 to 25 years-of-age preferred injecting methamphetamine. Older users preferred the use of opiates, which led to a 1.8 times higher risk of HIV than mixed opiates and stimulants use.

The survey analysis found an association between HIV infection and risky injecting practices. PWID who had at least one unsafe injecting practice had a 1.6 times higher probability of HIV compared with PWID who did not engage in these practices. In 2011, 81.5% of PWID reported that they had engaged in one or more of these risky injecting behaviors in the past 30 days [31]. Specifically, although most respondents (85% in 2009 [32] and 91.3% in 2011 [33]) did not use a needle or syringe previously used by another person in the past month, 7.9% did [34]. Also, over half (57.5%) admitted to receiving drugs in a pre-filled syringe and 63% and 59% of PWID shared flasks for the distribution of drugs and preparation of drugs, respectively [35].

Among PWID who knew that they are living with HIV, 11.6% reported sharing needles and syringes, and 2.7% gave their needle to another person to use after injecting [36].

Risky Sexual Behaviors

Numbers and Types of Partners: The 2011 bio-behavioral survey conducted by the Alliance among PWID [37] documented that in the last 90 days, 77% of respondents had a regular partner. Among PWID with regular partners, 45% said that their regular partner also injects drugs [38]. Some (33%) (37% among male PWID and 17% among female PWID) had a casual partner and few had commercial partners: 3% paid for sex, and another 3% sold sex. More women than men were engaged in commercial sex: 9.5% of female PWID and 0.2% male PWID indicated that they sold or exchanged sex in the 90 days before the survey [39].

Nearly one-third (29%) of PWID had sex with two or more partners within the last 90 days, twice as many male than female PWID, 44.2% vs. 26.6% [40].

27 Shulga L., Research of behavior and HIV prevalence among users of stimulant drugs, ICF International Alliance on HIV/AIDS in Ukraine./ L. Shulga, M. Varban, Pogorelaya N. et al., 2010; Analytical Report on Behavior Monitoring and HIV Prevalence Among Injecting Drug Users as a Component of Second Generation Sentinel Surveillance, Kyiv, 2012.

28 Balakiryeva, O.M. T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

29 Hurley, R., How Ukraine is tackling Europe's worst HIV epidemic, BMJ, 2010, p. 341.

30 Chintalova-Dallas R., Patricia Case, Nataliya Kitsenko, and Zita Lazzarini Boltushka, A Homemade Amphetamine-Type Stimulant and HIV Risk in Odessa, Ukraine, Int J Drug Policy, 2009 July; 20(4): 347.

31 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

32 Ibid

33 Ibid

34 Shulga L., Research of behavior and HIV prevalence among users of stimulant drugs, ICF International Alliance on HIV/AIDS in Ukraine./ L. Shulga, M. Varban, Pogorelaya N. et al., 2010;/ O.M. Balakiryeva, T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

35 Ibid

36 Balakiryeva, O.M. T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

37 Ibid

38 Ibid

39 Ibid

40 Ibid

The frequency of sexual intercourse was at least once per week among 73.3% of respondents. The average age of sexual debut among adult PWID was 16 years of age and among young PWID it was 15 [41], earlier than the 2.4% of general population who had sex before the age of 15 [42].

Condom Use: Condom use by PWID is low and inconsistent. Bio-behavioral surveys found that almost half of PWID who had sex in the past 30 days reported using a condom at last sexual contact with any partner, 54.5% in 2009 and 47.8% in 2011 [43].

At last sexual contact, 86.8% of PWID who sold sex and 83.4% who paid for sex reported condom use. 77.3% of PWID with casual partners reported using a condom at last sex and 47.1% of PWID with a regular partner reported using a condom with that partner [44].

Consistent condom use in the 90 days prior to the survey followed a similar pattern. Over half (57.6%) of PWID who sold sex and 62.6% of those who paid for sex reported consistent condom use. Of PWID with casual partners, 52.9% reported consistent condom use. Of those with regular partners, 26.9% consistently used condoms with the regular partner, and only 22% of female PWID [45]. Among HIV-positive PWID, 35.8% (32.3% male PWID and 42.7% female PWID) did not use a condom during their last sexual intercourse [46].

Condom use decreased with age and increased with NGO service participation. Among PWID older than 35 years of age, 41% had never used condoms with their regular partners and 15.6% had never used condoms with casual partners [47]. PWID who participated in an NGO program were 1.4 times more likely to use condoms during the most recent sexual contact compared with non-participants. Among clients of NGOs, 53% used a condom at last sexual contact compared to 45% of non-clients [48].

Knowledge of HIV: In 2011, 64% of PWID correctly identified how HIV is transmitted and knew how HIV is not transmitted. There was little difference between men and women.

Mental Health: PWID suffer greater rates of mental illness than the general population, and are often undiagnosed and untreated for such conditions [49].

Violence and Coercion: In the 2011 bio-behavioral survey of FSW, female PWID who sold sex experienced more sexual and economic violence than FSW who did not inject [50]. Female PWID who experience violence have little recourse. Most Ukrainian women's shelters do not accept women who are active drug users. Many women PWID lack the residency registration needed to receive free services and to have secure housing [51].

41 Ibid

42 Ministry of Health of Ukraine, National Report on Monitoring Progress towards the UNGASS Declaration of Commitment on HIV/AIDS, Reporting period: January 2008–December 2009, Kyiv, 2010.

43 Ibid

44 Ibid

45 Ibid

46 Ibid

47 Ibid

48 Ibid

49 Curtis, M., Building Integrated Care Services for Injection Drug Users in Ukraine. WHO Regional Office for Europe. World Health Organization, 2010.

50 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

51 Pinkham, S. and Anna Shapoval, Making Harm Reduction Work for Women: The Ukrainian Experience, Open Society Institute, New York, 2010.

Gender Aspects: In Ukraine, similar to other countries, women who inject drugs are 1.7 times more likely to be infected by HIV than men who inject [52,53]. In 2011, 23.6% of female PWID were living with HIV compared to 20.8% of male PWID [54].

The principal risk for female drug users is "double dependency" – to drugs and to men who involve them in drug use [55]. Female PWID are more likely to be sexually active, practice unprotected sex, use drugs in the context of a sexual relationship and share injecting equipment than male PWID [56]. In 2011, 51% of women used injecting equipment with a sexual partner compared to 25% of men [57]. Women are often initiated into drug use through boyfriends, inject after men – "last on the needle" – and are at high risk of sexual violence.

Women were more likely to have sexual partners who inject drugs. These risks are added to women's greater biological vulnerability to HIV through unprotected vaginal intercourse.

> ***"It's no secret that drug addicts often use the least strong member of their community, in particular women, as a "guinea pig" for testing a new skag or a speedball ... in addition, these drug-using women are instantly raped." [58]***

Female PWID also earned less and were more financially dependent on partners or parents than men. Some engage in sex work to support their own and their partners' drug habits [59], in exchange for housing, sustenance, and protection.

Gender also contributes to men's and boys' risk-taking and vulnerability – and their sexual partners' risk. Gender stereotypes can push young men to take risks and experiment with drugs, to assert and display their masculinity through injection and peer solidarity through needle sharing [60]. The current economic situation is disrupting traditional gender roles in families and relationships. As men lose their role as provider, many turn to alcohol and drug abuse, perpetrate violence against themselves and others, and engage in sex with multiple partners [61]. Gender stereotypes can also discourage men from caring about their health and using health and social services. Among PWID, more girls and women expressed concern about their health than boys and men [62].

Female partners of male PWID are at risk of HIV transmission, fueled by gender norms that do not encourage women or girls to refuse sex or negotiate safer sex.

Stigma and Discrimination: For women, the stigma of being an injecting drug user is added to gender discrimination, creating multiple barriers to health service access. Female PWID often do not want to register officially as a drug user because they suffer more stigma than male PWID, as this goes against expectations of women to be charming and as "nurturers of families". Pregnant PWID

52 Pinkham S, Malinowska-Sempruch K, Women, Harm Reduction, and HIV, New York: International Harm Reduction Development Program of the Open Society Institute, 2007.

53 Rhodes, T, Platt, L, Filatova, K, Sarang, A, Davis, M, & Renton, A (2002), Behaviour factors in HIV transmission in Eastern Europe and Central Asia. Geneva: UNAIDS. Berezhnova, I et al. 2006.

54 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

55 UNAIDS Programme Coordinating Board, Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine, Conference Room Paper. UNAIDS/PCB (20)/CRP1, 2007.

56 Shulga, L., et al., Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users, International HIV/AIDS Alliance in Ukraine, 2011.

57 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report, Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

58 All-Ukrainian Network of PLWH and UNIFEM, Gender-Sensitive HIV/AIDS Services: Analytical Report Based on the Results of Research, Kyiv, 2011.

59 Eurasian Harm Reduction Network, Young People & Injecting Drug Use, Siauliust, 5-1/21, Vilnius, Lithuania, 2009.

60 Ekström, AM et al., Gender and HIV/AIDS in Eastern Europe and Central Asia, Division of International Health (IHCAR), Department of Public Health, Karolinska Institute Stockholm, Sweden, World Health Organization, 2004.

61 UNAIDS Programme Coordinating Board, Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine, Conference Room Paper. UNAIDS/PCB (20)/CRP1, 2007.

62 All-Ukrainian Network of PLWH and UNIFEM. Gender-Sensitive HIV/AIDS Services: Analytical Report Based on the Results of Research, Kyiv, 2011.

and those who have children often do not access services due to these expectations, and out of fear that their children will be taken away [63,64].

Moreover, pregnant women with a history of drug use are significantly less likely to receive antenatal care, including timely HIV tests, PMTCT and other services. For example, the percentage of HIV-infected pregnant women who inject drugs who received MAT during pregnancy was 5.5% in 2009 and 7.3% in 2011. Opposition from male partners and social stigma can also make women less likely to visit service sites. For instance, a recent study found that pregnant HIV-positive women with a history of drug use were almost 50% less likely to receive PMTCT services [65].

Legal and Policy Framework

National HIV policies and plans prioritize PWID. PWID are recognized in the National AIDS Programme (NAP) 2009-2013 as a priority group. The NAP aims to provide harm reduction services to 60% of PWID in the country. Provision of integrated care for patients (e.g., HIV / drug dependence/ TB) is also a key focus of the NAP.

National standards and guidelines have been developed for providing HIV-related medical and social services to PWID, including antiretroviral treatment (ART) protocols for PWID. The policy environment also provides a strong foundation for medication-assisted treatment (MAT) [66]. In 2008, the MOH issued the first standards and guidelines for substitution therapy, which allowed methadone treatment to be offered at large scale [67]. In 2010 the standard of social services for people who receive substitution therapy was endorsed as a joint order of the Ministry of Family, Youth and Sports, Ministry of Labor and Social Policy, and Ministry of Health [68]. In 2012 the methodological manual was developed for trainings in post-graduate medical education courses [69].

A review of policies identified several gaps and limitations that constrain implementation and achievement of targets [70]. First, with the dissolution of the Ministry of Family, Youth and Sports, there is no central authority responsible for implementing programs for PWID. Inter-ministerial collaboration is limited (see MAT section for details). Second, bio-behavioral surveillance data on PWID are not officially recognized and thus are not used to inform planning and resource allocation. Additionally, no comprehensive strategy exists for providing harm reduction services to PWID. There are also no strategies to reach PWID with HCT and prevention services for sexual partners of PWID.

63 Pinkham S., Malinowska-Sempruch K., Women, Harm Reduction, and HIV, New York: International Harm Reduction Development Program of the Open Society Institute, 2007.

64 Nieburg P., Carty L., Injection Drug Use in Ukraine: the challenges of providing HIV prevention and care, CSIS, 2012.

65 Shulga, L., et al., Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users, ICF International HIV/AIDS Alliance in Ukraine, 2011.

66 Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine, Washington, DC: Futures Group, Health Policy Project, 2011.

67 Наказ МОЗ України № 476 від 19.08.2008 «Про затвердження стандарту лікування ВІЛ-позитивних людей, які є споживачами ін'єкційних наркотиків»; Наказ Міністарства охорони здоров'я України № 645 від 10.11.2008 "Про затвердження методичних рекомендацій «Замісна підтримувальна терапія в лікуванні із синдромом залежності від опіоїдів»" (Order of the Ministry of Health of Ukraine № 476 of 19.08.2008 "Standard of treatment for HIV-positive people who inject drugs"; Order of the Ministry of Health of Ukraine № 645 of 10.11.2008 "On methodical guidelines approval "opioid substitution therapy.")

68 Наказ Мінсім'ямолодьспорт України, Мінпраці України, МОЗ України від 13.09.2010 № 3123/275/770 "Стандарт надання соціальних послуг особам, які отримують замісну підтримувальну терапію агоністами опіоїдів "http://zakon2.rada.gov.ua/laws/show/z0907-10 (Order of the Ministry of Ukraine for Family, Youth and Sports, Ministry of Labour, Ministry of Health of Ukraine of 13.09.2010 № 312 3/275/770 "Standard of social services to people who receive substitution therapy of opioid agonists."

69 Дворяк С.В. та ін, Лікування опіоїдної залежності агоністами опіоїдів: навч.-метод. посіб. для лікарів-інтернів ті лікарів-слухачів закладів післядипломної освіти, К.: К.І.С., 2012. (Dvoryak S.V. et al., Treatment of opioid dependence by opioid agonist: methodological manual for interns and doctors attending postgraduate education institution, 2012).

70 Judice, N., O. Zaglada, and R. Mbuya-Brown., HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

Implementation of harm reduction services covered in the policy is also limited by gaps in regulations. Most importantly is the criminalization of drug users and intense social stigma of drug use force people to adopt risky injection practices and keep people away from HIV prevention, care and treatment services [71]. A core element of services for PWID is the distribution and exchange of needles and syringes. Public organizations cannot collect syringes due to out-of-date and incomplete legislation, which regulates medical wastes procedures [72]. Programs for pharmacy-based distribution and exchange of syringes are still in the pilot phase. While pharmacies can dispense syringes, they cannot collect used ones due to regulations that deem it too dangerous in a "public place" [73].

Police often interfere with the delivery of harm reduction services and stop NSP clients near, or at, syringe exchange sites. There is also evidence that this carries over to affect adherence to antiretroviral treatment (ART) among PWID [74]:

"One of the main problems is police – so it's not safe to carry ARV medications on you, it's dangerous, once they stop you and they find some pills, the police immediately assume these are drugs, arrest you and take you to the police station." – 35 year-old male

Furthermore, there is growing concern among NGOs about the new MOH Order on drug circulation, in which the threshold for possession of opiates has been lowered to the point that the amount of opiates left in a syringe after injection is sufficient to warrant a criminal offense. Some clients are afraid to exchange syringes to avoid being caught with used ones. Consequently, the number of syringes returned for exchange was reduced by half between 2010 and 2011, eroding gains in harm reduction.

Related to medication-assisted treatment (MAT), the policy framework contains gaps and lacks sufficient detail. Further complicating regulations for registration, a March 2012 MOH Order # 200 limits the potential for scale-up by requiring at least two documented unsuccessful previous drug treatment attempts in order to start a patient on MAT [75]. Concerns remain about MAT entering the illicit drug market and/or not being safely administered.

Regional budgets enable condom procurement, but there is no clear-cut state policy on the promotion of condoms as a method of prevention. Most condoms distributed among key populations are procured through GFATM and USAID support. The Governmentof Ukraine supported this with an exemption of condoms and syringes from customs duties and tax [76].

Core interventions for PWID (WHO, UNODC, UNAIDS):

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugsand their sexual partners
7. Targeted information, education and communication (IEC) for people who inject

To respond to the HCV epidemic, a national program for vaccination and treatment of viral hepatitis has been initiated but there is limited diagnostic testing or funding for treatment. Also, regional level data are lacking [77].

71 Curtis, M., Building Integrated Care Services for Injection Drug Users in Ukraine, WHO Regional Office for Europe, World Health Organization, 2010.

72 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

73 Ibid

74 Mimiaga, M. J. et al., We fear the police, and the police fear us: Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine, AIDS Care. November, 2010. 22(11): 1305–1313.

75 Наказ МОЗ України № 200 від 27.03.2012 «Про затвердження Порядку проведення замісної підтримувальної терапії хворих з опіоїдною залежністю» (Order of the Ministry of Health of Ukraine of 27.03.2012 № 200 "On approval of the procedure for substitution therapy in patients with opioid dependence.")

76 Ibid

77 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

Country Response to HIV among PWID

Ukraine is implementing all three central elements of a comprehensive HIV prevention package for PWID, as recommended in the PEPFAR updated policy and technical guidance on the development of HIV prevention-focused programs for PWID [78,79]: (1) community-based outreach programs; (2) sterile needle and syringe programs (NSPs); and (3) drug dependence treatment, including medication-assisted treatment (MAT).

Access to HIV Prevention and Treatment Services

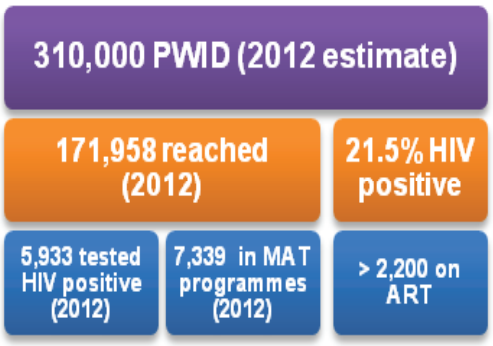

Figure 5. PWID coverage by different services

PWID are a priority for HIV interventions in Ukraine, and services are in place in most regions. The level of coverage with comprehensive HIV prevention services in 2011 was 54.1 % (157,011 people) [80], and 55.5% in 2012 (171,958) [81], which is close to the NAP target of 60% [82]. More than 5,900 PWID tested positive for HIV (during 2012), 7,339 enrolled in MAT, and more than 2,200 were on ART in 2011 [83].

In the following sections the details of the key components of HIV prevention and treatment services for PWID are presented.

(a) Community-Based Outreach

Community-based outreach programs are implemented country-wide with 171,958 PWID reached withat least one element of HIV prevention services [84].

(b) Needle and Syringe Programs (NSP)

Needle and syringe programs (NSP) are an essential part of a package of services for PWID. In Ukraine, NSP is supported as a part of the core package of services within the GFATM program [85] and the number of participating sites is growing. In the recent years, NSP has also become accessible through pharmacies – 1,667 in 2011. The average number of syringes distributed per PWID was 75.3 in 2011 [86].

Among all PWID respondents of the 2011 Alliance bio-behavioral survey [87], 47% reported receiving free needles and syringes during the last 12 months from NSP programs (45% male and 53% female

78 PEPFAR, Comprehensive HIV Prevention for People Who Use Drugs, Revised Guidance, July 2010, http://www.pepfar.gov/documents/organization/144970.pdf.

79 World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), and Joint United Nations Programme on HIV/AIDS (UNAIDS), WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (Geneva: WHO, 2009).

80 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

81 Program data of the HIV/AIDS Alliance in Ukraine, provided to RESPOND by the ICF International HIV/AIDS Alliance in Ukraine during January-April, 2013.

82 Ibid

83 Ministry of Health of Ukraine, Ukrainian AIDS Prevention and Control Center, SI Institute of Epidemiology and Infectious Diseases named after L.V. Gromashevsky, at AMS Ukraine, Central Sanitary and Epidemiological Service of the Ministry of Health of Ukraine, Kyiv City AIDS Prevention and Control Center (2012), HIV Infection in Ukraine, Information Bulletin № 37, Kyiv.

84 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010- December 2011, Kyiv. 2012.

85 Ibid

86 Ibid

87 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

PWID). More purchased equipment; 69% of PWID (72% male and 60% female PWID) reported buying needles and syringes.

PWID who were clients of NGOs received more free services during the last 12 months. Nearly all (95%) of PWID who were clients of NGOs received needles and syringes free of charge while 39% purchased needs and syringes. The average cost is 0.5 – 1.00 UAH per syringe (6 to 12 cents) depending on the size and producer.

(c) Medication-Assisted Treatment (Opioid Substitution Therapy (OST)

Information, support, and treatment provided within MAT programs are essential to reducing the impact of drug use on the epidemic in Ukraine. MAT can also reduce needle use and needle-sharing, a common route of HIV transmission.

Access to MAT has been aggressively rolled out. In 2007, only 547 persons received MAT [88] but by October 2012 MAT was provided in all 27 administrative units of Ukraine across 147 sites to 7,339 patients, of whom about 90% were taking methadone substitution therapy, according to the operational report of the Ukrainian AIDS Center [89]. Despite this increase, coverage remains very low compared to demand; less than 3% of the estimated 250,000 opioid drug users in Ukraine access MAT [90].

Continuous monitoring for MAT and analysis of best practices for scale-up was requested by the MoH order #161 [91]. To address this request, the ICF International HIV/AIDS Alliance in Ukraine supported a three-phase assessment of MAT effectiveness [92,93]. Retention of clients was high. In phase one, 83% was retained at six months and 75% at 12 months [94]. During phase two, 92% of Buprenorphine patients were retained over six months. In phase three, 76% of Methadone patients were retained after 18 months. Statistically significant changes in client status and behavior during a 6 month treatment period were observed:

- A 75% reduction in the use of opioids, cannabis and poly-drug use in the last 30 days;
- General health improved (50% increase);
- Patients reported 65% less depression, anxiety, aggression and suicide attempts;
- All HIV risk behaviors were reduced, most dramatically related to injecting risk (up to 82% reduction), less so for sexual behaviors and tattooing;
- Illegal income and criminal activity during the last 30 days declined by 70%-90%; and
- Social integration increased (the number of working days per month doubled).

According to the monitoring report, the feasibility, safety and effectiveness of MAT was equally good in all phases, with no difference between Buprenorphine and Methadone [95].

(d) HIV Counseling and Testing (HCT)

According to the Alliance study, almost two thirds (65.9%) of PWID indicated that they ever tested for HIV, more women and older PWID. Of these, 55.8% had been tested within last 12 months.

88 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

89 Ministry of Health of Ukraine, statistics on substitution therapy, available online:http://ukraids.gov.ua/index.php/uk/statystyka/profilaktyka/zamisna-pidtrimuvalna-terapiya.

90 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010-December 2011, Kyiv, 2012.

91 Наказ МОЗ України від 13.04.2005 № 161 «Про розвиток та удосконалення замісної підтримуючої терапії для профілактики ВІЛ/СНІДу серед споживачів наркотиків» http://www.moz.gov.ua/ua/portal/dn_20050413_161.html (Order of the Ministry of Health of Ukraine of 13.04.2005 № 161 "On the development and improvement of substitution therapy for HIV / AIDS prevention among people who inject drugs").

92 Uchtenhagen, A., Schaub, M., Final Monitoring and Evaluation Report on Opioid Substitution Treatment in Ukraine: outcomes from 3 phases of research. Research Institute for Public Health and Addiction associated with Zurich University a WHO Collaborating Centre, June 08, 2010.

93 Дворяк С.В., Оцінка ефективності програм замісної підтримувальної терапії бупренорфіном в Україні / Дворяк С.В., Штенгелов В.В./Всесвіт соціальної психіатрії, медичної психології та психосоматичної медицини. – 2009. – Т.1. №1 (1). (Dvoryak S.V. Evaluation of program effectiveness of substitutiontherapy by buprenorphine in Ukraine/Dvoryak S.V. Shtengelov V.V./The universe of social psychiatry, clinical psychology and psychosomatic medicine, 2009. – T.1 №1 (1).

94 Ibid

95 Ibid

In 2011, 35.7% of PWID had been tested in the last 12 months and knew the result of their test, an increase from 26% in 2009 [96].

(e) Anti-Retroviral Treatment (ART) for People Living with HIV

Access to anti-retroviral treatment (ART) in Ukraine has increased considerably in recent years. Cooperation between public health care facilities, NGOs and communities of people living with HIV have contributed to the scale-up of treatment services. However, despite the fact that PWID comprise the largest number of HIV cases, they represent only 8.3% of people on antiretroviral treatment (ART) (not including people on ART and substitution maintenance therapy). By the end of 2011, PWID made up 48% of all persons with HIV aged 15 years and older registered for regular medical observation [97]. PWID comprise 10.3% of people on the waiting list for ART; the low proportion of active drug users reflects PWID's limited access to HIV treatment and health services in general [98].

In 2011, the percentage of PWID living with HIV known to be on treatment 12 months after initiation of ART was 73.24% and on treatment after 60 months was 61.7%, significantly lower than among all people on ART [99]. The highest AIDS-related morbidity and mortality rates are observed among PWID, explained by late registration for the medical observation, co-morbid diseases, depression, negative life events, late initiation of ART and low adherence to treatment [100,101].

One of the attempts to address this problem was establishment of the Centers of the Integrated Care (CIC) for PWID [102]. AIDS Centers were assessed to be the most appropriate sites for integrated care [103, 104], but only three AIDS Centers have adopted CIC while three polyclinics, four TB clinics, and 8 psychiatric clinics have CIC [105].

(f) Condom Distribution for PWID and Their Sexual Partners

Distribution of condoms to PWID is included in the comprehensive package of services provided to PWID supported by the GFATM [106].

The 2011 integrated bio-behavioral study [107] found out that 47% of surveyed PWID received condoms during the last year through outreach, NSP points, counseling centers or other organizations. Coverage was better among PWID who were clients of NGOs; 90% of NGO clients received condoms in the last year. Among PWID who had sex during the last month, 28% indicated buying condoms. There are no programs for sexual partners of PWID.

96 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv,2012.

97 Ministry of Health of Ukraine, Ukrainian AIDS Prevention and Control Center, SI Institute of Epidemiology and Infectious Diseases named after L.V. Gromashevsky, at AMS Ukraine, Central Sanitary and Epidemiological Service of the Ministry of Health of Ukraine, Kyiv City AIDS Prevention and Control Center, HIV Infection in Ukraine. Information Bulletin № 37, Kyiv, 2012.

98 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

99 Ibid

100 Ibid

101 Mimiaga, M. J. et al., We fear the police, and the police fear us: Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine, AIDS Care, November, 2010. 22(11): 1305–1313.

102 Упровадження інтегрованих послуг для осіб із наркотичною залежністю в закладах охорони здоров'я: Практичний посібник, колектив аторів, упорядник К.В. Думчев *www.uiphp.org.ua/media/*1400 (Introduction of integrated services for people with drug dependence in health institutions. Practical manual, compiled by K.V. Dumchev).

103 Ibid

104 Кертис, М., Создание центров интегрированной помощи для потребителей инъекционных наркотиков в Украине, ВОЗ, 2010. (Curtis, M. Building Integrated Care Services for Injection Drug Users in Ukraine, World Health Organization, 2010).

105 http://www.uiphp.org.ua/ua/resursnyicenterip/modelicip

106 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv. 2012.

107 Balakiryeva, O.M. T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

Gender-Sensitive Services for Female PWID

Innovations developed and implemented in Ukraine include gender-sensitive services for female PWID [108]. ICF International HIV/AIDS Alliance in Ukraine and five NGOs implemented a package of services and evaluated their introduction in 2010 and 2011. The program supported women's access to harm reduction programs by reducing barriers to services for women and providing services in a physically and emotionally safe environment.

The resulting improvement of the service quality was reflected in increased project attendance, improved knowledge about risky injecting practices and sexual behavior, and advanced motivation to adopt safer practices among women PWID [109].

***"The group sessions helped me overcome my fear of the HIV infection, bring my drug use toa minimum and even find new friends who care about me. Life doesn't look as bleak and dreary to me as it used to!"*– Client, "Oberih'[110].**

The Alliance's research showed that there were still many unmet needs in the gender-specific services for female PWID. The gap was especially marked in the services that addressed social or psychological needs.In comparison with men, female PWID expressed a greater need in counseling; support groups, a safe, women-only space, and activities that made them feel engaged and helpful. These types of services were less common than services associated with medical needs (e.g., gynecologist's consultations).

Conclusions

In general, the results of the National AIDS Programme (NAP) assessment conducted in the end of 2012 indicate moderate progress in the national response to HIV among PWID:

- HIV prevalence has stabilized. There is ecological evidence that exposure to prevention programs for PWID has been associated with declining prevalence.
- There is improvement in the access to HCT service,
- Utilization of condoms remains unchanged,
- MAT coverage has increased three-fold but still requires scaling-up,
- Gender-sensitive services are developed and proven effective for female PWID,
- PWID are receiving ART [111]

Despite progress, HIV transmission related to drug use remains the driving force behind the epidemic in Ukraine. Among **weaknesses and gaps** in the country response to HIV among PWID, the following areas are the most urgent:

Legal and Policy Issues:

- Criminalization of drug use limits PWID participation in HIV programs [112,113].
- Challenges remain in disposal of syringes to allow NSP.
- MAT needs to expand to prisons, maternity wards, in-patient HIV and TB hospitals and hard-to-reach populations.
- There is no state funding for community-based outreach, harm reduction or MAT [114,115].

108 Shulga, L., et al., Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users, ICF International HIV/AIDS Alliance in Ukraine, 2011.

109 Ibid

110 Ibid

111 Horstman, R., Assessment of the National HIV/AIDS program implementation in 2009-2012: Presentation for stakeholders at the meeting of the National AIDS Council, 17 December 2012, Ukraine.

112 Strathdee SA., Hallett TB, Bobrova N, et al., HIV and risk environment for injecting drug users: the past, present, and future, Lancet, 2010; 376(9737): 268-284.

113 How the Criminalization of Drug Use Fuels the Global Pandemic: Report of the Global Commission on Drug Policy, June 2012.

114 Judice, N., O. Zaglada, and R. Mbuya-Brow, HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

115 Curtis, M., Building Integrated Care Services for Injection Drug Users in Ukraine, World Health Organization, 2010.

Strategic Information:

- Operational research on stigma and violence as experienced by male and female injecting drug users would inform programs and services.
- Data on TB and STI prevalence among PWID are lacking.

Prevention Services:

- Harm reduction needs to expand beyond needle and syringe distribution and exchange due to the multiple types risks during injecting. More attention should be paid to practices related to purchasing and using pre-filled syringes, and preparing and distribution of drugs from shared equipment, and back and front loading of syringes.
- There is a lack of screening, diagnosis and treatment for hepatitis C [116] and TB.
- Sexual partners of PWID urgently need to be reached with services. Evidence that there is not a large component of sexual transmission of HIV unlinked to drug use calls for increased attention to sexual partners of PWID [117], including gender transformative approaches for men as many partners do not use injecting drugs.
- Gender-sensitive programs for female PWID need to be expanded both in scope and geographic reach. Female PWID expressed need for greater access to harm reduction services as well as services that address social and psychological needs, provide safe, women-only spaces, and activities that made them feel engaged and helpful [118].
- Gender sensitive prevention content for male PWID also needs to be implemented to support greater use of HCT, MAT and ART among men, as well as risk reduction within groups of drug users, so that women are "first on the needle" andin couples.
- PWID population encompasses a broader age spectrum than before, raising challenges for HIV prevention programs [119,120].
- More attention should be paid to primary prevention of drug use and prevention of transition to injecting drug use among youth [121].

Figure 6. FSW size estimates and HIV prevalence

Treatment Services:

- Low levels of enrollment of PWID on ART [122].
- Identify and treat HIV-infected PWID at earlier stages of infection.
- Losses in referrals between NGOs and AIDS centers of PWID who tested positive with HIV rapid tests [123]. There is a need to strengthen cooperation between health care facilities and NGOs to ensure a timely and full access to health services and to support adherence to ART among PWID, as well as to ensure the further scaling up of MAT [124].

116 Ibid

117 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project. Draft Final Report, September 13, 2012.

118 Shulga, L., et al., Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users, ICF International HIV/AIDS Alliance in Ukraine, 2011.

119 Dutta, A., Andrea Wirtz, Anderson Stanciole, Robert Oelrichs, Iris Semini, Stefan Baral, Carel Pretorius, Caroline Haworth, Shannon Hader, Chris Beyrer, and Farley Cleghorn, The Global Epidemics among People Who Inject Drugs, Washington, DC: World Bank. 2013.

120 Vitek, C., HIV and IDU in Ukraine: Regional Workshop on Drug Use and HIV in Eastern Europe and Central Asia, 2011, Kyiv.

121 Balakiryeva, O.M. T.V. Bondar, Yu.V. Sereda, and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

122 Dutta, A., Andrea Wirtz, Anderson Stanciole, Robert Oelrichs, Iris Semini, Stefan Baral, Carel Pretorius, Caroline Haworth, Shannon Hader, Chris Beyrer, and Farley Cleghorn, The Global Epidemics among People Who Inject Drugs, Washington, DC: World Bank. 2013.

123 Ibid

124 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv. 2012.

2.2. Female Sex Workers (FSWs)

Female sex workers (FSWs) are a key population at risk of HIV in Ukraine. Recent HIV surveillance data suggest that an increasing proportion of infections are acquired through sexual contact, and that FSW networks play a major role in HIV transmission dynamics in Ukraine [125]. As little data are available on males who sell sex, this section focuses on FSW.

Studies show that sex workers in Ukraine are typically females aged 20-29 (56%), with a full secondary or vocational education (52%) and unemployed (45%) [126]. The substantial majority (77%) relies on commercial sex as their main source of income. In all regions of Ukraine, FSWs' income level is average to low, like women in the general population [127].

Epidemiological Situation

Size Estimates: In 2012, a national size estimate of 79,816 FSW was calculated using bio-behavioral survey data and official statistics [128]. This estimate does not include FSWs who inject drugs (PWID). The three oblasts with the highest estimated populations of FSW were Donetsk (10,700), Dnipetrovsk (9,800) and Odesa (7,100).

Previous size estimates suggested a higher range of 65,000 to 93,000 FSW [129]. However, organizations that made these estimates emphasize the 2012 number and those from prior years cannot be compared due to different methodology and software versions [130].

HIV Prevalence: As HIV infections among FSWs are not reported in Ukraine, prevalence is determined through bio-behavioral surveillance. A 2011 monitoring survey found 9% HIV prevalence among FSW [131]. Prevalence was higher with older age: 13% of FSWs over 25-years-old tested positive compared to 3% of FSWs under 25-years-old [132].

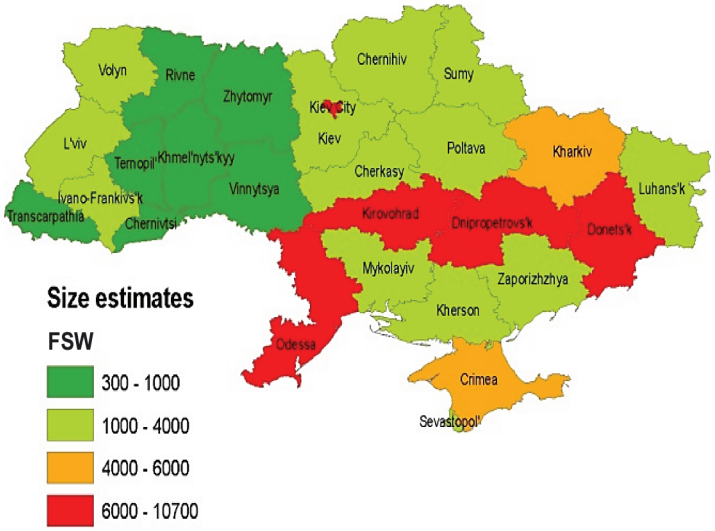

Figure 7. Size estimates for FSW population by region, 2012

125 Assessment of the Implementation of the National AIDS Programme Ukraine: Synthesis Report. UNAIDS Ukraine, Kyiv, 2012.

126 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

127 Ibid

128 ВІЛ-інфекціяв Україні. Інформаційний бюлетень, № 38, Київ, 2012. (HIV infection in Ukraine, Information Bulletin № 38, Kyiv, 2012).

129 Аналітичний звіт за результатами соціологічного дослідження «Оцінка чисельності груп високого ризику інфікування ВІЛ в Україні» станом на 2009 рік, Київ, 2010. (Analytical report on the survey results "Population estimates of the number of most at risk groups of HIV infection in Ukraine" of 2009, Kyiv, 2010).

130 Національна оцінка ситуації з ВІЛ/СНІДу в Україні станом на початок 2012 року. Український центр профілактики і боротьби зі СНІДом Міністерства охорони здоров'я України, Всесвітня організації охорони здоров'я (ВООЗ), Об'єднана програма Організації Об'єднаних Націй з ВІЛ/СНІД, Міжнародний Альянс з ВІЛ/СНІД в Україні. Київ - 2012 р. (National assessment of HIV/AIDS situation in Ukraine at the beginning 2012, Ukrainian Centre for AIDS Prevention of Ukraine MoH, WHO, UNAIDS, International HIV / AIDS Alliance in Ukraine. Kyiv – 2012) www.unaids.org.ua/files/National_Estimates_on_HIVAIDS_in%20Ukraine_2012_Ukr.doc

131 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010- December 2011, Kyiv. 2012.

132 Ibid

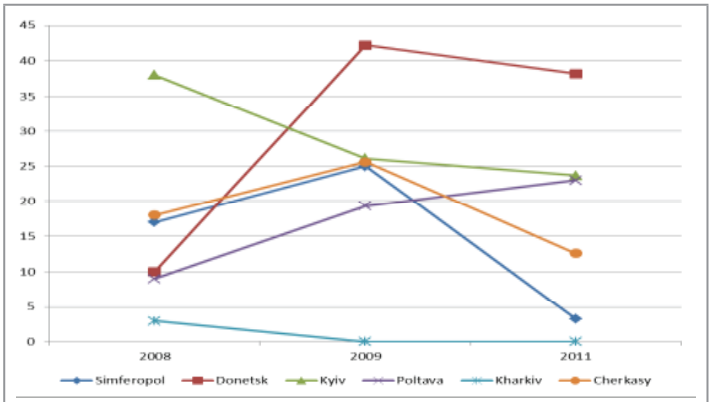

Figure 8. HIV Prevalence in FSW 2008 – 2011, by city

Prevalence also varied by city, ranging from 0% to 38%. Cities with the highest HIV prevalence were Donetsk (38.2%) Kyiv (23.7%), and Poltava (23%) [133].

Data suggest that prevention programs have led to declining HIV transmission in FSW [134]. Between 2008 to 2011 in Kyiv, for example, prevalence fell from 38% to 23.7% as program coverage accelerated [135].

STIs: According to the 2011 bio-behavioral monitoring survey conducted by the Alliance, 6% of FSWs tested positive for syphilis and 3% had Hepatitis B [136].

TB: There is no data on tuberculosis among FSWs.

Hepatitis C Virus (HCV): The 2011 monitoring survey found 12% prevalence of HCV in FSW. HCV was concentrated among FSWs who inject drugs: 48% of FSW who had used injecting drugs had HCV compared to 8% of FSWs who had never used drugs [137].

Behaviors and Needs of FSWs

Risky Sexual Behaviors

Types and Numbers of Partners: The 2011 bio-behavioral monitoring survey found that FSWs had an average of 7.6 commercial partners per week [138]. The average varied by the way FSWs found their clients, drug use and participation in NGO programs. FSWs who found commercial partners on the streets averaged 10.5 per week while those who got clients in hotels, bars and saunas had 5.7, and FSWs who found clients by telephone had 5.0. FSWs who used injecting drugs had more commercial clients per week (8.6) than those who did not use drugs (7.5). FSWs reached by NGO programs had 9.9 clients per week while those not reached had 5.0.

In the week prior to the survey, in addition to commercial partners, 33% had a regular partner and 12% had at least one casual partner. In the past year, 51% of FSW had at least one regular partner and 34% had at least one casual, non-commercial partner.

Condom Use with Commercial Clients: If used regularly, condoms are an effective barrier to HIV infection. According to the results of the 2011 bio-behavioral monitoring survey, the overwhelming majority of FSWs (92%) used a condom with their last client [139].

Condom use with clients was inconsistent, however. In the past month, 74% of FSWs reported consistent condom use during vaginal sex, 68% during anal sex and 58% for oral sex. Consistent condom use was lower among FSW who inject drugs; 65% consistently used condoms during vaginal sex, and 57% during anal sex. Among FSWs who know that they are living with HIV, 72% used a condom during vaginal sex, and 76% during anal sex [140].

133 Ibid

134 Abdul-Quader, A., Konstantin Dumchev,Yuri Kruglov, George Rutherford,TetyanaSalyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

135 Ibid

136 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

137 Ibid

138 Ibid

139 Ibid

140 Ibid

FSWs who were clients of NGOs reported higher consistent condom use: 83% of NGO clients consistently used condoms compared to 64% of non-clients of NGOs.

Compared with 2008-2009, the percentage of those who would not provide services without a condom increased from 47% to 60%. More than one-third, do, however; 37% of FSW said that they have provided sex services without a condom under certain circumstances, such as having a regular client who they know well or trust, or for extra charge. Another 2% of FSWs were willing to have unprotected sex anytime. Findings of another survey [141] conducted by the Alliance show that 66% of FSWs provided sex services without a condom. In addition to inconsistent condom use, over one-third of FSW (35%) have used condoms incorrectly.

The main reasons for unprotected sex with commercial clients were: client insisted (42.7%), client paid more (21.3%), did not think it was necessary (14.3%), did not have a condom at hand (13.7%), preferred sex without condoms (12.7%), and alcohol or drug use (9.6%) [142].

Condom Use with Non-Commercial Partners: The 2011 bio-behavioral monitoring survey found that condom use with casual, non-commercial partners was lower than with commercial partners but higher than with regular partners. In 2011, 82% of FSWs who had a casual partner in the last year used a condom at last sex, and 71% of FSWs with casual partners reported consistent condom use in the last month [143].

Condom use with regular partners was the lowest. Half (50%) of FSWs who had a regular partner used a condom at last sex. Consistent condom use with regular partners in the last month was 37.1% during vaginal sex, 36.1% during anal sex and 27.0% during oral sex.

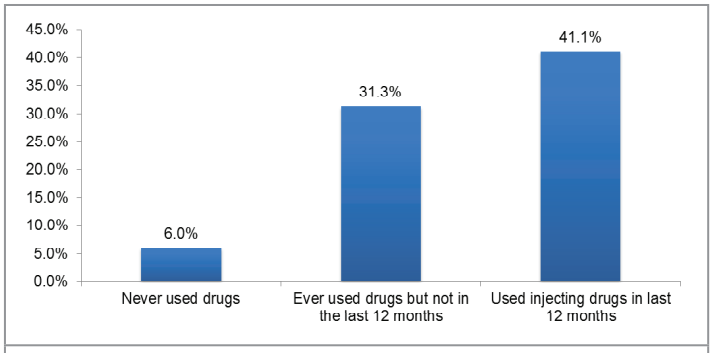

Figure 9. HIV Prevalence among FSW by drug use experience

More FSWs who were clients of NGOs reported consistent condom use with non-commercial partners. With casual partners, 80% of FSWs who were NGO clients reported consistent condom use compared to 60% of non-clients of NGOs. With regular partners, 42% of FSW who were NGO clients consistently used condoms during vaginal sex versus 32% of non-clients of NGOs [144].

The same bio-behavioral survey conducted by the Alliance showed that only 40% of FSWs living with HIV use condoms during vaginal sex with a regular partner [145].

Overlapping Risks: Injecting drug use is a significant risk factor for HIV among FSWs; drug use exacerbates the overall risk of HIV transmission in FSW networks.

Overall, 16% of FSWs had ever used drugs, and 8% had used injecting drugs in the past 12 months. Of those who used drugs, 59% used opiates and 57% used stimulants [146].

141 Аналитический отчет «Изучение причин, влияющих на проявление насилия по отношению к ЖСБ, как фактора повышенного риска инфицирования ВИЧ». – К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», 2012. (Analytical report Analysis of factors that influence on violence manifestation against female sex workers as a reason for the high risk of HIV infection, ICF International HIV/AIDS Alliance in Ukraine, 2012).

142 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

143 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance, (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

144 Ibid

145 Ibid

146 Ibid

HIV prevalence was considerably higher among this subset of the population: 41.1% of FSW who used injecting drugs in the past 12 months were living with HIV compared to 31.3% of FSWs who had ever used drugs, but not in the past year, and 6% among FSWs who had never used drugs [147]. Additionally, HIV infection was significantly associated with selling sex to PWID [148].

Knowledge of HIV: In 2011, just over half of FSWs had knowledge of HIV transmission; 56% could correctly identify ways of preventing sexual transmission and know ways that HIV is not transmitted [149]. FSW over 25 had better knowledge (59%) than those who were under 25 years of age (51%). FSW who were clients of NGO programs had better knowledge (64%) than those who had not been exposed to NGO services (46%) [150].

Mental Health: A study in 2012 found several mental health related issues among FSW. FSW demonstrated a low level of readiness to connect with other people and a high level of aggressiveness, which potentially results in non-constructive behavior in conflict situations. Self-satisfaction was significantly lower among FSW than other self-assessment indicators, although FSW try to show a strong outward appearance. The analysis concluded that these feelings can result in depression [151].

Gender-Based Violence (GBV) and Coercion: FSWs constantly face an extremely high level of violence which exacerbates HIV risk and vulnerability. Types of violence experienced in the past year emerged as follows: psychological violence (97%), sexual violence (96%), physical violence (84%), and economic violence (74%), such as not receiving payment for services or having their money or things stolen [152]. The main perpetrators of violence were their clients and law enforcement officers. With clients, 85% of FSWs experienced at least one incident of sexual violence in the past year: 70% were forced to have sex without a condom, 67% were forced to have sex in a way they did not want to, and 40% were raped [153]. Police were more likely to inflict psychological (53%) physical (38%) or economic violence (34%) than sexual violence (17%) [154]. Analysis of violence identified significant associations between the different types of violence; FSW who experienced one kind of violence were more likely to experience multiple types of violence [155]. FSW who inject drugs reported significantly higher levels of sexual and economic violence than those who do not inject [156]. The survey results showed differences in terms of violence by place of work. FSWs who find clients on the streets, highways and other public places had the highest risk of exposure to violence.

FSWs did not always regard cruel treatment as violence, further limiting preventive measures and/or reporting and care-seeking. If an act of violence had been agreed upon between a FSW and her client in advance (such as being beaten), or if she received monetary reward after such an act, FSWs often re-qualified the violence as a "special occupational condition" [157].

"Violence is the way you regard clients' behavior. If you are beaten and humiliated, but you will get paid more than agreed, in my opinion, this is not violence. But if you hadn't been reimbursed for it, yet being threatened to keep silence about "over the top, out of sight", this is the very violence itself. Everything can be settled for a certain amount [of money]..." ***– FSW***

Most FSWs (74%) had not sought support from anyone after experiencing violence [158]. Experts point at the interrelationship between violence and fear, and between violence and self- condemnation (i.e. sex workers "are guilty themselves in all things") [159].

147 Ibid
148 Ibid
149 Ibid
150 Ibid
151 Ibid
152 Artiuh, O., et al. Investigating Causes Influencing Manifestations of Violence against FSW as a Factor of Increased Risk of Exposure to HIV, Operational Survey, Brief Results, ICF International AIDS Alliance, Kyiv, 2012.
153 Ibid
154 Ibid
155 Ibid
156 Ibid
157 Ibid
158 Ibid
159 Ibid

Stigma and Discrimination: According to a stigma index study [160], being a sex worker compounds stigma associated with HIV. PLHIV who were associated with a key population such as FSW reported more stigma (77%) than those who were not (42%). Furthermore, PLHIV who are FSW had higher self-stigma than PLHIV who do not sell sex. Approximately one-third (35%) of FSWs attribute the stigma and discrimination they experience to a rejection of their lifestyle or behaviors.

Fear of being "recorded' as a FSW is a major barrier to use of health and HIV services, including reporting or seeking care for gender-based violence (GBV) [161].

Behaviors of Clients of FSWs[162]

Socio-demographic composition of interviewed FSW clients is as follows: for the most part these are middle-aged males (aged 30-44, 56%) who have higher education compared with other males. FSW clients mostly live in well-off households and their financial situation is much better compared with others living in the cities where the survey was conducted. Clients vary greatly by profession although businessmen (33%) are the most common. Almost half of the clients are officially married or live in common-law marriage (45%).

In most cases, clients seek FSW services in various ways, although most often they find such services on the street (55%), in casinos, bars, discos, etc. (43%), on highways (38%), by telephone or via the Internet (38%). Most of the respondents regularly seek FSW services – nearly half of them (45%) seek such services at least once per month, and the majority (74%) at least once per 2-3 months. It should also be noted that most of the clients (58%) had five different commercial sex partners in the past 12 months.

According to the survey, only 23% of the clients always used a condom during oral sex. The condom use rate for vaginal sex is much higher – 69%, but it still shows a large number of those who are engaged in unprotected sex. This indicator is alarming for anal sex – only 57%. Regular condom use with casual partners is 63%.

The overwhelming majority of the clients (94%) reported that they can always buy a condom when they need it. In other words, irregular condom use is not a matter of money but is rooted in other motives.

Only half of the clients (48%) were tested for HIV and received test results in the last 12 months.

Legal and Policy Framework

Ukraine's progressive policy to decriminalize sex work paved the way for an active national response. The National HIV/AIDS Programme identifies FSW as a key population at risk of HIV. However, there is a lack of anti-discrimination provisions for FSW, and administrative responsibility contributes to abuses of power on the part of law enforcement officers and thus obstacles to service delivery and use [163]. As a result, program implementation and service delivery remain complicated.

Core components of a minimum package of services for FSW (CDC):

- Peer education and outreach
- Condoms and lubricant
- STI screening and treatment
- HIV counseling and testing (HCT)
- HIV care and treatment
- Access to other health/social services as feasible (reproductive health, family planning, PMTCT, post-exposure prophylaxis (PEP), substance abuse, legal, psychosocial support)

160 Демченко, І.Л. та ін., Показник рівня стигми ЛЖВ – Індекс стигми. Аналітичний звіт за результатми дослідження. – К., 2011. (Demchenko, I.L., et al., Index of HIV stigma, Analytical report of research results, 2011).

161 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010- December 2011, Kyiv. 2012.

162 Hrushetsky, A., et al. Analytical report based on the results ofthe linked survey "Monitoring of behavior and HIV prevalence among clients of female sex workers as a component of second generation surveillance", ICF International HIV/AIDS Alliancein Ukraine, Kyiv, 2010.

163 National Report on Monitoring Progress Towards the UNGASS Declaration of Commitment on HIV/AIDS Reporting period: January 2008–December 2009.

Another gap in policies relates to the GBV response. There are strong national laws prohibiting sexual violence in Ukraine, but there is almost no attention to GBV within national HIV and AIDS policies and programs. There are no clinical management guidelinesfor services to GBV survivors [164], thus further limiting support to FSWs who frequently experience violence.

Country Response to HIV Among FSWs

UNAIDS guidance identified three pillars of the HIV response for FSWs: assure universal access to comprehensive HIV prevention, treatment, care and support; build supportive environments, strengthen partnerships and expand choices; and reduce vulnerability and address structural issues [165]. In Ukraine, these principles are followed to build the package of services for FSW.

Access to Prevention, Treatment and Support Services

Monitoring data show that coverage of FSW was estimated at 36.4% of FSW (29,043 persons in 2012), an increase from 9% in 2007 [166].

Prevention program coverage of FSWs was also studied as part of bio-behavioral monitoring [167]. In 2011, 62% of FSWs sampled had been reached by prevention services [168]. These FSWs were clients of NGOs (had a chart or an individual code).

FSWs who were not clients of NGOs were much less likely to receive any type of prevention service (22%). Coverage was also lower among younger FSWs under 25-years-of-age who were not working on the streets, not injecting drugs and HIV-negative [169].

In 2011, 54 NGOs provided prevention services for FSWs in all regions of Ukraine. Each client received a basic package of services [170] generally in line with a minimum of services as defined by the United States Centers for Disease Control (CDC).

(a) Peer Education and Outreach

NGOs supported by the Alliance provide informational materials and counseling by social workers, health workers and other specialists, as well as peers [171]. In the 2011 survey, 41% of FSWs reported having received informational booklets in the past year [172].

(b) Condoms and Lubricant

In 2011, 64% of surveyed FSWs reported receiving condoms in the past year, 99.6% of NGO clients and 25.7% of FSWs who were not clients of NGOs [173]. In addition to condom distribution, NGOs supported by the Alliance also distribute lubricant, local antiseptics, pregnancy tests, and other hygiene products. A total of 40% of FSWs sampled in the 2011 survey reported having received personal hygiene items [174].

164 Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

165 UNAIDS Guidance Note on HIV and Sex Work, 2009.

166 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project. Draft Final Report, September 13, 2012.

167 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance, (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

168 Ibid

169 Ibid

170 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

171 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance, (based on the results of the bio-behavioral survey of 2011). Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

172 Ibid

173 Ibid

174 Ibid

(c) STI Screening and Treatment

In 2011, 38% of FSWs received free STI screening [175].

(d) HIV Counseling and Testing (HCT)

The overwhelming majority of FSWs (91%) knew where to seek HIV testing and 76% reported having ever tested for HIV (94% of NGO clients and 57% of non-clients) [176]. In 2011, 58.6% of FSWs received an HIV test in the past 12 months and knew their results [177].

(e) HIV Care and Treatment

Of the FSWs who reported being HIV infected during interviews as part of the 2011 bio-behavioral survey, 74% were registered with the AIDS Center and 39% were receiving antiretroviral therapy. Another 6% had received ART in the past, but not at the time of the survey [178].

(f) Access to Other Health and Social Services

Other services recommended for FSW include reproductive health, family planning, prevention of mother-to-child-transmission of HIV (PMTCT), post-exposure prophylaxis (PEP), support for substance abuse, legal, psychosocial issues. There is no information about these services for FSWs in general.

Harm Reduction: NGOs supported by the Alliance also distribute needles and syringes and exchange needles and syringes to FSW who inject drugs.

Gender Aspects of Service Provision for FSWs: In addition to the standard package of services that proposes a specific gender-sensitive package of services targeting FSWs. This package includes [179]:

- Peer-driven intervention
- Distribution of pregnancy tests
- Training programs on the use of female condoms
- Response to violence against female sex workers
- Social and psychological counseling
- Online counseling
- Distribution of antiseptics
- TB doctor counseling
- Skills training and employment
- Day care centers for children
- Cosmetologist's and hairdresser's services
- Sewing and needlework courses

Conclusions

The National AIDS Programme Assessment conducted in 2012 concluded that the approach to working with key populations has demonstrated progress [180]. Comprehensive outreach programs and services are implemented through a network of NGOs in the majority of cities in Ukraine. As a result, there has been a substantial increase in service coverage and corresponding decline in prevalence [181]. Also, an FSW-specific package of services, in addition to a standard package, has been introduced.

175 Ibid

176 Ibid

177 Ibid

178 Ibid

179 Annual Report. ICF International HIV/AIDS Alliance in Ukraine, 2011.

180 Assessment of the Implementation of the National AIDS Programme in Ukraine: Synthesis Report, UNAIDS Ukraine, Kyiv, 2012.

181 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

Weaknesses and gaps in the country's response to the HIV epidemic among FSWs include the following:

Strategic Information:

- While annual improvements to the methodology of bio-behavioral surveys render results more reliable, it is not possible to compare survey results from previous years, so trend data are not available.
- For FSW programs it is important to enhance the system for generating strategic information and translating it into FSW program strategies. Additionally, information is required to design services for male who sell or exchange sex to other males.
- Additional information is required to clearly understand the level of TB among FSW.

Policy and Guidance:

- FSW programs lack sufficient implementation standards, guidelines, and management processes, and STI service delivery is inefficient and not evidence-based. There is a need to develop and implement evidence-based national standards and guidelines for FSW programs and provide tools and other resources to support implementation;
- Sex workers are included in the NAP without specification of being male or female. Considering the level of discrimination against the LGBT community, policy and guidance is required to develop programs and services for males who sell sex.

Services:

- Services are primarily provided by NGOs. FSWs who are not clients of NGOs are not adequately covered by services.
- Condom use is inconsistent, especially with non-commercial partners.
- The basic package of services for FSW should be extended [182], as well as services for GBV prevention and response.
- Services are focused on FSWs with multiple risks; new and young FSW need more attention to prevent HIV infection [183].
- In addition, given the extremely high HIV prevalence among FSW who use injecting drugs or have a history of drug use, more concerted efforts are needed to identify and provide services to these women, including MAT.

Stigma:

- A persisting high level of stigma of FSWs limits their access to health and social services. It also makes these women more vulnerable to violence and the effects of HIV infection.

182 Ibid

183 Grushetsky, A., Monitoring the behavior and HIV infection prevalence among commercial sex workers as a component of second generation surveillance, (based on the results of the bio-behavioral survey of 2011), Kyiv International Institute of Sociology and ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

2.3. Men Who Have Sex with Men (MSM)

Men who have sex with men (MSM) are a key population at risk of HIV infection in Ukraine. MSM is defined by behavior, regardless of whether the person identifies as homosexual, bisexual or heterosexual. Official statistics show that new infections attributed to male-to-male sex are growing [184]: between 2005 and 2011 the number of officially reported cases among MSM increased from 20 to 143 individuals. As official figures are low, Ukraine's Harmonized Report assumes that HIV infections among MSM are heavily underreported [185]. MSM may be misclassified as heterosexual men in the case reporting system [186].

Epidemiological Situation

Size Estimates: The number of MSM has been calculated in Ukraine since 2005. However, the absence of a single methodology limits comparable size estimates or the percentage of HIV cases in the MSM community [187]. In 2012, an improved methodology for calculating the numbers of "hidden" populations estimated 225,000 MSM (ranging from 200,200 to 245,350) [188], or 1.7% of the urban male population 15 to 59 years of age [189]. The total regional number is even lower at 176,000, since a number of oblasts disagreed with the estimate. The 2012 national estimate of MSM represents 1.2% of the total male population aged 15 to 29 years of age, yet UNAIDS recommends using a percentage of 2 to 5% if there are no national data [190]. Therefore, researchers believe that national and regional estimates are understated.

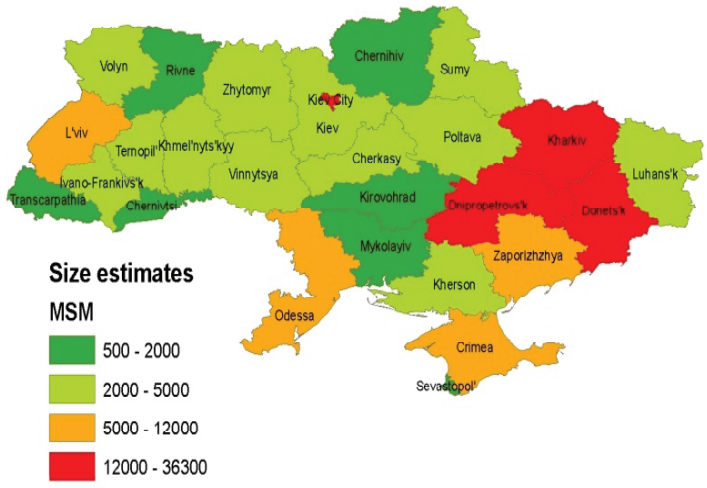

Figure 10. Size estimates for MSM population by region, 2012

184 ВІЛ-інфекція в Україні. Інформаційний бюлетень. № 38, Київ, 2012. (HIV-infection in Ukraine. Information bulletin № 38, Kyiv, 2012).

185 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv,2012.

186 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

187 Визначення потреб чоловіків, які практикують секс із чоловіками, в основних послугах з профілактики ВІЛ/СНІДу, лікування, догляду та підтримки: Аналітичний звіт за результатами дослідження, UNDP, 2011. (Identifying the needs of men who have sex with men in key services for HIV/AIDS prevention, treatment, care and support: Analytical Research Report, UNDP, 2011).

188 Abdul-Quader, A., Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project. Draft Final Report, September 13, 2012.

189 Аналітичний звіт за результатами дослідження «Оцінка чисельності груп високого ризику інфікування ВІЛ в Україні» станом на 2012 рік / Г. Берлева, К. Думчев, М. Касянчуктаін. – К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», 2012. (Analytical Research Report "Estimate of number of most at risk population of HIV – infection in Ukraine" of 2012/ G. Belyaeva, K. Dymchev, M. Kasyanchyk and others – K.: ICF International HIV/AIDS Alliance in Ukraine.

190 Національна оцінка ситуації з ВІЛ/СНІДу в Україні станом на початок 2012 року. Український центр профілактики і боротьби зі СНІДом Міністерства охорони здоров'я України, Всесвітня організація охорони здоров'я (ВООЗ), Об'єднана програма Організації Об'єднаних Націй з ВІЛ/СНІД, Міжнародний Альянс з ВІЛ/СНІД в Україні. Київ - 2012 р. www.unaids.org.ua/files/National_Estimates_on_HIVAIDS_in%20Ukraine_2012_Ukr.doc (National assessment of HIV / AIDS in Ukraine at the beginning of 2012. Ukrainian Centre for AIDS Prevention of Ukraine MoH, WHO, UN Program on HIV/AIDS, ICF International HIV/AIDS Alliance in Ukraine, Kyiv – 2012).

HIV Prevalence: National sentinel surveillance conducted in 27 regions of Ukraine in 2011 found 6.4% HIV prevalence among MSM, with variation between 0 to 20% in different oblasts: the most affected cities were Donetsk (20%) and Odesa (16%), and the least affected cities were Mykolayiv (2%), Chernihiv, Ternopil and Lutsk. HIV prevalence differed by age; among MSM over 25 years of age it was 4.2% while in MSM under 25 it was 7.8% [191].

Analysis of HIV prevalence among MSM based on the results of biennial monitoring (2007, 2009 and 2011) showed that HIV prevalence remains unchanged nationwide. However, estimates forecast that MSM is the only key population with increasing incidence; MSM are expected to comprise 22.1% of new HIV cases by 2015 [192].

STIs: STI prevalence among MSM is low [193]. A 2009 survey found that in the past 12 months 6.6% of MSM had contracted an STI and only 3% did not receive treatment.

TB: No data are available on TB among MSM.

Hepatitis C Virus (HCV): Data show that HCV among MSM is low and most received treatment [194].

Behaviors and Needs of MSM

MSM who identify as gay are the most reachable for projects on HIV prevention among MSM and surveillance studies [195]. The 2011 "Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance" analysis documented reported behaviors [196]. More than half of the sample (61%) was between 25 and 49-years-of-age while 10% was between 14 to 19-years-of-age.

Risky Sexual Behaviors

Numbers and Types of Partners: In the past six months, respondents had an average of four to five male partners with whom they had anal sexual contacts. Also in the past six months, about 80% had oral sexual contacts with two or more male partners.

Regular and Casual Partners: At last anal sex, approximately the same proportion was with a regular partner (51%) and a casual, non-commercial partner (46%).

Commercial Partners: In the past month, 5% of MSM received a payment for sex, and 3% paid another male for sex [197]. In a survey in Mykolaiv oblast in the last six months 7% of men received a payment for anal sex with another male and 2% paid for anal sex [198].

191 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

192 Assessment of the Implementation of the National AIDS Programme Ukraine: Synthesis Report, UNAIDS Ukraine, Kyiv, 2012.

193 Моніторинг поведінки та поширеності ВІЛ-інфекції серед чоловіків, які практикують секс із чоловіками, як компонент епіднагляду за ВІЛ другого покоління (аналітичний звіт за результатами зв'язаного дослідження 2009 року) / Большов Є.С., Касянчук М.Г. та ін. – К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», 2011. (Monitoring of behavior and HIV prevalence among men who have sex with men as a surveillance component of the second generation (Analytical report of coherent research results 2009)/ Bolshov Ye.S., Kasyanchyk M.G. et al. ICF International HIV / AIDS Alliance in Ukraine, 2011).

194 Ibid

195 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic, Regional Analysis Report, 2010.

196 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

197 Ibid

198 Аналитический отчет по результатам проекта «Связанное исследование среди МСМ методом RDS в г. Николаеве», Николаевская ассоциация «ЛиГА», Киев, 2011. (Analytical report on the results of the project «Associated research among MSM using RDS method in Mykolayiv», Mykolayiv Association «League», Kiev, 2011).

Heterosexual Partners: During the last six months, on average, half of the respondents engaged in heterosexual intercourse with one female partner [199]. Five percent of MSM with heterosexual experience reported having sex with FSWs during the past year. Among these, those married or living with a female partner were twice as likely to buy sex as those who were not married or living with a female partner.

Condom and lubricant Use: In 2011, with all partners, 70.5% of MSM reported condom use the last time they had anal sex with a male partner [200]. There was little difference by age; 68.9% of MSM under 25 years of age reported condom use at last anal sex compared to 71.6% of MSM 25 years and older [201].

During the last anal sex with a male partner, 77% of MSM reported using condom-compatible lubricant [202]. In the past six months, 54% of MSM reported consistent use of a lubricant during anal intercourse with a male partner. Condom use differed by type of partner, lowest with regular partners and highest with commercial partners [203]: 62% of MSM used a condom with a regular partner at last sex while 79% used a condom with a casual, non-commercial partner the last time they had sex. When buying sex the last time, 78% reported condom use compared to 86% who used a condom when selling sex.

Consistent condom use was lower. Half (49.8%) of respondents reported consistent condom use when they had anal sex with other men in the past 30 days in 2012 [204]. In 2009, this percentage was 53% [205], however, it should be noted that the 2012 survey covered all of Ukraine, including cities where the 2009 survey had not been conducted.

The main factors associated with the condom use during last anal sex with a man included living with a partner, imprisonment, and access to prevention services for MSM [206]. A case-control study nested in a cross-sectional survey among MSM in 2007 identified these factors as well as alcohol consumption. MSM who used alcohol daily, rather than monthly, were significantly less likely to use condoms with casual partners [207].

With all female partners, 47% of MSM reported consistent condom use in the last 6 months. With FSWs, 86% of MSM who paid for sex reported using a condom at last sex [208]. MSM who reported condom use during heterosexual sex increased between 2009 and 2011.

Knowledge of HIV: MSM generally have high knowledge level about HIV transmission and prevention. Most MSM interviewed (82.1%) correctly answered all five questions concerning HIV infection.

199 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

200 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv. 2012.

201 Ibid

202 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

203 Ibid

204 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

205 Моніторинг поведінки та поширеності ВІЛ-інфекції серед чоловіків, які практикують секс із чоловіками, як компонент епіднагляду за ВІЛ другого покоління (аналітичний звіт за результатами зв'язаного дослідження 2009 року) / Большов Є.С., Касянчук М.Г. та ін. – К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», 2011. (Monitoring of behavior and HIV prevalence among men who have sex with men as a surveillance component of the second generation (Analytical report of coherent research results 2009)/ Bolshov Ye.S., Kasyanchyk M.G. et al.: ICF International HIV/AIDS Alliance in Ukraine, 2011).

206 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance, Kyiv, 2012.

207 Klymenko, N., & Andreeva, T. (2012). Determinants of condom use with occasional partners among MSM in Ukraine. Tobacco Control and Public Health in Eastern Europe, 2(1), 43-54.

208 Ibid

However, many made a mistake answering at least one question [209]. The overall knowledge indicator is 64%, with higher knowledge among older respondents [210].

Gender Aspects: Traditional gender norms contribute to widespread homophobia and related silence, denial, stigma, and discrimination against MSM (Filippau and Vyshemirskaya 2011). These norms affect access to accurate information, limit the ability to negotiate consistent condom use, and impede access to treatment, care, and support for those living with HIV. Many men would rather admit to using drugs than having male-to-male sex.

Stigma and Discrimination: Surveys conducted in Ukraine reveal widespread stigma toward MSM [211, 212,213]. The percentage of people who treat gays and lesbians as ordinary people without stereotypes is only 15-17% [214]. According to the Alliance's 2009 bio-behavioral survey, the most common forms of stigma experienced by MSM were verbal abuse and being blamed by others; 38% of the respondents reported hearing abusive shouts and names [215]. The most frequent discrimination indicator was the assumption that homosexual men more commonly have HIV; nearly half had experienced this assumption and a quarter specified that they were alienated by relatives, friends and family [216]. Only 2% of MSM reported having been denied social or medical services due to their sexual orientation, and 5% experienced incidents when they lost their job or educational access [217].

However, other surveys show that the rights of MSM are most frequently violated by law enforcement agencies[218].

***"When the MSM community receives some threats or violations, they can't ask for help from the police or legal bodies. Police are often the ones that harass our community…."*– LGBT NGO[219].**

A United Nations Development Programme (UNDP) survey found that MSM living with HIV experienced stigma and discrimination by health workers, such as verbal intolerance, refusal to provide services, untimely services and charges for services that should be free [220].

209 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic. Regional Analysis Report, 2010.

210 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

211 Men having sex with men in Eastern Europe: Implications of a hidden epidemic. Regional analysis report. AIDSTAR-Two, 2010.

212 Шіффер Ш., Кацберт Т., Россманн С. Злочини на ґрунті ненависті в Україні. Групи жертв та програми допомоги у громадянському секторі, НУО Європейський діалог, 2010. (Shiffer S., Kacbert T., Rossmann S., Hate crimes in Ukraine. Victims' groups and assistance programs in civil sector, European dialogue, 2010).

213 Шаг вперед, два назад: Положение ЛГБТ в Украине в 2010-2011 гг. / А.А. Зинченков, М.Г. Касянчук и др., Киев, 2011. (One step forward, two steps back: The situation of LGBT in Ukraine of 2010-2011/ A.A. Zinchemkov, M.G. Kasyanchyk and others, Kyiv, 2011).

214 Украинские гомосексуалы и общество: взаимное проникновение. Обзор ситуации: общество, государство и политика, СМИ, правовое положение, гей-сообщество, НПО «Наш мир», 2007. (Ukrainian homosexuals and society: mutual penetration. Situation Overview: society and politics, the media, the legal position, the gay community, NGO "Our World", 2007).

215 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance, Kyiv, 2012.

216 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic. Regional Analysis Report, 2010.

217 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

218 Шаг вперед, дваназад: Положение ЛГБТ в Украинев 2010-2011 гг. / А.А. Зинченков, М.Г. Касянчук и др., Киев, 2011 (One step forward, two steps back: The situation of LGBT in Ukraine of 2010-2011/ A.A. Zinchemkov, M.G. Kasyanchyk and others, Kyiv, 2011).

219 Judice, N., O. Zaglada, and R. Mbuya-Brown., HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

220 Визначення потреб чоловіків, які практикують секс із чоловіками, в основних послугах з профілактики ВІЛ/СНІДу, лікування, догляду та підтримки: Аналітичний звіт за результатами дослідження, UNDP, 2011. (Identifying the needs of men who have sex with men in key services for HIV/AIDS prevention, treatment, care and support: Analytical Research Report, UNDP, 2011).

MSM have unique health service needs in part due to "internalization of societal stigma related to homosexuality and gender non-conformity, resulting in depression, anxiety, substance use, and other adverse outcomes" [221]. MSM may not seek HIV or STI related services and, when they do, they may not disclose sex with men, which is important knowledge for appropriate service delivery.

Legal and Policy Framework

In 1991, Ukraine was the first of the former Soviet republics to abolish criminal punishment for voluntary sexual relationships between adult men (clause 122, part 1, USSR Criminal code) [222]. More recently, MSM have been defined as a vulnerable group in the Ukraine-United States Partnership Framework and a target group in Ukraine's HIV Counseling and Testing (HCT) protocol [223]. However, critical gaps in policies result in weak legal protection for MSM. Sexual orientation is not specified within key laws and policies (e.g., the HIV/AIDS Law or the National HIV/AIDS Programme). Additionally, sex workers are assumed to be female; there is no mention of male sex workers in policy documents. These gaps make it more difficult to protect their rights in court [224]. Representation of lesbian, gay, bisexual and transgender (LGBT) in policy making is limited [225]. Furthermore, pending anti-homosexual legislation could create challenges to service delivery. Parliament is re-considering a bill to outlaw "pro-homosexual propaganda" that gives a "positive depiction" of gay people [226].

Civil society carries the bulk of the HIV response for MSM. Ukraine's LGBT community is undergoing mobilization and organizational development, with LGBT organizations active in nearly all oblasts. Approximately one-tenth of respondents in Alliance's bio-behavioral survey [227] recognized themselves as activists and leaders in the LGBT movement and MSM services, while one-fifth knew nothing about such activities. Only NGOs have special programs in place to work with MSM, whereas governmental organizations do not have experience working with MSM and do not always consider it necessary [228].

Country Response to HIV Among MSM

According to program monitoring data of HIV/AIDS Alliance in Ukraine, 20 059 MSM were covered with basic HIV services. In 2011 20.1% of MSM in Ukraine were reached by prevention services, an increase from 3% in 2007 to 13.5% in 2009 [229].

Core components of a comprehensive package of services for MSM and their partners (PEPFAR):

- Community-based outreach
- Distribution of condoms and condom-compatible lubricants
- HIV counseling and testing (HCT)
- Active linkage to health care and antiretroviral treatment (ART)
- Targeted information, education and communication (IEC)
- Sexually transmitted infection (STI) prevention, screening and treatment

221 Mayer, K. et al., Comprehensive clinical care for men who have sex with men: an integrated approach, The Lancet. 380(9839) Pages 378 - 387, 28, 2012.

222 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic, Regional Analysis Report, 2010.

223 Judice, N., O. Zaglada, and R. Mbuya-Brown., IV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

224 Ibid

225 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic, Regional Analysis Report, 2010.

226 Stern, D. Ukraine takes aim against "gay propaganda', BBC News online accessed October 13, 2012. http://www.bbc.co.uk/news/magazine.

227 Ibid

228 Ibid

229 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report, Reporting period: January 2010 - December 2011, Kyiv, 2012.

According to the Alliance's 2011 bio-behavioral survey [230], 53% of MSM were covered by HIV services, meaning that they received condoms in the past 12 months and knew where to receive an HIV test. It should be noted that many experts consider the indicator, "HIV prevention program coverage among MSM" defined as receiving condoms and being able to name an HIV test site inadequate to reflect adequate coverage [231].

A basic package of services for MSM has been developed. In 2011, 26 non-governmental organizations (NGOs) in 15 oblasts provided core components of a package of services to MSM [232]. They also provide referrals to specialists, leisure activities, services through mobile clinics and peer counseling. The ICF International HIV/AIDS Alliance also offers specialist services, mentoring, safer sex counseling and online counseling (through social networks), as well as viral hepatitis testing, immunization against hepatitis B [233].

(a) HIV Counseling and Testing

In 2011, 37.8% of MSM had received an HIV test in the past 12 months and knew their results. Testing was low among all ages; 36.2% of MSM under 25 years compared to 38.9% of MSM 25 and older had tested in the past 12 months [234].

Among those tested, the number of MSM NGO service clients was almost twice as high as those who were not NGO clients (61.2% compared to 29.9%). Ukraine has recently introduced rapid testing for key populations, which explains the considerably greater level of testing among clients of NGOs [235]. In 2011, 7,660 MSM received a rapid HIV test [236]. The overwhelming majority of MSM (90%) reported knowing where to get testing, and 92% believed that testing was accessible. Those who believed that HIV testing was inaccessible did not know where to seek testing and feared disclosure of their status.

Conclusions

Overall, according to statistics and surveys, HIV infections among MSM are increasing. The national program assessment [237] conducted in 2012 found that although service coverage among MSM shows a marked growth, it remains insufficient to have a meaningful impact on the epidemic. HIV incidence among MSM is expected to increase and by 2015 comprise one-fifth of all new HIV cases. Yet, appropriate programming and services remain limited.

Weaknesses and gaps in the country's response to the HIV epidemic in the MSM community that need to be addressed are as follows:

There is *insufficient strategic information* to guide service delivery for MSM. A lack of a single methodology causes a lack of integrated regular data on MSM numbers and the percentage of HIV positive MSM among them. The approach to calculating the indicator "HIV prevention program coverage among MSM" needs to be improved.

230 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

231 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

232 Аналітичний звіт за результатами дослідження «Оцінка чисельності груп високого ризику інфікування ВІЛ в Україні» станом на 2012 рік / Г. Берлева, К. Думчев, М. Касянчук та ін. – К.: МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», 2012. Analytical Research Report "Estimate of number of most at risk populations of HIV infection in Ukraine" of 2012. G. Belyaeva, K. Dymchev, M. Kasyanchyk et al., ICF International HIV/AIDS Alliance in Ukraine.

233 МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», Зічний звіт, 2011 рік. (ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011).

234 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

235 Ibid

236 МБФ «Міжнародного Альянсу з ВІЛ/СНІД в Україні, річний звіт, 2011. (ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011).

237 Horstman, R., Assessment of the National HIV/AIDS program implementation in 2009-2012: Presentation for Stakeholders at the meeting of the National AIDS Council, 17 December 2012, Ukraine.

The ***basic package of prevention services*** for MSM needs to be extended in reach and depth [238] to reduce sexual risk. The youngest MSM and older MSM over 35 years of age need more services. Geographic expansion is also required in small towns [239] and more regions of the country, the western region in particular. Services are mainly provided to those MSM who are regular clients of NGOs, and need to be extended through local networks (i.e., apartment parties, cruising areas, Internet dating contacts, etc.) [240].

Services for *MSM **living with HIV*** need to be developed and implemented.

Widespread ***stigma and discrimination*** toward MSM limits access to services and quality of service delivery. Health providers need targeted training and supportive supervision to provide friendly services. Community-based drop-in services and case management to link communities to health services arealso recommended [241].

238 Ibid

239 AIDSTAR-TWO, Men having sex with men in Eastern Europe: Implications of a hidden HIV epidemic. Regional Analysis Report, 2010.

240 Ibid

241 Ibid

2.4. Prisoners

Epidemiological Situation

Size Estimates: As of January 1, 2013, 147,112 inmates and detainees were in 182 penal institutions [242] of Ukraine under the State Penitentiary Service of Ukraine. Of this number, 30,854 were kept in investigation and pre-trial detention facilities, 114,992 in penal and correctional institutions, and 1,264 in juvenile correctional facilities [243]. In 2011 94.3% of prisoners were men and 5.7% were women.

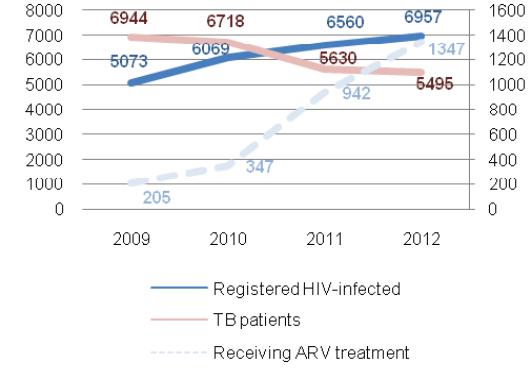

Figure 12. Numbers of prisoners with HIV, TB and receiving ART

HIV Prevalence:

HIV prevalence among the prison population varies between 10% and 30% or higher, depending on the source [244,245,246].

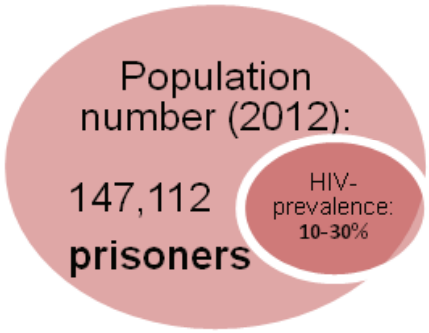

Figure 13. Numbers of prisoners and HIV prevalence

The integrated bio-behavioral survey in 2009 found 15% HIV prevalence: 12% in male prisoners and 32% in female prisoners [247]. HIV prevalence was higher among repeat offenders (18%) than among first-time offenders (14%). No cases were identified in adolescents in juvenile correctional facilities [248]. A 2012 study conducted among prisoners soon to be released revealed 19.4% HIV prevalence: 17.3% among men and 28.4% among women [249]. This study showed differences by region and sex: in Central and Western regions, the proportion of women who tested positive for HIV was three or more times higher than men, while in the Central and Southern regions, more men tested positive than women [250].

242 Hereinafter all penitentiary institutions will be referred to as prisons for convenience. All inmates and detainees will be referred to as prisoners.

243 Загальна характеристика Державної кримінально-виконавчої служби України as of 10-Jan-2013. http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/628075 (Overview of the State Penitentiary Service of Ukraine as of 10-Jan-2013).

244 O.M. Balakireva, et al., Analysis of HIV/AIDS Response in Penitentiary System of Ukraine: Summary Report On The Comprehensive Study. Ukrainian Institute for Social Research after Olexander Yaremenko, and United Nations Office on Drugs and Crime in Ukraine (UNODC), Kyiv, 2012.

245 Assessment of the Implementation of the National AIDS Programme Ukraine: Synthesis Report, UNAIDS Ukraine, Kyiv, 2012.

246 Raykhert I, et al., HIV seroprevalence among new TB patients in the civilian and prisoner populations of Donetsk Oblast, Ukraine. Scand J Infect Dis. 2008;40(8):655-62.

247 Demchenko, I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

248 Abdul-Quader, A. Konstantin Dumchev, Yuri Kruglov, George Rutherford, TetyanaSalyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

249 Altice, FL., Dvoryak S. PUHLSE Survey Results: presentation of the survey results, Kyiv, August 2012.

250 Ibid

Three times more prisoners with a history of injecting drug use had HIV (23%) than those without injecting drug use experience (7%) [251].

The number of prisoners living with HIV in Ukraine is estimated at 10,000 [252]-20,000 [253]. The State Penitentiary Service of Ukraine (SPSU) is aware of about only one-third of HIV infected prisoners [254]. In 2012, 6,957 prisoners were under medical observation and 1,347 were receiving ART [255].

STIs: Among prisoners sampled in the 2009 bio-behavioral survey, 39% reported ever having been diagnosed with a sexually transmitted infection (STI), including 53% of female and 36% of male prisoners. Diagnosis increased with age; 45% of people over 25 reported being diagnosed with an STI compared to 26% of those 16 to 24 years of age[256]. A 2012 study found 10% prevalence of syphilis [257].

TB: In 2012 there were 5,495 registered TB patients [258].

Hepatitis C Virus (HCV): A 2012 study of prisoners in four regions found 60.2% prevalence of Hepatitis C Virus (HCV). There were high levels of co-morbidity with HIV; among those living with HIV, 92.3% also had HCV [259]. The State Penitentiary System reported 113.7 cases of viral Hepatitis per 1,000 prisoners in 2011 [260].

Behaviors and Needs of Prisoners

Prisoners perceive their health to be average or less than average. Surveys conducted in 2004 and 2007 show that approximately 45% of male prisoners evaluated their health as normal for their age, and only 26 to 31% of female prisoners considered their health normal.

Risky Injecting Behaviors

The HIV epidemic in prisons is driven by injecting drug use. In 2007, 40% of male prisoners and 49% of female prisoners overall had ever injected drugs, in some prisons up to 60%. Monitoring data suggest that in some women's prisons up to 70-75% inject drugs [261]. Most prisoners diagnosed with HIV reported ever using drugs (81%) and injecting drugs (74%)[262]. In 2009, 48.7% of prisoners reported ever injecting drugs and 9% injected within last 12 months [263].

251 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

252 Policy guidance for key populations most at risk: HIV in prisons http://www.euro.who.int/en/what-we-do/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-key-populations-most-at-risk2/hiv-in-prisons.

253 Assessment of the Implementation of the National AIDS Programme in Ukraine: Synthesis Report UNAIDS Ukraine, December 2012.

254 Ibid

255 Ibid

256 Demchenko, I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

257 Altice, F. L., Dvoryak, S., PUHLSE Survey Results: presentation of the survey results, Kyiv, August 2012.

258 Інформація щодо організації охорони здоров'я та медико-санітарного забезпечення (станом на 01.01.2013). http://www.kvs.gov.ua/peniten/control/main/uk/publish/article/662625 (State Penitentiary Service of Ukraine, Information on the provision of health care services as of 01.01.2013).

259 Altice, F. L., Dvoryak, S., PUHLSE Survey Results: presentation of the survey results, Kyiv, August 2012.

260 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

261 Assessment of the Implementation of the National AIDS Programme in Ukraine: Synthesis Report UNAIDS Ukraine, December 2012.

262 Demchenko, I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

263 Ibid

Injecting practices were risky among those who continued to use injecting drugs in prisons. Although drug use is prohibited, 17% (20% of men and 3.5% of women) used drugs while imprisoned [264]. In 2007, 46% of prisoners who continued to use injecting drugs in prisons shared syringes and needles, and another 14% did not recall if they had shared equipment or refused to respond. In 2009, sharing equipment reached 55% [265].

As drug use in prisons is prohibited, it is impossible to legally own and store needles and syringes. Consequently, some prisoners manufacture their own injecting tools using pens, plastic tubes, etc. Such methods often damage veins, form scars, and cause other complications. Although the vast majority of the respondents denied using self-made injection tools (86% in 2004, 91% in 2007), limited needle and syringe programmes (NSPs) still put prisoners at risk for HIV and other infections.

Tattooing

Another HIV-related risk behavior is tattooing using non-sterile instruments. The 2009 monitoring survey found that 12% of respondents in prisons indicated that they had received a tattoo in the past 12 months, 14% of men and 1% of women [266]. In 2007, 63% of prisoners who received tattoos testified that the instruments used for tattooing were sterile, 18% identified that the instruments used were not sterile, and the rest did not remember or did not answer. Among those who shared instruments for tattooing with other prisoners, 9% were HIV-positive, 15% had been tested for HIV but did not know their results, and 7% did not disclose their HIV status [267].

Risky Sexual Behaviors

Another risk in prison is unprotected sex between prisoners and persons who visit them [268]. Subject to the internal regulations in prisons, the majority of prisoners are permitted to have conjugal long visits, during which they can have sexual relations with their wife or husband.

In 2009, 11% of prisoners reported having had sex with their spouse during the last six months: 12% of males and 5% of females [269]. Only 4% of prisoners reported having sex with other inmates [270].

Consistent condom use was very low [271]; 15% of prisoners who had sex with their spouse during the last six months always used condoms. Another 15% used condoms occasionally, and the remaining 70% never used condoms during sex with spouse, or did not answer. Among prisoners who reported having sex with other inmates, 39% used a condom at the last sex.

Knowledge of HIV: Prisoners sampled in the 2009 monitoring survey [272] demonstrated moderate knowledge of HIV transmission; 41% could correctly identify modes of preventing sexual transmission of HIV and know how it is not transmitted, a national indicator. Prisoners who had been exposed to NGO services had higher knowledge at 57%. Nearly all (90%) knew the risks of sharing non-sterile injecting equipment to inject drugs and tattoo (90%) and more than half were aware of the risks of sharing equipment for making drugs (73%). Knowledge of STIs was lower; only 15% of the sample could answer questions about symptoms of STIs [273].

264 Balakiryeva, O.M., T.V. Bondar, Yu.V. Sereda and Ya.O. Sazonova, Analytical Report. Behaviour monitoring and HIV prevalence among injecting drug users as a component of second generation surveillance (based on the results of the bio-behavioral survey of 2011), ICF International HIV/AIDS Alliance in Ukraine, Kyiv, 2012.

265 Ibid

266 Ibid

267 Ibid

268 Kalashnik N., Demchenko I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance," Kyiv, 2007.

269 Demchenko I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

270 Ibid

271 Ibid

272 Ibid

273 Ibid

Mental Health: A 2012 survey of prisoners within six months of release revealed mental health concerns: 27.9% had suicidal tendencies and 33.2% were depressed [274]. A study of people living with HIV recently released from prisons found that 56.7% were experiencing moderate to severe depression [275].

Gender Aspects: Regional studies have found that incarceration greatly increases the numbers of heterosexual men who engage in sex with other men, however there is a lack of data in Ukraine due to shame and stigma around male-to-male sex [276].

Violence and Coercion: Sexual violence can be a hidden practice among prisoners. Of all respondents of a 2007 survey only 7% reported fear of being sexually abused, but among those who had sexual relations with other prisoners, sexual violence was considered a problem by 25% (27% males and 12% females) [277].

Stigma and Discrimination: A survey among 243 prison staff and community narcologists found negative attitudes towards prisoners who use drugs. Half (53.1%) of prison staff and 25% of community narcologists believed that drug users should blame themselves and 68.2% of prison staff and 75% of community narcologists disagreed with parole for drug users [278].

Legal and Policy Framework

The State Penitentiary Service of Ukraine oversees prisons. Recent policies have supported coordination with health and social sectors, such as the HIV Counseling and Testing (HCT) Protocol which includes procedures for providing HCT to prisoners, among other populations. A 2009 Cabinet of Ministers of Ukraine resolution approved an implementation plan for assisting with re-integration of prisoners, and a joint order in 2010 coordinates efforts between sectors for TB case management of individuals released from prisons [279].

The assessment of the National AIDS Programme carried out in 2012 identified progress in offering prevention, treatment and care, and training in the penitentiary system. Additionally, attempts to develop a continuum of care approach through the collaboration of the MoH and Ministry of Justice (MoJ) were recognized. However, these efforts have not yet achieved an adequate public health response to the HIV epidemic in prisons [280]. Additionally, gaps include the lack of collaboration across ministries to allow prisoners to continue MAT while in prison or start MAT [281], and limited scope for needle and syringe programs. Additionally, storage of instruments for tattooing is prohibited by the "internal order" of penitentiary institutions, which forces prisoners to resort to unhygienic methods.

274 Altice, F. L., Dvoryak, S., PUHLSE Survey Results: presentation of the survey results, Kyiv, August 2012.

275 Altice, F. L., Dvoryak, S, Prison Post-Release Survey of HIV+ Persons in Ukraine: Odessa and Kyiv, PowerPoint Presentation, 2012.

276 Bolshov, Ye.S., et al., Analytical Report: Behavior monitoring and HIV-prevalence among MSM as a component of second generation surveillance (based on the results of the bio-behavioral survey 2011), ICF International AIDS Alliance in Ukraine, Kyiv, 2012.

277 Kalashnik N., Demchenko I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance", Kyiv, 2007.

278 Altice FL., and Sergey Dvoryak, Attitudes and Beliefs About Drug Use, HIV/AIDS and Substitution Therapy Among Prison Staff. Powerpoint presentation, 2012.

279 Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

280 Assessment of the Implementation of the National AIDS Programme in Ukraine: Synthesis Report (Draft), December 2012.

281 Ibid

Country Response to HIV Among Prisoners

Access to HIV Prevention and Treatment Services

The World Health Organization (WHO) and the United Nation's AIDS Programme (UNAIDS) defines core services for prisoners as: peer education programs, HCT, prevention of sexual transmission (provision of condoms, prevention, detection and reduction of sexual violence, PEP for survivors of sexual violence), NSPs and decontamination services, OST, andtreatment, care and support for PLHIV.

Core interventions for prisoners (UNODC, ILO, UNDP):

1. Information, education and communication
2. HIV testing and counselling
3. Treatment, care and support
4. Prevention, diagnosis and treatment of tuberculosis
5. Prevention of mother-to-child transmission of HIV
6. Condom programmes
7. Prevention and treatment of sexually transmitted infections
8. Prevention of sexual violence
9. Drug dependence treatment
10. Needle and syringe programmes
11. Vaccination, diagnosis and treatment of viral hepatitis
12. Post-exposure prophylaxis
13. Prevention of transmission through medical or dental services
14. Prevention of transmission through tattooing, piercing and other forms of skin penetration
15. Protecting staff from occupational hazards

In 2011, services were provided to 25,497 prisoners (18% of allprisoners) [282], on-site in 54 institutions in 15 oblasts by 19 NGOs supported by ICF International HIV/AIDS Alliance in Ukraine through the GFATM's "Delivery of HIV Prevention Services to Those Convicted and Detained" [283]. Services included:

(a) Information and Education, Including Peer Education

In 2009 HIV prevention materials reached 70% of adult prisoners and 87% of juvenile prisoners, increasing from 66% in 2007 [284]. The common sources of information were medical workers (51% in 2007 and 54% in 2009) and CBO social workers (18% in 2007 and 34% in 2009).

ICF International HIV/AIDS Alliance's activities implemented by NGOs in 54 institutions in 15 oblasts [285] include awareness-raising trainings for prisoners on prevention of HIV and STIs, Hepatitis, and TB as well as condom use negotiation and communication skills. NGOs also educate staff, and support events such as commemorations of World AIDS Day [286].

Education programs implemented in prisons show positive results [287]. In 2009, in prisons where programs are run by NGOs supported within the GFATM grant, awareness about HIV and AIDS was considerably higher than where prevention programs were only provided by prison staff (74% versus 55%). The most frequent method of informing prisoners was passive (67% of prisoners with exposure to NGOs services and 57% in prisons with no activities run by NGOs), which includes distribution of leaflets, radio programs, posters, etc. Active education (lectures, trainings, individual consultations) reached 50% of prisoners in prisons with CBOs support compared to 32% in prisons without NGO services.

282 ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011.

283 Ibid

284 Kalashnik N., Demchenko, I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance", Kyiv, 2007, and Demchenko, I., Maryna Kostyuchok and Natalya Byelonosova. Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

285 ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011.

286 Ibid

287 Аналітичний звіт за результатами операційного дослідження «Оцінка ефективності програм профілактики ВІЛ в пенітенціарних установах, МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», Київ 2009 (Analytical report of operational research "Evaluation of the effectiveness of HIV prevention programs in prisons", International HIV/AIDS Alliance in Ukraine, Kyiv 2009).

Peer education is one of the most effective methods of HIV prevention in prisons as the level of trust of peers is higher. Peer education also has a positive impact on re-socialization of the peer educators themselves. This is still limited, but is part of the ICF International HIV/AIDS Alliance's activities implemented by NGOs on-site in 54 institutions in 15 oblasts [288]. These trained peer educators volunteer to support risk reduction and referrals to HIV and STI testingamong peers.

(b) HIV Counseling and Testing (HCT)

Less than half (44%) of prisoners have tested for HIV and one-quarter (25%) tested for HIV in the past 12 months and knew their result [289]. In 2007, 33% were tested within last 12 months, of these, 37% knew their result [290]. In 2009, 16% tested, and 12% knew their result [291]. HCT is mostly available through rapid tests, however confirmatory tests and the official registration of HIV status is complicated. Blood samples must be collected from prisoners and sent to regional AIDS centers, the access to diagnosis for prisoners depends primarily on the availability of test systems in AIDS centers or on availability of donor funds for this [292,293].

(c) Prevention of Sexual Transmission

In 2007 only 11% of prisoners (3% females and 13% males) received condoms during last 12 months; 87% (84% males and 96% females) had never received condoms in prison [294]. Almost half of prisoners (47%) said that condoms were not available for sale in prisons, but even where condoms were available, only 2% of respondents reported buying them regularly and another 3% reported buying condoms occasionally. The highest access was reported in those prisons where NGO and prison staff combineddistribution methods, both active and passive (for example, placing in visiting rooms, bathrooms or medical units) [295].

In 2009, in addition to the condom distribution supported by the HIV/AIDS Alliance, the State Penitentiary Service also procured and distributed 600,000 condoms with support from a World Bank loan. As a result, condom access within last 12 months doubled (22% overall, 25% among males and 15% among females), and 56% confirmed that they knew where to obtain condoms in case of need [296]. Condom distribution did not always reach people at risk: 78% of prisoners who received condoms in 2009 had no sex within last 6 months [297].

In 2009 STI diagnostics services were used by 39% of prisoners, including 53% females and 36% males. Among those who sought STI diagnostic services, 37% received treatment [298].

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288 ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011.

289 Demchenko I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

290 Kalashnik N., Demchenko I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance", Kyiv, 2007.

291 Demchenko I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

292 Kalashnik N., Demchenko, I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance", Kyiv, 2007.

293 Аналітичний звіт за результатами операційного дослідження «Оцінка ефективності програм профілактики ВІЛ в пенітенціарних установах, МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», Київ 2009 (Analytical report of operational research «Evaluation of the effectiveness of HIV prevention programs in prisons", ICF International HIV / AIDS Alliance in Ukraine, Kyiv 2009).

294 Kalashnik N., Demchenko, I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance", Kyiv, 2007.

295 Аналітичний звіт за результатами операційного дослідження «Оцінка ефективності програм профілактики ВІЛ в пенітенціарних установах, МБФ «Міжнародний Альянс з ВІЛ/СНІД в Україні», Київ 2009 (Analytical report of operational research «Evaluation of the effectiveness of HIV prevention programs in prisons", ICF InternationalHIV / AIDSAllianceinUkraine, Kyiv 2009).

296 Demchenko I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

297 Ibid

298 Ibid

(d) Needle and Syringe Program (NSP), Supplies of Decontamination Materials

Drug use and storage of syringes and instruments for tattooing is prohibited by the "internal order" of penitentiary institutions [299]. This considerably limits the possibility of needle and exchange programs in prisons. Moreover, 68.2% of prison staff absolutely does not tolerate drug use [300].

The situation with decontamination solutions is improving. In 2007, 85% of survey respondents (84% malesand 90% females) had never received decontamination solutions for disinfection of blades and syringes [301], but in 2009 30% had received solutions. [302].

(e) Opioid Substitution Therapy

Despite concerted advocacy for implementation of OST and other MAT of drug dependence in prisons, these services are not yet available. In a 2012 survey, prison staff believed that the largest barriers to implementing MAT in prisons are insufficient funding (58%) and licensure restrictions (45%) [303]. Prison staff also cited corruption, insufficient training, security, and lack of leadership as barriers to MAT. The 2012 National AIDS Program assessment recommended raising awareness for evidence-based treatment of PWID, especially MAT and other harm reduction measures [304].

(f) Treatment, Care and Support for PLHIV

As of 2012, 1,347 PLHIV were receiving ART in penitentiary institutions, funded through the All-Ukrainian Network of PLWH within the Global Fund program [305]. NGOs supported by the ICF International HIV/AIDS Alliance to provide case management services for people who test positive for HIV, positive prevention, and refer people to the All-Ukrainian Network of PLWH [306].

Conclusions

Prisoners (detainees and convicts) are a key population at risk of HIV infection in Ukraine. HIV prevalence in prisons has reached 15% or higher. Despite recent progress in offering prevention commodities, information and education and ART, services remain at a level far below an adequate public health response to the HIV epidemic.

The primary **weakness and gap** of the country response to HIV among prisonersis inadequate coverage with core services, with the following areas most urgent:

Services are still limitedfor prisoners. HIV prevention and treatment strategies in prisons require improvements in scope and quality.

- Provision of condoms, lubricants and other supplies for prevention of sexual transmission is inadequate to meet the demand, and do not always reach those who at risk, such as MSM.
- In addition to more supplies, peer involvement in prevention service delivery would facilitate deeper reach of key populations within prisons.

299 Наказ №275 від 25.12.2003 про Правила внутрішнього розпорядку Державної пенітенціарної служби України (Internal Regulations of the State Penitentiary Service of Ukraine, Order N 275 of 25.12.2003).

300 Altice, F. L., Dvoryak, S., Attitudes and Beliefs About Drug Use, HIV/AIDS and Substitution Therapy Among Prison Staff: presentation of study results, Kyiv, 2012.

301 Kalashnik N., Demchenko I., et al., Analytical Report "Monitoring of Awareness and Behavior among Prisoners as part of Second Generation HIV Surveillance," Kyiv, 2007.

302 Demchenko I., Maryna Kostyuchok and Natalya Byelonosova, Analytical Report on Results of the Linked Research: Monitoring of Awareness, Behavior and HIV Prevalence among Prisoners as part of Second Generation HIV Surveillance, Kyiv, 2010.

303 Altice, F. L., Dvoryak, S., Attitudes and Beliefs About Drug Use, HIV/AIDS and Substitution Therapy Among Prison Staff: presentation of study results, Kyiv, 2012.

304 Horstman, R., Assessment of the National HIV/AIDS program implementation in 2009-2012: Presentation for Stakeholders at the meeting of the National AIDS Council, 17 December 2012, Ukraine.

305 Ministry of Health of Ukraine (MoH), Ukrainian AIDS Prevention and Control Center, SI "Institute of Epidemiology and Infectious Diseases named after L.V. Gromashevsky", at AMS Ukraine, Central Sanitary and Epidemiological Station of the MOH of Ukraine, Kyiv City AIDS Prevention and Control Center (2012), HIV Infection in Ukraine. Information Bulletin № 37. Kyiv.

306 ICF International HIV/AIDS Alliance in Ukraine, Annual Report, 2011.

- Harm reduction services are even more limited due to internal regulations.
- Information, screening and treatment for STIs, HCV and TB are needed.
- HCT and ART also need to expand. Dependence from AIDS centers limits access to HCT and confirmatory results. Only one-third of prisoners living with HIV are known to the penitentiary system. Although there has been a small but steady increase in the number of prisoners receiving ART, mainly due to NGO involvement, far more remain untreated [307]. The scope and quality of services vary, with remote prisons worse off.
- The national planning and budgeting rules mandate the use of national statistics for planning purposes and do not allow the use of datasets including surveys (e.g. IBSS survey), size estimation studies, or operational research. Thus, quantities of ART ordered for prisons may beinsufficient to meet need,for example.

The lack of coordination between ministries and systems puts people at risk of discontinuation of services, especially MAT and ART, when entering or leaving the penitentiary system. There are serious gaps between the prison system and the health sector. This affects quality and volume of services offered to prisoners and imposes limitations on the national response to HIV.

Services are ***largely provided by NGOs***. Greater involvement and coordination by ministries and between ministries is needed to develop sustainable services and systems.

307 Assessment of the Implementation of the National AIDS Programme in Ukraine: Synthesis Report (Draft), December 2012.

2.5. Most-at-Risk Adolescents (MARA)

Most-at-risk adolescents (MARA) are recognized as a key population at risk of HIV in Ukraine. MARA is defined by the World Health Organization, and citied in a 2011 UNICEF document as [308]: children and young people, both girls and boys, within the age group defined by the World Health Organization as adolescent (10–19 years old), who are most at risk of HIV infection as a result behaviours, namely:

- injecting drug users who use non-sterile injecting equipment;
- males and females who practice unprotected sex because of sexual exploitation, including those victims of human trafficking who have unprotected (oftenforced) sex for profit;
- males who have unprotected anal sex with males, including sex for profit;
- vulnerable adolescents who are "one step away" from engaging in risk.

The National HIV/AIDS Programme 2009-2013 defines children at-risk for HIV infection as:

- those who inject drugs
- orphans
- homeless children
- children detailed or incarcerated
- children from families in crisis
- sex workers
- MSM
- migrants, and other similar groups [309].

According to the WHO definition, these children and adolescents include both most-at-risk and vulnerable.

Epidemiological Situation

Size Estimates: The comprehensive study on size estimates conducted in 2008-2009 provides national size estimates of MARA at the level of 85,000 that is based on the results of population estimates among sub-groups of MARA as detailed below [310]. There are no subnational data.

- *Adolescents who inject drugs*: The number of adolescents who inject drugs in Ukraine is estimated at 50,000 (35,000 boys and 15,000 girls). Those between the ages of 14-19 years reflect 11.6% of the total estimated number of PWID. Up to one-third of adolescents who inject drugs are believed to be girls.
- Among young people in school between the ages of 15-17, a school-based survey found that 14,121 have ever used injecting drugs and 12,866 have used injecting drugs three or more times, representing 0.5% of the population of adolescents in school.
- *Adolescent Female Sex Workers*: The total number of female adolescents between 14 to 19 years of age who sell sex is estimated to be 10,990 (range of 10,400 to 14,880). Those between the ages of 14 to 19 reflect 16% of the total number of FSW.

308 Balakireva, O. et al., Population Size Estimates of Most-at-Risk Children and Youth in the 10-19 Age Group. Assessment of the number of most-at-risk children and young people in the age group of10–19 years / UNICEF, UISR after O.Yaremenko, Kiyv, 2011.

309 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

310 Balakireva, O. et al., Population Size Estimates of Most-at-Risk Children and Youth in the 10-19 Age Group. Assessment of the number of most-at-risk children and young people in the age group of10–19 years / UNICEF, UISR after O. Yaremenko. – Kiyv, 2011.

- *Adolescent MSM*: The total number of adolescent MSM between the ages of 10 to 19 years in Ukraine is 20,000 (range from 16,400 and 22,400). This was calculated by applying the estimate of 1.5% of the number of sexually active adolescent boys. The estimated number 14 to 19 year old MSM is 10.5% of the total MSM estimate in Ukraine.
- *Street-based youth*: An estimated 150,000 youth between 15 to 24 years of age are living and working on the streets [311].

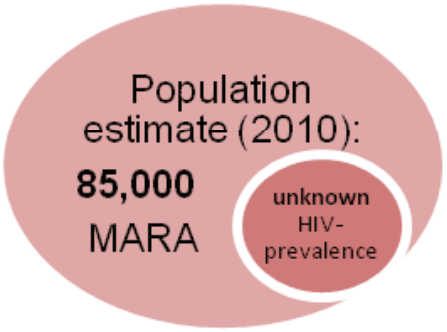

Figure 14. MARA size estimates and HIV prevalence

HIV Prevalence: HIV prevalence data are available by key populations of adolescents and street-based youth. National sentinel surveillance studies have found 39% HIV prevalence in adolescent girls 15 to 19 years of age who inject drugs and 29% in boys 15 to 19 years of age who inject drugs. Prevalence was 11% among adolescent FSWs 15 to 19 years of age and 4% of young MSM 15 to 24 years of age [312]. Official case registration shows that 65% of boys' infections are attributed to injecting drug use and 89% of girls' infections are attributed to sex [313].

Among street-based youth from 15 to 24 years of age, a Health Right International study of 929 street youth across three cities found a prevalence of 18.4%, with regional variation: 18.6% in Kyiv, 26.7% in Odessa and 9.8% in Donetsk [314]. There was no difference between male and female street youth.

Almost 44% of youth living and working on the streets were single orphans and about one-third were double orphans or so-called "social" orphans, that is, children who did not know if their parents are still alive [315]. Evidence suggests higher risk and vulnerability among those who had been orphaned and those who were homeless, with highest prevalence among those who were both orphaned and homeless.

- 7% for street youth neither orphaned/homeless,
- 16% for orphaned youth,
- 17% for homeless, and
- 28% for orphaned and homeless youth [316].

Use of injection drugs followed a similar trend with 15% of youth neither orphaned nor homeless injecting, 32% of youth who are either orphaned or homeless (but not both) injecting, and 48% of youth who are both orphaned and homeless injecting drugs.

National prevalence trend data are available only for youth from 15 to 24 years of age. Between 2007 and 2011, HIV prevalence decreased among youth from 15% to 9% [317].

STIs: In 2010, a cross-sectional survey of 805 street-based adolescents found that 18% reported ever experiencing a possible symptom of an STI: 27% of girls and 15% of boys. The proportion of

311 Cohen, J., HIV Moves In on Homeless Youth. Science 9 July 2010: Vol. 329 no. 5988 pp. 170-171.

312 Ukrainian AIDS Prevention Centre (2006/2007) reported in Olena Sakovych, UNICEF Country office Ukraine Olga Balakireva, Ukrainian Institute for Social Research. PowerPoint Presentation: "The Ukraine MARA programming experience", 2009, Geneva.

313 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

314 Robbins, CL., et al., Multicity HIV seroprevalence in street youth, Ukraine. International Journal of STD & AIDS 2010; 21: 489–496.

315 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

316 Hillis, S., et al., (2012, 2nd January) "HIV sero-prevalence among orphaned and homeless youth: no place like home", AIDS 26 (1) 105-110.

317 Ministry of Health of Ukraine, Newsletter HIV Infection in Ukraine, Kyiv 2012.

older adolescents (18 to 19-year-olds) who ever experienced a symptom was higher (30%) and the proportion of younger adolescents (10 to 14-year-olds) was lower (12%) [318].

A pilot supported by UNICEF for support to 108 adolescent FSW in the city of Simferopol found one case of syphilis, two cases of gonorrhea and three cases of chlamydia [319].

TB: There are no data on TB among MARA.

Hepatitis C Virus (HCV): A study of HCV among PWID in Vinnitsya found 65.8% prevalence among youth under 25, significantly less than 77.4% prevalence among PWID over 25 [320]. There was no MARA-specific disaggregation of the data. A pilot model for adolescent FSWs in Lviv tested 62 girls for HCV and none were positive for HCV [321].

Behaviors and Needs of MARA

In Ukraine, studies have found that adolescent key populations engage in higher risk behaviours than their older counterparts. MARA also have unique needs due to age and stage of development, as well as social and structural vulnerabilities.

Risky Injecting Behaviors

PWID often inject locally or home-produced substances, including poppy straw extract, cooked amphetamines and, as recently reported, methcathinone made from cold medications containing phenylpropanolamine, referred to as "boltushka" [322]. Among a sample of street-based adolescents in four cities, 15.5% used injecting drugs: 16.3% of boys and 13.8% of girls. Differences by city were seen; 23% of the sample used injecting drugs in Kyiv, 16% in Mykolaiv, 13% in Dnipropetrovsk, and 11% in Donetsk [323].

One-third said that they inject daily and another third said that they inject two to six times a week [324]. Experience with injecting drugs increases with age: 18 to 19-year-olds were 6.7 times more likely to have injecting drug experience than 10 to 14-year-olds.

A substantial proportion of adolescents who inject drugs practice risky injecting behaviors. Nearly three-quarters (72.7%) of those who used injecting drugs in the past month, stated they had used sterile injecting equipment the last time they injected, but studies have demonstrated that between 44.1% - 60% shared needles at least once in the previous month [325,326]. Sharing was common; 17% shared with one partner, 37% shared with two partners, 34% shared with three to five partners and 12% shared with more than five partners [327]. Additionally, 47% used a common mixing container,

318 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine, J Epidemiol Community Health, 2011; 65: 1166-1170.

319 Ensuring Access of Adolescent FSW to Comprehensive Services: Results of Intervention Models Implementation in the Cities of Lviv and Simferopol within the Project "HIV Prevention among Most-at-Risk Adolescents"/UNICEF, UISP after O. Yaremenko, Kyiv, 2012.

320 Dumchev, K.V., et al., HIV and hepatitis C virus infections among hanka injection drugusers in central Ukraine: a cross-sectional survey. Harm Reduction Journal, 2009; 6:23.

321 Ensuring Access of Adolescent FSW to Comprehensive Services: Results of Intervention Models Implementation in the Cities of Lviv and Simferopol within the Project "HIV Prevention among Most-at-Risk Adolescents"/UNICEF, UISP after O. Yaremenko, Kyiv, 2012.

322 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine. J Epidemiol Community Health, 2011; 65: 1166-1170.

323 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

324 Ibid

325 Ibid

326 Ibid

327 Ibid

22% gave or sold their syringe to others after injecting, 37% used syringes from a "working" syringe, and 17% used a filter or cotton previously used to draw up drugs [328]. Sex and age differences were insignificant. Equipment sharing is higher than among adult PWID.

Risky Sexual Behaviors

The number of sexual partners increases with age. The mean number of lifetime sexual partners for male adolescents 15 to 19 years of age who had ever had sex was 2.9. This is lower than the 6.2 mean number reported by 25 to 49-year-old men and 6.8 for men 40 to 49 years of age [329].

Reported condom use during higher-risk sex, defined as more than one sexual partner or sexual intercourse with a non-marital, non-cohabiting partner, in the past year was higher among adolescents than adults; 73% of adolescents used a condom at last higher-risk sex compared to 52% of 15 to 49-year-olds.This was also true for young men; 64% of 15-to-24-year-old men used a condom at last higher-risk sex compared to 74% of 15 to 19-year-olds.

A considerable proportion of **adolescents who inject drugs** engage in unsafe sex, doubling their risk of HIV infection. Over 80% have ever had sex (vaginal, oral, and/or anal). Among those reporting sex in the last 12 months, almost half had three or more sexual partners in the last three months.

Condom use is low and inconsistent: 22% of female and 35% of male adolescents who inject consistently used condoms with regular sex partners during the last year [330]. Specifically among girls who inject drugs and sell sex, 86% reported condom use at last sex, but only 33% reported consistent condom use with clients in the past month. With casual and regular partners, these girls reported lower condom use: 27% and 22% respectively [331].

Among **adolescent FSWs** in the last year, 99% reported vaginal sex, 94% oral sex and 62% anal sex. They had on average three commercial sex partners per day and 15 per week [332].

Condom use is inconsistent with clients, particularly among younger adolescent FSWs. Consistent condom use with clients in the last month was 52% (41% among those aged 13 to 17-year-olds and 57% among 18 to 19-year-olds). Younger FSWs reported more anal sex with clients (72% of 13 to 17-year-olds) than did their older counterparts (57% of 18 to 19-year-olds). Of the 62% of adolescent FSWs who reported having had anal sex with clients in the last year, only half consistently used condoms [333].

In addition, over half of adolescent FSWs had one or more regular and/or casual sex partners in the last week. Condom use is very low with regular partners; 25% reported consistent condom use with regular partners [334].

Among **adolescent MSM**, 66% have had insertive anal sex (active) in the past six months, and 65.5% reported having had receptive anal (passive) sex. Some 71% reported ever having had heterosexual sex; 53% in the last six months. Of these, 23% had more than three heterosexual sex partners. Among boys reporting MSM sex, the mean number of partners in the past year was 3.2 [335].

A survey of street-based adolescents in four cities found that 10% of boys reporting ever having anal sex with a male. There were differences by city; in Mykolaiv 12% of the male sample were MSM, compared to 10% in Kyiv, 9% in Dnipropetrovsk and 2% in Donetsk.

328 Ibid

329 Abdul-Quader, A. Konstantin Dumchev, Yuri Kruglov, George Rutherford, Tetyana Salyuk, Charles Vitek, Ukraine HIV Data Synthesis Project, Draft Final Report, September 13, 2012.

330 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

331 Ibid

332 Ibid

333 Ibid

334 Ibid

335 Busza, J.R., et al. Street-based adolescents at high risk of HIV in Ukraine, J Epidemiol Community Health 2011; 65: 1166-1170.

Half of the boys who had sex with men during the last year (52%) reported transactional sex, in other words, they received money, various goods, drugs, food or clothes in exchange for sex. Sometimes "*adults come and propose sex, then treat [me] with alcohol and food and provide money*", said a boy MSM, 15-years-old in Mykolayiv. Among street-based adolescents, evidence suggests that some or many of the boys engage in male-to-male sex as a way to survive on the streets rather than an expression of a homosexual identity [336].

Condom use was very low; 36% used condoms during their last sex with casual or regular partners, 39% used condoms during their last anal sex with clients, and 4% reported consistent condom use with clients in the last year. Boys reported that they use condoms if clients wish. Instead of condoms, *some "clients buy mineral water to clean the sex organs*", shared a boy MSM, 15-years-old in Donetsk [337].

Although differences by key population of adolescents are reported above, surveys to describe street-based adolescents as a group have been conducted and can reveal risks and vulnerabilities among this particular sub-group of MARA. Among **street-based adolescents**, nearly three-quarters were sexually active and 75% had casual sex partners in the last year, including 42.9% of the youngest age group. MARA have a range of different types of sexual partners, regular, casual or commercial. Regular and transaction partners were lower, but substantial; 37% had regular sex partners. Among those who were sexually active, boys had a mean number of 4.7 partners and girls 4.9 partners in the past year [338]. Over half (56.7%) of girls and some boys (16.5%) receive money, gifts or drugs in exchange for sex, and 7.4% of boys reported paying for sex.

Condom use is generally very low among these adolescents. In the past year, 12% reported using them consistently with regular sex partners in the last year; 15% used them consistently with casual partners and 10% used them consistently with commercial partners[339]. More girls reported consistent condom use with regular partners: 18% of girls and 9% of boys said that theyconsistently used condoms with regular partner during the last year. However, more boys used condoms consistently with casual and commercial partners: 16% of boys and 11% of girls consistently used condoms with casual partners while 15% of boys and 8% of girls consistently used condoms with commercial partners [340]. Differences in condom use with casual partners by city were uncovered; in Mykolayiv 91% of respondents had unprotected sex with casual partners compared to 88% in Kyiv, 87% in Donetsk, and 70% in Dnipropetrovsk.

Risk starts early for MARA; approximately half of adolescents who inject drugs, FSWs and MSM initiate risk behaviour before turning 15, an indicator of elevated social and biological vulnerability [341]. Half of the adolescents who inject drugs started before turning 15, and nearly half of adolescent FSWs reported having sex before the age of 15 and started to sell sex at the age of 16, on average. Among a sample of street-based adolescent FSWs, 60% started selling sex before the age of 15 [342]. Furthermore, among sexually active street-based adolescents, 76.1% experienced sexual debut before the age of 15. Among MSM, 74% of the respondents had had sex with a male before they turned 15.

Younger MARA are often at highest risk, particularly related to unprotected sex. Adolescent girls involved in commercial sex are less informed about risks and lack skills and ability to negotiate condom use with their clients. In addition to low levels of knowledge their sexual and physical immaturity puts them at heightened risk of HIV and STI.Younger adolescent FSWs between 13 to 17 years old used condoms less consistently with clients (41%) than those between 18 to 19 years old (57%). Younger FSWs also reported more anal sex with clients (72%) than older counterparts (57%) [343].

336 Ibid

337 Ibid

338 Ibid

339 Ibid

340 Ibid

341 Ibid

342 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko. Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

343 Ibid

Overlapping Risk Behaviors: Overlapping risk behavior is common among adolescents who inject drugs, FSWs and MSM. Nearly one in five (19%) adolescent FSWs also inject drugs. Some 3% of adolescent males who inject drugs and 25% of females reported having transactional sex. Few (1.4%) young MSM overall use injecting drugs.

The survey of street-based adolescents in four cities also revealed clear associations between risk behaviors, particularly selling sex and injecting drugs. Among female adolescents who inject drugs, 75.8% of girls and 22.8% of boys also reported exchanging sex for money, gifts, or drugs. Among girls who had exchanged sex, 18.4% also injected drugs. Additionally, 29.6% of the sample of adolescent MSM used injecting drugs [344].

Knowledge and Use of HIV Services: MARA have higher knowledge about HIV services than use services. Almost 80% of boys and girls who inject drugs could identify a HIV testing site, but only 14% had HIV tested in the past 12 months and know their results. Similarly, 71% of adolescent MSM could identify an HIV testing facility, but only 24% had tested for HIV and know their results. Also, while over 80% of adolescents who inject drugs know of a formal source of condoms, only 47% had obtained condoms in the last month.

Among street-based adolescents surveyed in four cities, only 13.3% could correctly identify ways of preventing sexual transmission of HIV and rejected major misconceptions, with significant differences between boys (11.7%) and girls (17.1%). Fewer than half knew that HIV could not be spread through mosquito bites (41.4%), or sharing crockery (37.4%). The majority of both boys and girls knew that using condoms at each sex act reduced HIV risk (63.5%), and that using clean injecting equipment did so (61.2%) [345]. Street-based adolescents who inject drugs had more knowledge, with 68.8% replying correctly that HIV could be prevented through the use of clean, unused needles and 75.2% by consistent condom use [346].

Mental Health: Qualitative research among children of labour migrants aged 12 to 17 indicatesthat quite a few of the adolescent boys and girls belonging to this population experience psychological problems.It indicates that some start engaging in risk behaviours because they receive insufficientcare and support from their temporary caregivers, educational institutions and/or social services.

Experience from other countries with MARA who lack parental care and who inject drugs and sell sex suggests that substance use initiation is often associated with being “acutely lonely” and seeking to fulfill “a need for affection and acceptance” [347].

Violence and Coercion: Data on violence and coercion among street-based adolescents show high levels among adolescent girls and MSM. Over half, 52.2% of street-based girls have ever been forced to have sex, among whom 70.9% had been forced in the past year. Nearly half, 49.0%, of adolescent MSM reported experiencing violence in the past year [348]. Among all boys, 11% have ever been forced and 7% in the last year.

Other Protection Needs: MARA face a wide range of vulnerabilities that directly and indirectly contribute to risk. Low education, migration and police harassment create access barriers to services. Inadequate family care, lack of support systems, age-related power dynamics, and social and sexual networks contribute to social vulnerability.

Research has documented these vulnerabilities among street-based adolescents in detail. The majority of street-based adolescents aged 18 to 19 (86%) had not completed basic education, although it is obligatory in Ukraine. Nearly half were internal migrants from other Ukrainian cities or regions to their places of current residence, and 58% of those over 16 years of age lacked passports, which include registration information. Healthcare providers often demand payment for health services from homeless children and youth.

344 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine. J Epidemiol Community Health 2011; 65: 1166-1170

345 Ibid

346 Ibid

347 Mastro T., et al., Youth and HIV: the intersection of homelessness, orphaned status, injection drug use and sexual risk, AIDS 2012, 26:111–113.

348 Ibid

"Without money and documents – noservices."– **Street-based adolescent.** [349]

Oppressive police street raids that "round up" MARA off of the streets create fear and distrust, and force them into temporary stay institutions continues, and these institutions may not offer the full spectrum of services [350]. In a study in four cities with 805 street-based adolescents, over 600 (75.5%) had been stopped or harassed by the police in the past, 328 of them over three times in the past year and 62 of them more than 21 times. Boys experienced police harassment and incarceration at substantially higher rates than girls.[351]

"They just take & beat us – all problems come from the police." "I do not know about any services. Why should I go? What if they will take me to the police station?'– **Street-based adolescent [352]**

Qualitative research shows that adolescents often live or spend time in groups within which risk behaviors are widespread [353].

The street environment places adolescents at risk of abuse, exploitation, violence and crime. The latter may lead to detention or incarceration where they face additional exposure to HIV risk [354]. Over half (57%) of MARA in a UNICEF study reported having stayed in shelters for minors. Detention centres and other penitentiary facilities put all adolescents who enter them at increased risk of HIV infection. Cases of severe rights violations (physical violence and sexual abuse) were reported for all institutions/facilities listed in the research. Physical violence and sexual abuse occurred in all the institutions and temporary facilities in which adolescents spent time.

Safe shelter was also highlighted a problem; more street-based adolescents reported living at home in Dnipropetrovsk (28%) and in Donetsk (24%) than in Kyiv where 29% reported living in a temporary dwelling unsuited for habitation, such as an abandoned building.

Gender Aspects: Girls are particularly vulnerable to HIV due to biologicalfactors combined with socially constructed gender roles and power dynamics. Adolescent girls, particularly those whoare exploited for sex and who live in the street, find numerous barriers to safer sex practices. Sex partners may not want to usecondoms consistently. Theremay be vulnerable to overlappingrisk behaviours (such as sex work and injectingdrug use). Thereis widespread violence and coercion, and they lack police protection. They also have limited access to adequatehealth care services [355]. Research shows that girls whose partners are using injecting drugs are exposed to a double burden of risk: HIV infection and of starting to inject drugs.

Pregnant adolescent FSW face increased risks of complicated pregnancies, maternal morbidity and mortality, as well as complications following safe and unsafe abortions. A UNICEF study of street-based adolescents found that 18% of girls living and working on the streets was pregnant. Most (55%) pregnancy cases were among 18to 19-year-olds. More than half (64%) of the pregnant girls were pregnant for the first time and while 23% were in their second pregnancies and13% had been pregnant three and more times [356].

Migration also affects girls more than boys; not living permanently at the current place of residence was associated with a fivefold increase in the odds of multiple partnership for young women but not for men.

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349 Olena Sakovych, UNICEF Country office Ukraine Olga Balakireva, Ukrainian Institute for Social Research. PowerPoint Presentation: "The Ukraine MARA programming experience", September 3, 2009, Geneva.

350 HIV Prevention among Most-at-Risk Adolescents: Implementation Results of the Targeted Models, UNICEF, Kyiv, 2011.

351 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine. J Epidemiol Community Health 2011; 65: 1166-1170.

352 Ibid

353 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko, Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

354 Ibid

355 Ibid

356 Ibid

Boys' HIV risk is also shaped by social and gender roles and expectations. Masculinity is often defined by a denial of weakness or vulnerability combined with emotional and physical control. These norms create environments that accept, and sometimes even encourage, violence and risk-taking, and discourage care-seeking. Among street-based MARA, more girls and women expressed concern about their health than boys and men [357].

Stigma and Discrimination: Stigma and discrimination toward MARA within the society, the penitentiary system and among health care providers, together with high levels of intolerance to those who fall beyond the socially accepted gender "norms", create important barriers to accessing needed preventive, treatment and support services.

UNICEF research has documented discrimination against street-based adolescents from health service providers.

> ***"I do not go to the hospital, they do not talk to the 'dirty'."***
> ***– Street-based adolescent [358]***

Legal and Policy Framework

MARA has been increasingly included in national policies and guidance. The National HIV/AIDS Programme 2009-2013 includes young people as a priority target group for prevention and sets a coverage target of 60% for "at risk groups" including MARA girls and boys who inject drugs, orphans, homeless children, children detailed or incarcerated, children from families in crisis, sex workers, MSM, migrants and other similar groups [359].

In June 2009, the MOH issued orders establishing interimstandards of medical care for adolescents and youth, including HCT and youth-friendly clinics, with HIV prevention as a major objective [360].

The revised HIV/AIDS Law in 2010 changed the regulations surrounding HIV testing for youth by allowing the testing of youth age 14 and above without the consent or presence of a parent or guardian, although providers remain confused about this change [361].

While this legislation shows progress, important gaps remain in social protection legislation.

- No clear minimum age exists for sexual consent.
- There is a limited and low-quality state services to protect and assist families.
- Workers in temporary institutions are often unaware of children's right to healthcare and routinely violate children's confidentiality.
- In temporary placement settings, caregivers are not legally authorized to provide medical care to children who are not officially "orphaned" or "deprived of parental care."
- The vulnerability of MARA living and working on the street is increased by several gaps in Ukraine's legal and regulatory framework, making it difficult to provide services to them. While national legislation defines the concept of a homeless child, it does not contain a definition of a "neglected child," nor does it regulate the rights of homeless and neglected children. There are no mechanisms in place to enable homeless and neglected children to exercise their rights. Althoughit is not a requirement to institutionalize children living on the street, these children are regularly "rounded up and put into a shelter by police services" [362].

357 HIV Prevention among Most-at-Risk Adolescents: Implementation Results of the Targeted Models, UNICEF, Kyiv, 2011.

358 Olena Sakovych, UNICEF country office Ukraine Olga Balakireva, Ukrainian Institute for Social Research. PowerPoint Presentation: "The Ukraine MARA programming experience", 3 September 2009, Geneva.

359 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

360 Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine, Washington, DC: Futures Group, Health Policy Project, 2011.

361 Ibid

362 Ibid

Once in those temporary shelters, service providers do not always provide a full spectrum of required services, and many children escape—not wanting to be returned to homes or institutional settings.

The dissolution of the Ministry of Family, Youth and Sports, the executive body administering social protection programs, creates uncertainty on the future ofthese programs [363].

There are also gaps in service guidelines that affect young people's access to HIV services and confidentiality.

- ART guidelines and regulations in temporary placement settings need to be revised. Many physicians are unable to provide services according to international standards until clinical guidelines are updated.
- HIV prevention education is offered in educational institutions, but there are no standardized protocols or authorities for training.
- Adolescents who inject drugs lack access to MAT before the age of 18 years.

In addition to remaining gaps in legislation and guidance, new regulations will potentially contribute to greater risk among adolescents who inject drugs. Lower threshold drug possession regulations may result in more children entering the juvenile justice system [364].

Country Response to HIV Among MARA

Access to HIV Prevention and Treatment Services

HIV prevention programs, including drug rehabilitation, for MARAs have low coverage, scope, and quality.

According to the program data of the HIV/AIDS Alliance, 26,830 MARA in the age between 10 and 18 years old were covered with basic HIV services. HIV testing among MARA is very low [365]. Among street-based adolescents, more girls than boys have tested, and used other HIV services.

Core interventions for MARA (UNICEF/ Ukraine) – delivered through outreach with referral to service providers trained to work with MARA:

- Information and counselling
- Condom programming
- Harm reduction
- Diagnosis, treatment and care for STIs
- Diagnosis, care and treatment for HIV

(a) Comprehensive Services

For street-based adolescents, however, UNICEF and ICF International AIDS Alliance have worked with Government agencies to create a comprehensive response and service package.

In collaboration with local government authorities and civil society organizations, UNICEF has supported several pilot models and documented thorough process and impact assessment (See Annex for details). These experiences and lessons provide detailed guidance for developing, implementing and assessing future programs for MARA, particularly street-based adolescents. All of the pilot model assessments found that MARA had not been reached prior to the pilots and staff and clients expressed high levels of satisfaction with the services.

***"I am not alone. I am more confident about my health now. I can openly discuss a lot of issues with the staff of the project and find ways out."* – Adolescent FSW**

UNICEF identified several factors that influence the success of the models. First was political support at the regional and city levels and advocacy activities that help to form the project and a MARA-friendly environment and to attract additional resources. They also learned that a multidisciplinary team and

363 Ibid

364 Ibid

365 Teltschik, A., et al., United Nations Children's Fund (UNICEF) and the Ukrainian Institute for Social Research after Olexander Yaremenko, Most-at-Risk Adolescents: the evidence base for strengthening the HIV response in Ukraine, 2008.

inter-sectoral coordination and referral systems are needed to deliver services and meet the needs of MARA. Finally, difficulties with gaining access to MARA groups require the involvement of adolescents themselves to disseminate information about the project and services and to recruit clients [366].

There is also extensive work on-going in Ukraine supported by ICF International AIDS Alliance together with 17 Ukrainian partner NGOs through the Global Fund for AIDS, TB and Malaria (GFATM). This initiative is scaling up a "social patrol" model to provide street-based adolescents with information, counseling, possibility of testing for HIV, STI, Hepatitis, medical, social, psychological and legal support, household services and food, and, above all, facilitate the adolescents" socialization and their "quitting" the street lifestyle. From July to December 2012, the Alliance and its partners provided prevention services and training on HIV prevention for 12,312 youths in all oblasts of Ukraine, 572 in the city of Kyiv and 1,220 in the city of Odesa, as well as for 182 workers of the services on children's affairs, centers for social services for family, children and youths, 77 workers of orphanage schools [367].

International organizations are also implementing services for street-based youth. HealthRight International (HRI) provides outreach services in Kyiv and Donetsk (reaching 1,315 youth in 2010-2011), drop-in centers in Donetsk and Kyiv (for girls) [368]. Services include psychosocial counseling, referrals, HIV counseling and testing, and STI testing. In 2009, HRI initiated an interactive training curriculum with 10 sessions called STEPS. It aims to reduce high-risk behaviors and increase knowledge of HIV transmission and risk among street-based youth. STEPS has been taught through outreach, drop-in centers and state shelters and detention centres [369].

(b) Condom Programming

Condom distribution to MARA has been a gap. The study of street-based adolescents in four cities found that theyobtained condoms from newsstands (35.2%), pharmacies, shops or petrol stations (31.9%) or friends (28.9%). Almost half (48.8%) of girls also get condoms from sexual partners, while only 29.7% of boys do so. Of the few MARA who received program services, more girls than boys accessed these services [370].

(c) Harm Reduction Programming

Access to harm reduction services for MARA is also an urgent gap. Only 8.9% of street-based adolescents who inject drugs surveyed in four cities had used a needle exchange programme in the past year, and only seven MARA reported contact with anoutreach worker. They reported obtaining needles where they inject (alleyways, stairwells, basements), from friends (68.8%), sexual partners (26.4%), from the street (18.4%) and theft (11.2%). Over half (55.2%) have purchased needles from pharmacies [371].

Conclusions

Risk of HIV among MARA is closely associated with injecting drug use, being the partner of a PWID, and commercial sex. These risk factors are themselves shaped by determinants of wider vulnerability, including orphanhood and homelessness [372], working or living on the street [373], unstable living arrangements, and poor access to health services [374].

366 HIV Prevention among Most-at-Risk Adolescents: Implementation Results of the Targeted Models, UNICEF, Kyiv, 2011.

367 Data received from the International HIV/AIDS Alliance in Ukraine, 2013.

368 Street Youth in Ukraine: Focus on Girls and HIV Prevention - Halyna Skipalska PowerPoint Presentation International AIDS Conference, Washington, DC, July 2012.

369 Ibid

370 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine, J Epidemiol Community Health, 2011; 65: 1166-1170.

371 Ibid

372 Ibid

373 Ibid

374 Pylypchuk, R., Marston, C. Factors associated with sexual risk behaviour among young people in Ukraine, Cent Eur J Public Health, 2008 Dec; 16(4):165-74.

Risk among MARA starts early, and particularly among street-based adolescents, new and young drug users and sex workers face higher risk and vulnerabilities than older counterparts. Lower knowledge, skills and confidence contribute to this situation, in addition to less program coverage and social and structural vulnerabilities.

The current prevention and harm reduction programs are insufficient to deal with the HIV infection risk. Outreach, comprehensive service packages and advocacy interventions show potential, but coverage remains far too low to have an impact on the epidemic among MARA. Efforts must continue and expand, likely be becoming more cost-effective, and become more responsive to gender issues and the social and sexual networks.

Among **weaknesses and gaps** of the country response to HIV among MARA, the following areas are the most urgent:

Size Estimates and Mapping: There are numerous descriptive studies of street-based adolescentsin Ukraine. These are the model for other countries in the region and around the world. However, there are few size estimates, data on MARA who are not on the streets, or evidence of program impact. If the focus on MARA (15-19 years of age), rather than on young key populations (15-24 years), continues in Ukraine, then accurate size estimates and mapping data, including both street and non-street-based MARA, are needed to target program interventions according to needs. This may be accomplished through inclusion of this age group in national and subnational surveillance studies and sample calculations.

Interventions that Address Families: The complexity of the situations for MARA requires a comprehensive response. For those who are most vulnerable, MARA who are orphaned and homeless, for example, it is necessary to strengthen alternative family-based care to avoid institutionalization [375]. For those with families, interventions to assessand provide tailored support to families would be an innovative option for long-term support to MARA.

Coverage of Non-Street-Based MARA: MARA in school and/or living at home may be at high risk of HIV infection (i.e., injecting drugs or partners of drug users). These young people may not be reached by adult programming and require greater understanding to develop effective and tailored interventions. Furthermore, primary prevention of drug use needs to be intensified during early adolescence.

Strengthened Harm Reduction and SRH Interventions for Street-Based Adolescents: The numbers of pregnancies found in a cross-sectional survey of street-based adolescents [376] suggests the need for greater reproductive health services, as well as opportunities to establish positive contact with MARA who may be more willing to seek services during pregnancy than other times. Peer led outreach could be considered as a cost-effective and efficient way to find and develop trust with the most vulnerable MARA, even before they are willing to attend the full range of services offered, as well as develop MARA leadership skills. This would also help reach sexual partners of MARA, a major gap in programming.

Evidence of Impact: Despite long-term and expanding programming for street-based MARA, and high quality quantitative and qualitative descriptive research studies, there is little evidence of program impact on risk reduction, harm reduction, or health outcomes such as STI prevalence, treatment seeking or HIV incidence. Specific impact by key populations of adolescents would inform national programming efforts.

375 Mastro, T., et al., Youth and HIV: the intersection of homelessness, orphaned status, injection drug use and sexual risk. AIDS 2012, 26:111–113.

376 Busza, J.R., et al., Street-based adolescents at high risk of HIV in Ukraine. J Epidemiol Community Health 2011; 65: 1166-1170.

2.6. People Living with HIV (PLHIV)

Epidemiological Situation

Size Estimates: From 1987 until 2012, 223,530 cases of HIV infection were officially registered, along with 56,373 cases of AIDS and 28,498 deaths from AIDS-related diseases. Estimates suggest higher numbers; 0.8% of the adult population, 230,000 people 15 years of age and older, are estimated to be living with HIV. Only half of this number is aware of their HIV status [377].

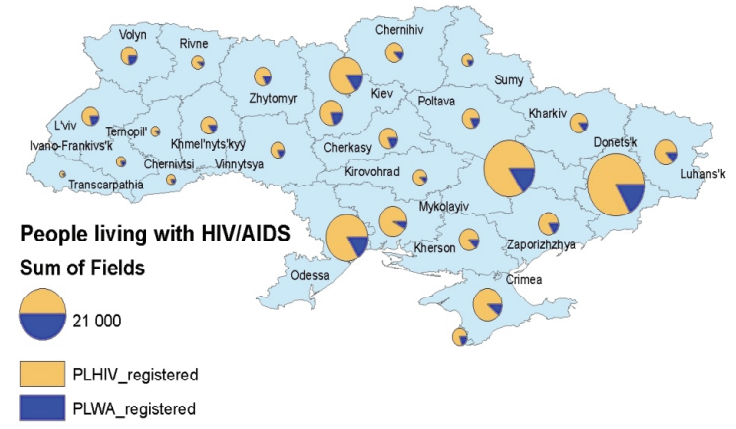

Figure 3. Size estimates for PLHIV/PLWA population by region, 2012

In 2011, 21,177 new cases of HIV were registered (46.2 per 100 thousand population), the highest annual number of cases since 1987. The number of new HIV cases registered in 2012 was lower than in 2011 and made up 20,743 cases. However, approximately 25% of people who needed treatment in 2012 received it or 26,720 people, including 2,268 children[378] .

STIs: There are no data on STIs among PLHIV.

TB: TB is the most widespread AIDS-related disease in Ukraine; in 2011 there were 5,745 cases (62.5%) out of 9,189 new AIDS cases. Service records show that 35.7% of estimated HIV-positive incident TB cases received treatment for TB and HIV in 2011 [379].

Hepatitis C Virus (HCV): There are no data of HCV among PLHIV in general, but among PWID living with HIV, 83.7% are also estimated to be co-infected with HCV [380].

Behaviors and Needs of PLHIV

Estimates of PLHIV suggest that many people either do not know that they are living with HIV or have not registered for treatment. Resulting low ART coverage affects potential risk of transmission through risky injecting behaviors and sexual practices.

Risky Injecting Behaviors

HIV positive PWID reported that they still share injecting equipment, with 11.6% sharing needles and 2.7% passing on the needle after injection to others [381]. A study of PWID in central Ukraine found that those who shared injecting equipment with HIV positive partners were 3.4 times more likely to be HIV positive than those who did not [382].

377 UNAIDS Country Office in Ukraine, Summary Report of the National Consultation on Building Sustainability and Strategic Investments into the National HIV Response in Ukraine, Kyiv, Ukraine December 3-4, 2012.

378 Ukrainian AIDS Centre, Ministry of Health of Ukraine, WHO, ICF International HIV/AIDS Alliance in Ukraine and UNAIDS, National HIV/AIDS Estimates in Ukraine as of beginning of 2012, April 2012, Kyiv.

379 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

380 Sergeeva, T. How many people with hepatitis C are living in Ukraine? (presentation), Presented at the Roundtable on Hepatitis C, September 5, 2009. http://hepatit.org.ua/2009/11/05/skolko-v-ukraine-bolnyih-gepatitom-s-otsenka-uchyonyih/

381 http://www.aidsalliance.org.ua/ru/library/our/2012/me/idu_en_2011.pdf.

382 Dumchev, KV, et al., HIV and hepatitis C virus infections among hanka injection drug users in central Ukraine: a cross-sectional survey, Harm Reduction Journal 2009, 6:23.

Adherence to Treatment

Qualitative research with PWID living with HIV in 2009 identified challenges to adherence. Barriers included harassment and discrimination by police, drug dependence, complexity of the drug regimen, side effects, forgetting, mental health problems, and HIV stigma [383].

Gender Aspects: Gender norms underlie the implications of HIV infection [384]. Although women in Ukraine have historically been driving many aspects of social and public spheres, gender norms limit their ability to control their sexual and substance use practices at home. Women also have a double-burden of working and taking care of the family and home, including care-giving of PLHIV [385].

Additionally, gender-based violence is far more likely to be experienced by women; the All-Ukrainian Network of PLWH has found that many women do not disclose their HIV status to their partner, being afraid of losing him or being fearful of violence" [386].

Women living with HIV who have a history of drug use had poorer outcomes and were almost 50% less likely to receive PMTCT than non-drug using HIV-positive women [387].

Stigma and Discrimination: PLHIV in Ukraine continue to face stigma and discrimination. PLHIV respondents in a 2008 study most commonly described segregation and isolation as the main type of stigma. Others described the dominant response as a lack of understanding of real needs and problems PLHIV face [388]. In 2011, 22% of PLHIV surveyed in 2011 reported rights violations within the last 12 months. One in four PLHIV respondents (25%) believed that they experienced barriers to social or health services due to their HIV status, especially medical care [389].

I was hospitalized into the orthopaedic department of Cherkasy regional hospital. There Isaid about my HIV + status to orthopedists, who opened abscesses on my knee. After this, all staff knew about my status. The next day... there were large red letters "HIV" on all appointment cards, even on a container for urine. And all those with me in the ward could read my diagnosis
(Life story, Cherkasy) [390].

The vast majority of PLHIV respondents described HIV-related internal stigma: 82% had experienced negative feelings regarding themselves (58% blamed themselves, 47% felt guilty, 38% had low self-esteem, 37% felt shame). Due to these feelings, 37% of respondents had chosen not to have children, 20% decided not to marry, 26% refused to attend a health clinic despite a need,and 19% have rejected hospitalization [391].

383 Mimiaga, M. J., et al., We fear the police, and the police fear us: Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine, AIDS Care, November, 2010. 22(11): 1305–1313.

384 Burruano, L., and Y.Kruglov, HIV/AIDS epidemic in Eastern Europe: recent developments in the Russian Federation and Ukraine among women, Gend Med. 2009 Apr;6(1):277-89.

385 All-Ukrainian Network of PLWH, Gender-Sensitive HIV/AIDS Services: Analytical Report Based on the Results of Research, 2011.

386 Ibid

387 Ibid

388 Kiev Institute of Sociology, Vulnerability Assessment of People Living With HIV (PLHIV) in Ukraine: Final Report, United Nations Development Programme (UNDP), Eastern Europe and the CIS project, 2008.

389 The All-Ukrainian Network of PLWH, with financial support of Global Network of Positive People (GNP +) The People Living with HIV Stigma Index, Kyiv, 2011. http://www.gnpplus.net/images/stories/Rights_and_stigma/Stigma_Index_Leaflet_final2.pdf.

390 Ibid

391 Ibid

Legal and Policy Framework

PLHIV are officially included in the policy process through representation on the National Council for HIV and TB.

A review of Ukrainian codes, laws, programs, and regulations found strong legal protections against discrimination toward PLHIV [392]. Like the 1991 HIV/AIDS Law, the 2010 HIV/AIDS Law (Law 2861) Article 14 guarantees equal rights to legal protection and prohibits discrimination against PLHIV and populations at "high risk of HIV." It also specifically prohibits rejection in admission to medical care facilities or denial of health and socialservices based on HIV status. Article 16 prohibits discrimination due to HIV status in employment, education, medical services, and social care and support [393]. Furthermore, Article 132 of the Criminal Code protects the confidentiality of PLHIV from improper disclosure of their HIV status by a medical worker. Finally, the 2012 Human Rights Anti-Discrimination Strategy of Ukraine ensures legal, medical, and social support to people who have experienced discrimination. The HIV/AIDS Law also guarantees inclusion of stigma reduction education in the curricula of secondary, vocational and technical, and higher education facilities.

However, components of the legal code remain stigmatizing, such as criminal liability for HIV transmission to a partner even with disclosure, statutes that legalize violence against PLHIV, named reporting, and requirements for disclosure of children's HIV status [394].

Country Response to Needs of PLHIV

Available details of the country response follow. Although coverage of treatment remains low, and there are remaining gaps in policy documents to protect rights of PLHIV, these are the most advanced interventions.

Care and Treatment

The National Strategy Program for PMTCT has achieved a significant reduction in the level of mother to child transmission of HIV. Cases of mother-to-child transmission decreased six fold since from 27.8% in 2001 to 4.2% in 2009 [395]. Percentage of infants born to HIV-positive mothers receiving antiretroviral (ARV) prophylaxis reached 99.1% in 2011.

Core interventions for PLHIV

- Antiretroviral Treatment (ART)
- Care and support
- Harm reduction
- Sexual and Reproductive Health
- Protection of human rights, including reduction of stigma and discrimination

ART has been made available in all 27 regions of Ukraine. Currently over 32,000 PLHIV receive treatment, a tremendous increase since 2004 when 1,300 people received treatment. However, coverage remains low; estimated needs met range from 13.4% by civil society organizations to 53% by Government data, constituting the lowest coverage in the world, and the main reason of the increasing AIDS-related deaths in Ukraine [396].

392 Judice, N., O. Zaglada, and R. Mbuya-Brown, HIV Policy Assessment: Ukraine. Washington, DC: Futures Group, Health Policy Project, 2011.

393 Boyko, A., K. Beardsley, and C. Wild, Designing an HIV Discrimination Monitoring, Reporting, and Referral System—International best practices and current policy, practice, and opportunities in Ukraine. Washington, DC: Futures Group, Health Policy Project, 2012.

394 Ibid

395 UNAIDS Country Office in Ukraine, Summary Report of the National Consultation on Building Sustainability and Strategic Investments into the National HIV Response in Ukraine, Kyiv, Ukraine December 3-4, 2012.

396 Ibid

Among key populations coverage is even lower. Only 8.3% of PWID living with HIV were on ART in 2012 [397]. Few PWID have successfully received preparation for ART and support for taking ART due to restricted availability of opioid substitutiontherapy and low adherence; only 7.3% of pregnant women who were injecting drug users and living with HIV received substitution therapy [398].

Of people who tested for HIV during bio-behavioral surveillance, 62.7% received treatment. Among people on treatment, 82.3 % adhered.

Care and support services are also limited in Ukraine. The All-Ukrainian Alliance of PLWH describes support services as nascent and still inadequate relative to needs. In particular, PLHIV have limited access to services, few confidential services and limited access to palliative care, pain relief and hospice care and in rural areas to confidential services. Care and support are often not available for hard to reach clients.

Sexual and Reproductive Health

A review conducted by the All-Ukrainian Network of PLWH of services for PLHIV found that information on health support and prevention and diagnosis of STIs were among the most popular services [399].

Gender Equality

The principle of equal rights for men and women is enshrined in the Constitution of Ukraine and other legislativedocuments [400]. However, the gender aspects of support to PLHIV are not specified; there is a lack of precise regulations which would govern the rights and opportunities of both women and men living with HIV.

Conclusions

Due to concerted efforts by civil society organizations, especially the All-Ukrainian Network of PLWH, and Government support, services for PLHIV are increasingly available.

- Access of PLHIV to healthcare services has considerably improved [401].
- While still limited, there is increasing availability of gender-sensitive services. Clients of these services gave very positive feedback [402].

Among **weaknesses and gaps** of the country response to PLHIV, the following areas are the most urgent:

- A national vision and plan for a specialized package of medical and social services for PLHIV is needed [403].
- Stigma continues to limit access to services especially among vulnerable groups, and in villages and towns [404].

397 Médecins Sans Frontières, Speed up scale-up: Strategies, tools and policies to get the best HIV treatment to more people, sooner, 2012. http://aids2012.msf.org/2012/speed-up-scale-up/ (Last accessed on August 19th, 2012).

398 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

399 The All-Ukrainian Network of PLWH, with financial support of Global Network of Positive People (GNP +,The People Living with HIV Stigma Index. Kyiv, 2011 http://www.gnpplus.net/images/stories/Rights_and_stigma/Stigma_Index_Leaflet_final2.pdf.

400 Ibid

401 Kiev Institute of Sociology, Vulnerability Assessment of People Living With HIV (PLHIV) in Ukraine: Final Report. United Nations Development Programme, Eastern Europe and the CIS project, 2008.

402 The All-Ukrainian Network of PLWH, with financial support of Global Network of Positive People (GNP +,The People Living with HIV Stigma Index, Kyiv, 2011. http://www.gnpplus.net/images/stories/Rights_and_stigma/Stigma_Index_Leaflet_final2.pdf.

403 Ibid

404 Ibid

- Greater ART enrollment for PWID who are living with HIV is urgently required. Additionally, pregnant women living with HIV who use drugs need greater access to gender-sensitive substitution therapy, rehabilitation and psychosocial support [405].
- "Hard-to-reach clients" also require greater access to care and support services and which support developing trust between clients and professionals [406].
- Integration of TB and HIV services is an evidence-based intervention to concurrently responding to HIV and TB problems, however this has not occurred yet [407].
- There is limited access to screening, diagnosis and treatment for STIs or hepatitis C.
- Local governments need to allocate adequate budget financing and to integrate and coordinate services in their localities [408].
- More effective support to ART adherence among PLHIV receiving treatment include education, training of health care providers, and identification cards to show police that medication is for treatment of HIV, not for abuse; and involving family members and other systems of support for HIV treatment [409].

405 Ministry of Health of Ukraine, Ukraine Harmonized AIDS Response Progress Report. Reporting period: January 2010 - December 2011, Kyiv, 2012.

406 Assessment of the Implementation of the National AIDS Programme Ukraine: Synthesis Report. UNAIDS Ukraine. Kyiv, 2012.

407 Ibid

408 Ibid

409 Mimiaga, M. J., et al., We fear the police, and the police fear us: Structural and individual barriers and facilitators to HIV medication adherence among injection drug users in Kiev, Ukraine, AIDS Care. November, 2010. 22(11): 1305–1313.

3. Conclusion and Recommendations

Conclusion

Ukraine's HIV response has demonstrated progress in recent years. Particular areas of strength include policies that guide a national response, mobilization of resources from Government, civil society and donor organizations leading to greater access to HIV services, and strengthened partnerships and platforms for collaboration between Government and civil society to decentralize and deliver services in the community. CSOs have created a strong system for delivery of preventive services to key populations that supplements the public health care system.

Nevertheless, the HIV epidemic continues. An estimated 0.8% of the adult population, 230,000 people, lives with HIV in Ukraine. About a half of PLHIV is not aware of their HIV status. In 2011, a record high of 21,177 new HIV cases were recorded, along with 9,189 AIDS cases and 3,736 AIDS related deaths. Increase in HIV-related mortality and morbidity becomes a serious problem in health sector, aggravated by losses in the continuum of care and late detection of HIV cases.

The main reasons for the limited impact of the national HIV response not producing the expected impact are the low coverage, inadequate scope and quality (including the inadequate evidence base), and high costs of programs. Progress is impeded by lack of policy support, health systems deficiencies, lack of data demand and use for decision making (including inefficient resource allocation and use), high levels of stigma and discrimination, and financing and human resource constraints.

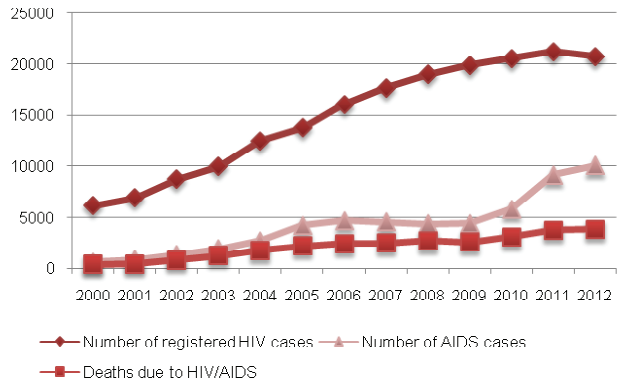

Figure 16. HIV/AIDS morbidity and mortality, 2000-2012

Over 50% of annual expenditures on the HIV response are from external sources, with annual increases in financial needs and gaps. The central state budget funds ART procurement and PMTCT, while local budgets support labor, facilities maintenance and PMTCT, ART and other treatment services. However, local budgets have almost no funding for focused prevention among key populations. Donors and civil society provide HIV prevention for key populations, as well as care and support services. Resources are spread thinly across interventions that are not always based on evidence.

This review of epidemiological data, behavioral and contextual data, and service delivery identified achievements and specific gaps that require emphasis in the next phase of the national HIV response.

Legal and Policy Framework

The state-defined priority directions for the HIV response include strengthening HIV prevention, provision of treatment, upholding human rights of PLHIV and encouraging the public's tolerant attitudes towards PLHIV. A relatively strong legal and regulatory framework is limited by notable gaps, as well as inadequate implementation and enforcement. Gaps include:

- A lack of attention to gender-based violence and the capacity to prevent and respond among public and CSO programs and services.
- Some key populations (i.e. MSM) and their sexual partners are not specified within the NAP or the 2010 HIV/AIDS Law, or prioritized for programs and services.

- Data are inadequate on adolescents and youth engaging in risk practices, and those living and working on the streets.
- Children living and working on the street and "neglected children" are not clearly defined in legal or regulatory frameworks, hindering service provision.
- Data on PWID are not officially recognized and thus cannot be officially used in planning and resource allocation.
- Recent changes to drug possession regulations threaten to reduce the impact of NSP.
- Centralized procurement policies and supply management systems are a barrier to high-quality, cost-effective HIV services. The high cost of ART is a major barrier for regions.
- HIV services are not integrated with TB or HCV. This leads to lack of data on service needs, gaps in service delivery and a loss of patients.
- Although reducing stigma and discrimination is a key priority, there is no specified strategy or plan for addressing this in the health care sector, with in-service or pre-service health workers.

Limitations to policy implementation include insufficient dissemination of policy documents, a lack of training on new standards and protocols, limited communication between providers and government and a lack of inter-sectoral coordination. Ministries differ in their interpretation of laws and policies related to key issues, and regulations and implementation vary considerably both between national and regional levels and across regions. Implementation is also hindered by variable regional and district funding for HIV programs and materials, resulting in disparities in service coverage and quality.

There are no enforcement mechanisms to prevent violations of the rights of key populations, including service delivery for key populations such as PWID. Moreover, although an HIV anti-discrimination law is in place in Ukraine, no regulations have been approved to implement the law and subject violators to penalties.

HIV Prevention

There is an urgent need to further expand access to effective HIV prevention services for key populations. Program monitoring data reveals that the coverage of prevention services based on the estimated number of PWID, FSW, MSM and prisoners remains low. Similarly, the most recent bio-behavioral surveillance data for each key population shows that coverage with the most basic prevention services (received condoms in the last 12 months and know where to get an HIV test) is low for PWID, FSW, and MSM, and well below the level needed to achieve impact. There are no equivalent data for MARA or PLHIV.[410]

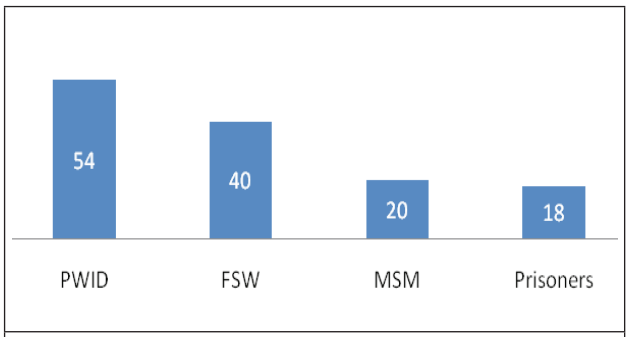

Figure 17. Coverage with basic prevention services in last 12 months, based on size estimates (%)

Source: *Ukraine Harmonized AIDS Response Progress Report, 2012*

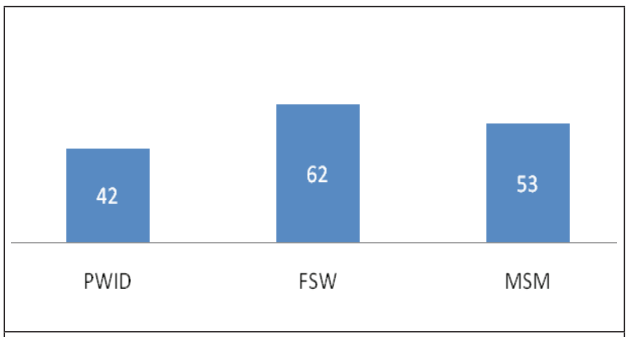

Figure 18. Coverage with basic prevention services in last 12 months, bio-behavioral surveillance findings (%)

Source: *Bio-behavioral surveillance: PWID (2011), FSW (2011), MSM (2011)*

[410] The Ukraine Harmonized AIDS Response Progress Report shows the coverage of prevention services based on the Alliance's program monitoring data and estimated number of each key population. Bio-behavioral surveillance counts the number of covered services as part of those who responded positively to two questions (Have you received in the last 12 months condoms? & Do you know where to address when you need to test for HIV?).

A standardized package of prevention services based on evidence of effectiveness is needed for each key population. While most core components of HIV prevention and treatment services are accessible to some people in some areas, there is a considerable variation in coverage across regions of the country, and complete service packages are not widely available. Notable gaps in services recognized to be important include STIs, TB and viral hepatitis screening and treatment and services for sexual partners of key populations. MAT is extremely limited.

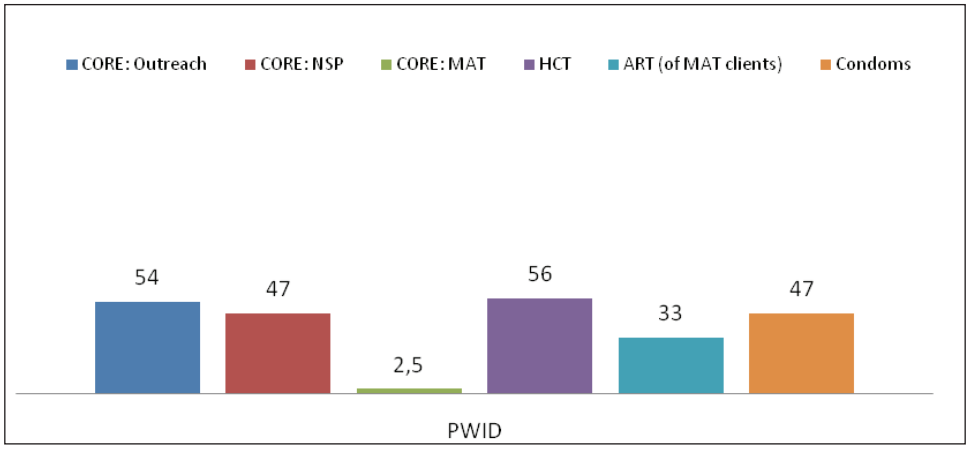

Figure 19. PWID covered with services (last 12 months) (%)

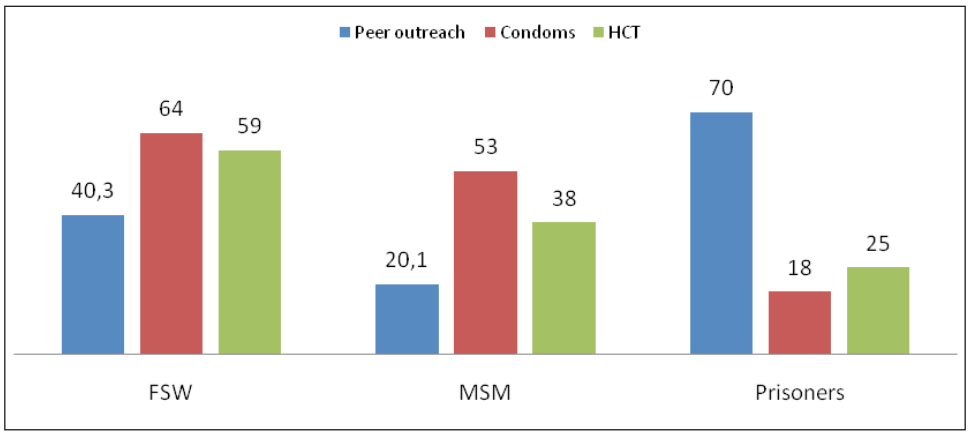

Figure 20. FSW, MSM and prisoners covered with core services (last 12 months) (%)

Complex legal, regulatory and political constraints make the provision and expansion of HIV prevention to key populations difficult.

There is also a lack of evidence about what interventions contribute to risk reduction, and how to effectively implement key interventions. For example, condom distribution to PWID has remained steady over the past years, but condom use has not increased. In 2011, approximately half of PWID used a condom at last sex.

The new wave of HIV infections is associated with risky sexual behavior of PWID and their sexual partners. There is no evidence of what works to reduce risk among sexual partners of PWID or standardized services being implemented.

Another gap in prevention is targeted HIV services to MSM. The design of programs and services is limited by a lack of data on HIV cases among MSM, currently greatly underestimated, although evidence suggests that MSM as a group are at high risk of HIV infection. Services, as well as the research to advocate for and design services, are constrained by widespread stigma and discrimination toward MSM. This puts MSM, and their sexual partners, at increased risk for HIV infection and limits the availability of appropriate HIV prevention, care and treatment services. Structural factors such as laws and policies that deny MSM protection further limit the availability and quality of HIV prevention services and medical care.

HIV Testing

Only half of people living with HIV are aware of their HIV status. HTC promotion and coverage of key populations are still insufficient to ensure early detection of HIV and timely initiation of treatment. Increased use of rapid HIV tests has enabled greater access to HCT, however, some clients who test positive do not receive confirmatory tests and do not register for care at AIDS Centers The existing network of cabinets for HIV testing ("Dovira" cabinets) is not extensively participating in HIV detection among key populations. Moreover, there are numerous barriers to linkage to treatment after testing positive. Insufficient integration of and linkages between HIV and health systems also contribute to late HIV diagnosis and late initiation of treatment.

HIV Care and Treatment

HIV treatment coverage is increasing through a national network of AIDS centres, but is still low compared to the need. In 2011, 26,000 people received ART and estimates suggest that only 25% of the estimated needs are currently met, constituting one of the lowest treatment coverage rates in the world. Of those that have tested through bio-behavioral surveillance, 62.7% are receiving care and treatment. Among people on treatment, 82.3% are alive and still on treatment after 12 months, a proxy measure of adherence to treatment.

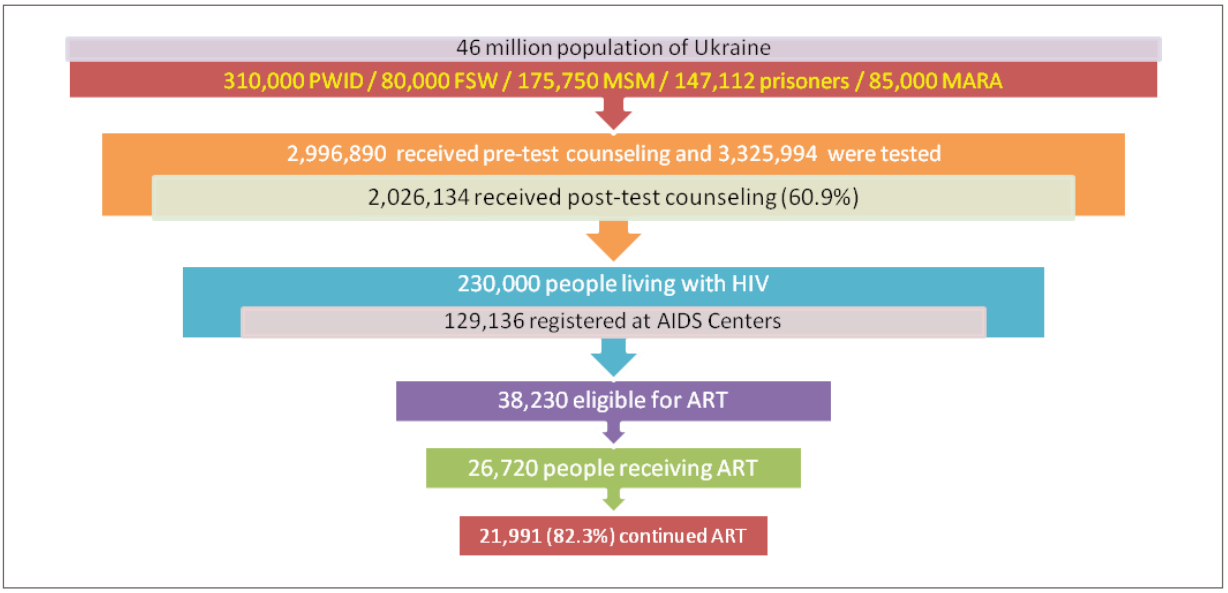

Figure 21. HIV Service cascade

Stigma and Discrimination

Stigma and discrimination has a direct impact on HIV-related morbidity and mortality. Key populations, including PLHIV, face stigmatizing attitudes in many aspects of their lives, most frequently related to self-stigma and from others in the education, employment and health sectors. Experiences of personal discrimination are most frequent in the health care; health workers are the only social group who demonstrate greater stigma than support towards PLHIV after learning that a person is living with HIV.

While laws are designed to protect key populations, including PLHIV, from discrimination, a lack of enforcement, promotion, or monitoring of these laws limits their overall effectiveness.

Recommendations

A standardized package of prevention services *based on evidence of effectiveness* is needed for each key population.

Evidence about what interventions contribute to risk reduction, and how to effectively implement key interventions needs to be systematically assessed and applied to develop the service package.

An integrated, client-centered continuum of care approach is recommended to provide services to key populations systematically from outreach and prevention to involvement in ART and care. The system of care must include prevention, diagnosis and treatment of STIs, access to MAT, timely initiation of, and retention on, ART, treatment of opportunistic infections and TB and hepatitis, and care for PLHIV.

This approach would link prevention to treatment services for all key populations. Prevention and social support services should be linked and directly contribute to the effectiveness of testing and treatment services by ensuring early HIV detection, early initiation of ARV treatment and high retention rates. All types of healthcare institutions and providers should be involved in ensuring continuum of HIV services from prevention to treatment and care. Health care providers and law enforcement officers would also benefit from education on quality of care to key populations, with incorporation of stigma, mental health and gender related issues, potentially including alcohol abuse and violence. These issues should be integrated into pre-service training curricula for health providers.

Address stigma towards key populations. Stigma and discrimination remains a major barrier to risk reduction and the use of prevention practices, HIV testing, and treatment. Laws designed to protect key populations from discrimination should be enforced, promoted and monitored. Additionally recommendations to address stigma also include generating useable data for advocacy, focusing on cases of discrimination rather than stigma, which is more appropriate for research, and responding to discrimination against all of the key populations, including PLHIV. Specific program actions should be begin with the health care and law enforcement sectors, due to the large scale of discrimination and the direct impact on HIV risk, morbidity and mortality.

Expand gender-sensitive services for women and men. Women from key populations have the dual burden of gender discrimination and the stigma associated with being part of a key population (PWID, FSW, prisoners, etc.). Gender-sensitive programs for female PWID are a best practice developed in Ukraine that require scale up and expansion geographically, and to other key populations, women in prisons, for example. Gender-sensitive services to support men would facilitate greater use of risk reduction and prevention services for themselves, and protect their drug use and sexual partners.

Gender-based violence is largely unaddressed, despite evidence of persistent violence against FSW. Prevention, reporting and access to post exposure prophylaxis for FSW and other women are urgently needed. Research on the level of violence experienced by partners of PWID is needed to design interventions, if needed.

Recommendations by Key Population

PWID

In Ukraine HIV remains concentrated in key populations, particularly PWID. Although HIV incidence is declining in PWID, the increasing rate of heterosexual transmission among women is largely linked to sexual partners of PWID.

While access to services for PWID has increased, it remains below the level expected. Additionally, outreach and education do not always focus on actual risks of injecting. Harm reduction outreach needs to be more specific to documented injecting risk behaviors, beyond promoting the use of a clean needles and syringes, which include front and back-loading of syringes, sharing drug cooking utensils, etc.

Medication-assisted treatment should be dramatically scaled up at the primary healthcare level and in institutions such as maternity wards, and integrated with TB, STIs, and viral hepatitis diagnosis and treatment, and ART. The expansion of prescription services should also continue to be explored.

Partnerships with the private sector such as pharmacies and more horizontally integrated continuum of care services offer opportunities to expand access.

Greater attention to the sexual risks of PWID and their sexual partners is needed, including services such as HIV counseling and testing for couples of PWID, and sexual partners of PWID as well as

prevention specific to PWID who sell or exchange sexual services, and their partners. Research is needed to identify how to reach and provide services to sexual partners in an effective way.

Increased ART access for PWID is needed, as well as integration of ART and MAT for PWID. Experience in Ukraine suggests that this integration would contribute to higher treatment adherence. The procedures for outpatient registration and initiation of ART and medication-assisted treatment are complicated and need to be simplified in order to provide greater coverage. Additionally, TB co-infection is a serious gap. Despite the guidelines that say that patients with HIV/TB co-infection should receive ART, coverage is very low.

FSW

Develop and implement evidence-based national standards and guidelines for FSW programs and provide tools and other resources to support implementation.

Evidence-based standards for the management of STIs among FSW also need to be developed and implemented. Regular screening, diagnosis and treatment of STIs are equally as important as periodical HIV testing. Some CSOs have demonstrated coverage of STI screening and treatment through service linkages with HCT, including static and mobile testing and treatment that visit locations where FSW work.

All services for FSW are primarily provided by NGOs. FSWs who are not covered by NGOs are not adequately covered by services. The basic package of services for FSW should be extended, and reach those who are NGO clients and those who are not yet clients.

New and young FSW, and male clients and sexual partners of FSW, need tailored services. Additionally the extremely high level of violence that FSW experience on a daily basis requires response, to support prevention as well as response, including PEP.

Due to the high HIV prevalence among FSW who use injecting drugs or have a history of drug use, more concerted efforts are needed to identify and provide services to these women, including MAT.

TB among FSW requires additional information to design services, recommended to be integrated with other health and HIV services.

MSM

Growing social stigma towards MSM is particularly damaging to strategic information and service delivery – access, use and quality.

Due to the scale of stigma toward MSM in Ukraine, efforts to reduce stigma and discrimination may need to start with health care services. Training of health professionals and outreach workers is recommended to increase their capacity for delivering high-quality prevention and health care services for MSM and their sex partners that are free from discrimination and ensure the confidentiality of all people who receive these services. Integration of psychosocial and social support services would bolster resilience, especially for younger MSM who may have questions and want support to use services. At the same time, more emphasis on reflection on sexual and gender norms and stereotypes would foster greater openness among the public, especially among young people in schools and through youth-centered media.

Research, if conducted in an appropriate way such as through peer researchers, would identify the most effective interventions for MSM within each epidemic context; support delivery of high-quality services to clients and evaluate innovative strategies to improve and strengthen comprehensive HIV prevention services for MSM and their sex partners. Research is also needed to identify segments that need tailored services, such as male sex workers.

Coverage of basic services could be expanded through local networks such as apartment parties, cruising areas, and social media (i.e., dating websites).

Health care providers need targeted training and supportive supervision to provide friendly, less stigmatizing services. Community centers with drop-in services and case management to link the MSM communities with a network of friendly health services are also recommended.

Prisoners

Despite recent progress in offering prevention commodities, education, and ART in the prison system, services remain at a level far below an adequate public health response to the HIV epidemic.

Greater coordination between ministries and systems is needed to avoid discontinuation of services, especially MAT and ART, when a person enters or leaves the penitentiary system. Moreover, more involvement and coordination between ministries is needed to develop sustainable services.

The full package of prevention services in prisons, including harm reduction and provision of condoms, needs to be scaled up and improved in scope and quality.

NSP and MAT are constrained by internal regulations; these need to be changed to respond to documented needs. Due to the high level of drug use among prisoners, MAT should be both expanded and integrated with TB, STIs, and viral hepatitis screening, diagnosis and treatment. HCT needs to be widely scaled up through rapid tests.

Peer involvement is recommended to effectively and discretely reach those who are at risk of HIV infection.

MARA

Evidence of the impact of programs and services on risk reduction, harm reduction, or health outcomes such as STI prevalence, treatment seeking or HIV incidence is lacking. Specific impact by key populations of adolescents would inform national and subnational programming.

Peer led outreach is a cost-effective and efficient way option to find and develop trust with MARA, both those on the streets and those who are not, even before they are willing to attend the full range of services offered, as well as develop MARA leadership skills. This would expand coverage of basic services and help reach sexual partners of MARA, a gap in programming.

MARA who are orphaned and homeless are the most at risk of HIV infection. More alternative family-based care services are needed to avoid institutionalization. For MARA with families, interventions to strengthen families would reduce risks for MARA and the next generation.

PLHIV

In order to increase early detection of HIV among the estimated half of PLHIV who do not know their HIV status, HCT through rapid testing should be expanded. Linkages between rapid testing sites with care and treatment need to be strengthened in order to reduce the number of PLHIV that do not register, or register late, for care and treatment. Protocols and practices for early treatment initiation would increase much-needed coverage of ART. Integration of and linkages between HIV and health systems should also be improved.

Data on continuation of ART over time suggest that adherence is low. Among PWID living with HIV, adherence would improve with greater integration of MAT. For PLHIV who do not use drugs, research on adherence would shed light on needs and options to design services.

Gender-sensitive services for PLHIV are well received, result in greater use of services, and should be scaled up.

In-service and pre-service medical providers should be ready to work with PLHIV. It is also necessary to place a high emphasis on mastering new knowledge related to HIV, including the treatment of opportunistic infections, as well as raising tolerance and clarifying legal requirements.

The Ministry of Health and the Center of Medical Statistics should set standards and systems for keeping HIV-related information confidential. This requires a statutory act to regulate the handling, storage, and dissemination of documents.

New technologies present opportunities to create a standard data collection and reporting platform that allows for both passive and active data collection and multiple points of access (e.g., via Web, phone, in person, by third party).

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ANNEX

Summary of Pilot Models for HIV Prevention Among MARA in Ukraine Within the Framework of the UNICEF Project "HIV Prevention in Most-at-Risk Adolescents in Ukraine and South Eastern Europe"

Pilot Model	Lead Partners	Location and Time	Services	Outcome or Impact Data	Lessons
Street HIV-prevention work with most-at-risk adolescents (MARA) according to the multidisciplinary team approach[1]	Kyiv Centre of Social Services for Family, Children and Youth, UNICEF	Kyiv *(2009)*	Outreach Trust rooms Referrals	Adolescents 14-19 years: 1) living and working on the streets; 2) having unprotected sex; 3) living with HIV/AIDS; 4) chemically dependent, and their sexual partners; 5) girl and boy CSW; 7) boy MSM; 8) from disadvantaged (crisis) families spending most of their time on the streets. 1,131 MARA received participant cards. 685 persons were tested for HIV (8+)	Showed the possibility of delivering servicesthrough multidisciplinary teams Showed the need for legal regulation of the support delivery process to HIV-positiveadolescents and adolescents in need of medical services in the absence of parents or guardians. Highlighted usefulness of 24/7 centres to meet basic (clothing, food, shelter, etc.).
Implementation of the model of "friendly" HIV-prevention interference through establishment of informal leaders in the environment of most-at-risk adolescents-injecting drug users' in the city of Donetsk[2]	Donetsk Oblast Centre of Social Services for Family, Children and Youth, UNICEF	Donetsk *(2009-2010)*	Outreach, "Respect" Counselling Centre, Referrals through partners	455 MARA reached Less than ¼ were repeat clients Very high level of staff and client satisfaction *"When I come here it seems that my inner personality wakes up. My self-esteem increases. I feel like a person here»* (girl, 18 years).	Expand work with MARA in Donetsk and other cities of the oblast. According to many girls, they agreed to join the model only after recommendations from a female outreach worker. Some boys also said it was easier to communicate with the female outreach worker. Evidence of need to strengthen referrals Clients wanted informational materials for adolescents, low threshold services, more convenient location of the center

1 HIV Prevention among Most-at-Risk Adolescents: Implementation Results of the Targeted Models. UNICEF, Kyiv, 2011

2 Ibid

Pilot Model	Lead Partners	Location and Time	Services	Outcome or Impact Data	Lessons
HIV/STI prevention, support service delivery, development and adjustment of work methodology on rehabilitation of underage girls-victims of violence, including sexual violence, or involved in commercial sex [3]	Faith. Hope. Love, UNICEF	Odesa *2009 (9months)*	Rehabilitation course	36 girls from 12-18 years who were abused or involved in sex work High staff satisfaction and some client satisfaction	MARA on the streets for several years are more difficult to find, build trust with, and they do not agree to be in (locked) shelters High demand for low threshold services (2 months of shelter, food)
HIV/STI prevention and development of social rehabilitation services for adolescents drug users in Odesa city [4]	Way Home, Odesa Narcological Dispensary, UNICEF	Odesa *2009*	Information and education; social and psychological support	152 adolescents aged 12 to 18 63 referred for treatment 56 completed medical, social, psychological rehabilitation Staff and in-patient clients gave very positive feedback	This model demonstrated the possibility of effective work taking place at the Department for Children at the Narcological Dispensary Recommendations included the addition of social workers and psychologists in social rehabilitation efforts
Adolescent Female Sex Workers in Ukraine: Targeted Intervention Model[5]	ICF Nikolaev Charitable Fund UNITUS, UNICEF	Mykolaiv city *2009*	• Outreach Community Centre with education and skills, information /BCC • Harm reduction • Medical component • Counseling • Social support • Materials (ie condoms) • Decrease in stigma, violence	117 Adolescent FSW High levels of client satisfaction; repeat clients 53 girls tested for HIV - found 4+ 45 girls tested for STIs - found 11+	Recruitment Successful at educational institutions, not street-based FSW (very few recruited) Most clients had mobile phones and liked telephone counseling, etc Build a strong network of multi-sectoral partners, because education, child-care organisations and police are recruiting points Extend services beyond health to economic and protection

3 Ibid
4 Ibid
5 Adolescent Female Sex Workers in Ukraine: Results of the Targeted Intervention Model: analytical report / UNICEF, Ukrainian Institute for Social Research after Olexander Yaremenko. K., 2010

Pilot Model	Lead Partners	Location and Time	Services	Outcome or Impact Data	Lessons
Ensuring Access of Adolescent FSW to Comprehensive Services: Results of Intervention Models Implementation in the Cities of Lviv and Simferopol within the Project "HIV Prevention among Most-at-Risk Adolescents" [6]	UNITUS, UNICEF	Lviv and Simferopol *2011 (9 months)*	• Medical and counselling • Community Centre with group thematic classes • Consultations of a social worker and a lawyer; referrals • Information materials • Consumables (ie, condoms) • Telephone counselling.	116 girls 10-19 years who experience sexual exploitation or are involved in commercial sex. 45% made repeat visits 62 girls tested for HIV, STIs, HCV High client satisfaction • Increase in consistent condom use with clients from 40 -44% • Increase in correct knowledge about HIV from 13% - 34% • Of 26 girls WID, clean needle use increased from 52% - 91% (significance unknown)	Funded through Round 10 grant of the Global Fund for "Street Children" to reach adolescent FSW Basic package of services should be concentrated "under one roof" as much as it is possible Case management requires more staff Involve adolescent girls in joint activities and events for personal development and socialization & involve MARA in volunteer work to help in accompanying clients to the specialists Organize mini-focus groups with clients to make service package and less generic

[6] Sereda, Y., Ensuring Access of Adolescent FSW to Comprehensive Services: Results of Intervention Models Implementation in the Cities of Lviv and Simferopol within the Project "HIV Prevention among Most-at-Risk Adolescents" / UNICEF, UISP after O. Yaremenko – Kyiv, 2012 - 99 p.

Pilot Model	Lead Partners	Location and Time	Services	Outcome or Impact Data	Lessons
HIV Prevention Among Adolescents who Use Psychoactive Substances [7]	Main Healthcare Administration of Dnipropetrovsk and Dnipropetrovsk Oblast Centre of Social Services for Family, Children and Youth, UNICEF	Dnipropetrovsk Oblast *2010-2011*	• Youth Friendly Clinic (YFC) • Skills, information • Harm reduction • Medical services • Counselling • Social support and referrals • Materials (condoms) • Reduction of stigma • Around-the-clock telephone consulting	272 adolescents and youth who use psychoactive substances (namely: alcohol, narcotic drugs, psychoactive substances); 30% made repeat visits High client satisfaction 40 clients tested for HIV	YFC offers MARA a safe place Integration of the YFC into an in-patient medical institution worked well A wide network of partners can offer comprehensive services, increase recruiting & provide a platform for development of regional policy.

7 UNICEF/Ukraine, Ukrainian Institute for Social Research after Olexander Yaremenko. Case Study (2011) HIV Prevention Among Adolescents who Use Psychoactive Substances: Results of the Intervention Model in the City of Dnipropetrovsk.